



**Medicaid Transformation
Accountable Communities of Health (ACH)
Project Plan Template**

*Revised
October 18, 2017*

Table of Contents

PROJECT PLAN TEMPLATE OVERVIEW 3

PROJECT PLAN SUBMISSION INSTRUCTIONS 4

SECTION I: ACH-LEVEL..... 5

 Regional Health Needs Inventory 5

 ACH Theory of Action and Alignment Strategy 6

 Governance 7

 Community and Stakeholder Engagement and Input..... 8

 Tribal Engagement and Collaboration 9

 Funds Allocation..... 9

 Required Health Systems and Community Capacity (Domain 1) Focus Areas for all ACHs 11

SECTION II: PROJECT-LEVEL 14

 Transformation Projects 14

 Project Selection & Expected Outcomes 14

 Implementation Approach and Timing 15

 Partnering Providers 15

 Regional Assets, Anticipated Challenges and Proposed Solutions 16

 Monitoring and Continuous Improvement 16

 Project Metrics and Reporting Requirements 17

 Relationships with Other Initiatives 17

 Project Sustainability 17

SUPPLEMENTARY MATERIALS CHECKLIST 18

PROJECT PLAN TEMPLATE OVERVIEW

Sub-Section	Response Format	Suggested Word Count
Regional Health Needs Inventory	Narrative	4,000 words
ACH Theory of Action and Alignment Strategy	Narrative	1,500 words
	Attachment: Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes	n/a
Governance	Narrative	1,000 words
	Attachment: Visual/chart of the governance structure	n/a
Community and Stakeholder Engagement and Input	Narrative	1,000 words
	Attachment(s): Evidence of how the ACH solicited robust public input into project selection and planning (more details in template below)	n/a
Tribal Engagement and Collaboration	Narrative	1,000 words
	Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region	n/a
Funds Allocation	Narrative	3,000 words
	Attestation	n/a
	Supplemental Data Workbook: Funds Distribution Tabs	n/a
Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs	Narrative	2,000 words
Project Selection & Expected Outcomes	Narrative	2,000 words

Sub-Section	Response Format	Suggested Word Count
Implementation Approach and Timing	Supplemental Data Workbook: Implementation Approach Tabs	n/a
Partnering Providers	Supplemental Data Workbook: Partnering Providers Tabs	n/a
	Narrative	500 words
Regional Assets, Anticipated Challenges and Proposed Solutions	Narrative	1,000 words
Monitoring and Continuous Improvement	Narrative	500 words
Project Metrics and Reporting Requirements	Attestation	n/a
Relationship with Other Initiatives	Attestation	n/a
Project Sustainability	Narrative	500 words

PROJECT PLAN SUBMISSION INSTRUCTIONS

Word Count. ACHs are strongly encouraged to be both responsive and concise. Suggested word count by sub-section are provided as guidance only and ACHs will not be penalized for responses that exceed the suggested word count.

Response Boxes. ACHs must clearly respond to questions in the Project Plan Template response boxes. Tables and graphs may be inserted into the narrative response boxes.

Attachments. If including additional attachments beyond those that are required or recommended, label and make reference to these attachments in the responses. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA reserves the right not to review attachments beyond those that are required or recommended. Suggested word counts do not pertain to attachments.

File Format. Each ACH will submit Project Plan applications to the Independent Assessor (IA) through a web-based document repository, the Washington Collaboration, Performance, and Analytics System (WA CPAS). The IA will provide a user guide with instructions for user registration and uploading of documents. Additionally, the IA will provide Help Desk support should users have questions.

Deadline. Submissions must be uploaded no later than 3:00 pm PT on November 16, 2017. Late submissions will not be accepted.

Questions. Questions regarding the Project Plan Template and application process should be directed to medicaidtransformation@hca.wa.gov.

SECTION I: ACH-LEVEL

ACH	SW Washington ACH
Name	Dawn Bonder
Phone Number	360-553-1845
E-mail	Dawn.bonder@southwestach.org

Regional Health Needs Inventory

Under the Demonstration, ACHs will use data to support project selection and design. As part of this data-driven planning effort, ACHs conduct an assessment to identify regional health needs, disparities in care, and significant gaps in care, health, and social outcomes. Data used in the regional health needs analysis may include data sources provided by the state and other public sources, as well as regional and local-level data sources, and existing reports or other assessments (e.g. community, hospital). It is expected that the regional health needs inventory will be conducted in collaboration with regional stakeholders, partners, and providers who have knowledge of local data and conditions.

Describe how the ACH has used data to inform its decision-making, from identifying the region's greatest health needs, to project selection and implementation planning. This section should serve as a summary description of how data were used. Additional data relevant to specific projects should be referenced in each project description and justification in Section II of the Project Plan Template.

Address the following:

- Describe how the ACH has used data to inform its project selection and planning.
- Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community Based Organizations (CBOs), etc.).
- Provide a high-level summary of the region's health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if/as appropriate. For each identified topic, cite the data sources and the processes/methods used:
 - Medicaid beneficiary population profile, including number of beneficiaries, geographic, demographic and socio-economic characteristics, and prevalence of adverse social determinants of health
 - Medicaid beneficiary population health status, including prevalence of chronic conditions, vital statistics, and other measures of health
 - Existing healthcare providers serving the Medicaid population (e.g., hospitals, federally qualified health centers, primary care providers, mental health and substance use disorder treatment providers) available across the care continuum in the community, and how these healthcare providers are currently serving the Medicaid population
 - Existing community-based resources available to the Medicaid beneficiary population (e.g., supportive housing, homeless services, legal services, financial assistance, education, nutritional assistance, transportation, translation services, community safety, and job training or other employment services), and how those community-based organizations are currently serving the Medicaid population

- Medicaid beneficiary population’s level of access or connection to care, and their greatest barriers to accessing needed health care and supportive services
- Outline any identified capacity or access gaps between the Medicaid population’s identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs.

ACH Response

Describe how the ACH has used data to inform its project selection and planning.

As part of project selection and design, the Southwest Accountable Community of Health (SWACH) is using data to:

- Identify health care and community needs, gaps, and potential disparities
- Explore populations in order to inform the theory of action and understand project impact
- Identify partnering providers and organizations and engage stakeholders

SWACH began by reviewing community health needs assessments (county, regional, and hospital) to understand areas of high regional need, with a focus on community input (e.g., surveys, listening sessions). These existing assessments provided a solid foundation for understanding the community and potential avenues for ACH projects, as well as context for administrative data.

In May 2017, SWACH established the Data and Learning Team (DLT) as part of its governance structure; the DLT supports data-driven decision-making by reviewing and interpreting available information, identifying data gaps and needs, and making recommendations to the RHIP Council and SWACH leadership (see SWACH-Appx-1-DLT-Materials-20171116.pdf for the DLT charter, current roster, and October meeting materials).

DLT members have the ability to go back to their own organizations or partners to further explore data, or bring data forward to supplement the discussion. For example, MCO DLT members have been most helpful in providing learnings from internal analyses around high-risk pregnancy, opioids, and utilization.

SWACH’s process for using data has been iterative. For example, RHIP Council members provided suggestions for potential populations or data to explore. Staff compiled available information for DLT discussion and internal planning. At that point, concepts may be refined at the DLT, partners may explore their own organizational data to inform the discussion, additional questions might be asked, etc., and then the refined concept or recommendation presented to the RHIP Council.

As part of this process, the DLT and the RHIP Council have adopted data-informed criteria as part of the project selection and decision-making process (table below). While not every decision must meet all of these criteria, they provide a helpful framework to guide discussion and recommendations.

Criteria	Key Questions
Need	<ul style="list-style-type: none"> ● Does the priority population disproportionately experience poor health outcomes? ● Are there subgroups that experience disparities? ● Is there a gap in existing services to effectively address these outcomes?
Impact	<ul style="list-style-type: none"> ● Is there a strong potential for the project / strategy to improve outcomes for the priority population in 2-3 years?

	<ul style="list-style-type: none"> Is the priority population large enough for improvements to drive community-wide outcomes?
Feasibility	<ul style="list-style-type: none"> What data currently exist to explore the priority population, track outcomes, and evaluate impact?

One example of how SWACH has used data to guide initial planning is by reviewing publicly available and HCA-provided data products to identify high volume providers and potential partner organizations who serve significant numbers of Medicaid beneficiaries (see SWACH-Appx-2-Providers-20171116.pdf). This helps guide the universe of partners who could be involved in which projects, and it ensures that SWACH is not missing anyone for inclusion in workgroups or other project planning.

To inform project selection, SWACH reviewed available data to understand current regional performance on the Pay For Performance (P4P) measures and which measures fell into which project areas. This review, coupled with a more detailed look at measure denominator populations, helped inform SWACH strategies for project selection. It also helped staff and workgroups find alignment between the selected projects and develop an interconnected project framework in which no one project is disconnected from the overall transformation design.

Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community Based Organizations (CBOs), etc.).

SWACH has used a variety of data sources to identify regional health needs and to inform project selection and planning. These sources range from publicly available reports and dashboards (e.g., Healthier Washington Data Dashboard, Community Checkup, Healthy Youth Survey fact sheets) to data HCA released specifically for ACH planning purposes (e.g., RHNI “starter set” data files, provider reports, measure decomposition files, see SWACH-Appx-3-Data-Sources-20171116.pdf for additional detail on data sources SWACH utilized.)

Local partners also provided data to support planning, primarily in response to specific questions. Some examples include:

- Clark and Skamania County Sheriff’s Offices shared jail booking and release data
- Council for the Homeless provided information on housing hotline call volume and disposition, and point-in-time homelessness counts
- MCOs shared information on high risk pregnancy and NICU utilization
- Klickitat Father’s House Fellowship Peer Support Services shared their opiate usage survey

Clark County Public Health has been a key partner in accessing and providing additional analysis on public health data sets including Behavioral Risk Factor Surveillance System (BRFSS) and vital records. Clark County Public Health was also able to access and analyze Klickitat and Skamania county data on behalf of the region. These data were particularly helpful for shaping the chronic disease project and exploring pregnant women and prenatal care initiation to inform the target population for care coordination. Clark County Syringe Program also shared data on Naloxone distribution and reported overdose reversals.

SWACH also had conversations with potential partners around data capacity – understanding what is being collected, or key indicators, and understanding how easy it might be to report out (e.g., conversations with Clark County Fire and Rescuer highlighted the National Emergency Medical Services Information System (NEMSIS) data). Understanding local data capacity will be critical in supporting implementation and ongoing monitoring efforts throughout the MTP period.

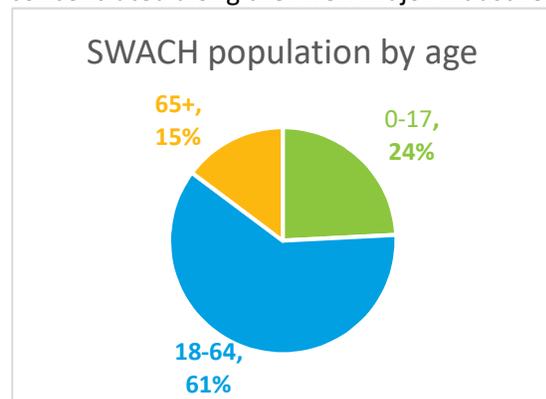
In addition to these state or local data sources, SWACH occasionally turned to national reports or published research for findings that could be applied locally, or could provide context to more region-specific data. For example, MACPAC and CHCS both have reports on co-occurring behavioral health and physical health conditions that were utilized for workgroup discussion prior to HCA releasing the Category 1 Behavioral Health and Chronic Conditions data file. And finally, staff were actively involved in community meetings and individual conversations with partners, providers, and community members, including the community listening session and key informant interviews for rural feedback. Project planning is ongoing. As SWACH moves into conducting a current state assessment and implementation planning, these structures and data sources will be revisited and refined, and supplemented with stakeholder and community feedback.

Provide a high-level summary of the region’s health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if / as appropriate. For each identified topic, cite the data sources and the process methods used.

About the Region

The SWACH region covers an estimated 504,350 people (6.9% of Washington’s population), spanning 4,200 square miles across three diverse counties: Clark (urban), Klickitat (rural), and Skamania (frontier).¹

All three counties border the Columbia River and Oregon, and significant portions of Klickitat and Skamania counties are parts of the Gifford Pinchot National Forest, resulting in smaller populations concentrated along the river. Major industries



include healthcare and the public sector (local government, public education, social services) in Clark County, the public sector and tourism in Skamania, and agriculture and tourism in Klickitat.² The population is less racially and ethnically diverse than the statewide population: more than 90% of residents in Klickitat and Skamania are white. Klickitat has a slightly higher percentage of American Indian / Alaska Native residents than the state population, and Clark has slightly higher percentage of Native Hawaiian / Pacific Islanders. A quarter of the population is under age 18.³

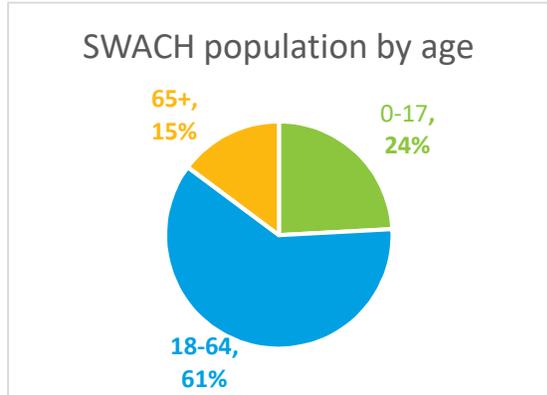
Median household income for the region is at or below the statewide average (\$64k), ranging from \$64k in Clark to \$50k in Klickitat. Almost a quarter of children in Klickitat County are living in poverty

¹ Office of Financial Management, April 2017 population estimates <https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/april-1-official-population-estimates>

² Washington State Employment Security Department, Oct 2016 County Profiles. <https://esd.wa.gov/labormarketinfo/county-profiles>

³ Office of Financial Management, 2015 Population Report. Accessed via HCA “starter set” data files. 24% of the population is aged 0-17, 61% aged 18-64, and 15% 65+.

(24%), compared to 15% of children in Clark, and 16% statewide. Unemployment is also higher in Skamania (5.7%) and Klickitat (5.8%) than in Clark (5%), or compared to the state average (5%).⁴ Urban communities within the SWACH region are adjusting to the economic consequences of a



growing economy and gentrification, including shortages in affordable housing and resultant homelessness. According to census data, almost 40 percent of Clark County residents spend at least 30% of their income on housing (compared to 33% in Klickitat, and 28% in Skamania), and the 2015 Washington State Housing Needs Assessment found that there were only 16 affordable (<30% of income) and available housing units per 100 households in Clark County (compared to 18 per 100 in Skamania and Klickitat, and 28 per 100 statewide).⁵

In 2015, 3.6% of SWACH Medicaid members were homeless at least one month during the year, and data from the Council for the Homeless' housing hotline indicate an uptick in the first part of 2017 (compared to the first part of 2016) of individuals who are being discharged from the hospital or jail/prison to the streets.⁶

Access to food is also a known challenge for SWACH residents. The 2016 Healthy Columbia Willamette Community Health Needs Assessment identified this as one of the important needs for Clark County in particular, along with not eating enough healthy foods; the 2016 PeaceHealth Community Health Needs Assessment also identified food insecurity among children as a major concern for Clark County.⁷ The 2016 Gorge Wide Food Survey found that 1 in 5 individuals ran out of food and 1 in 3 were worried about running out.⁸ More than a third of students across the region are eligible for free or reduced price lunch, and more than 20 people per 100 receive food stamps (SNAP).⁹

The SWACH region has a higher 5-year graduation rate than the state (84-86%, compared to 82%), and fewer than 5 percent of students drop out without completing high school. However, chronic absenteeism is a known problem that local school districts and community partners are working to address.¹⁰ In addition, a majority of kindergarteners entering school in the region are not ready in at

⁴ Income and employment data from the 2017 Robert Wood Johnson Foundation County Health Rankings and the Washington State Employment Security Department (May 2017), accessed online at <http://www.countyhealthrankings.org/app/washington/2017/overview> and <https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/local-unemployment-statistics>

⁵ Housing data from the Washington Tracking Network and the Washington State Department of Commerce. <http://www.commerce.wa.gov/housing-needs-assessment/>

⁶ Percent homeless data for CY 2015, from RDA Measure Decomposition files, provided by HCA July 2017. Council for the Homeless housing hotline information provided via email exchange with Kate Budd, Council for the Homeless, Oct 24, 2017.

⁷ <http://www.q-corp.org/sites/qcorp/files/HWCWC%202016%20Community%20Health%20Needs%20Assessment.pdf> and https://www.peacehealth.org/sites/default/files/sw_chna_11.14.16_final_2-with_appendix.pdf

⁸ 2016 Columbia Gorge Regional Community Health Assessment. <http://cghealthcouncil.org/wp-content/uploads/2017/03/Columbia-Gorge-Community-Health-Assessment-Full-Documents-December-2016.pdf>

⁹ SNAP and free or reduced price lunch data from DSHS County Risk Profiles <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>

¹⁰ Education data from the Office of the Superintendent for Public Instruction and DSHS County Risk and Protection Profiles *ACH Project Plan Template (October 16, 2017)*

least one of six domains. These kindergarten deficits are difficult to make up and can lead to lower levels of high school completion and vulnerabilities later in life.¹¹

SWACH residents have lower arrest rates (for both adolescents and adults) than the statewide average; however, both Clark and Klickitat counties have higher rates of adult prisoners in the state correctional system than the state average¹².

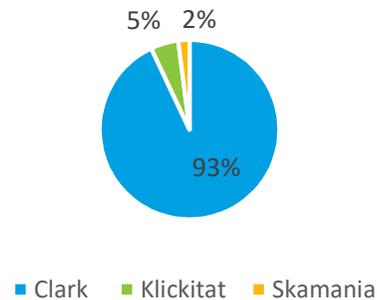
Medicaid Beneficiary Population Profile

As of September 2017, SWACH serves approximately 133,000 Medicaid beneficiaries, accounting for 7% of statewide enrollment. Twenty-seven percent of Clark County residents rely on Medicaid for their health insurance, similar to the statewide average (26%), and ranging from 21% in Skamania to 32% in Klickitat. The majority of SWACH’s Medicaid population resides in Clark County.¹³

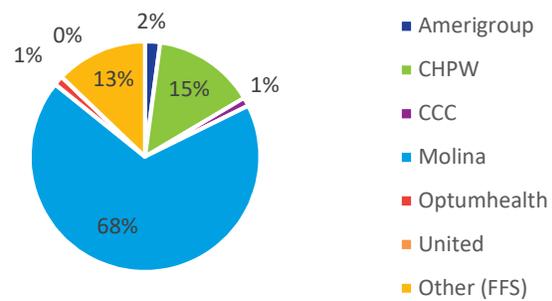
The majority of SWACH’s Medicaid population (87%) is enrolled in managed care organizations, primarily Molina Healthcare (68%), followed by Community Health Plan of Washington.¹⁴

SWACH’s Medicaid population is predominantly white (70%), non-Hispanic (65%) and English-speaking (89%), and is generally less diverse than the statewide Medicaid population. Skamania and Klickitat Counties are slightly less racially diverse than Clark County. SWACH’s Medicaid population is slightly more female (53%) and slightly younger (48% of covered lives are < age 19).¹⁵

SWACH Medicaid beneficiaries by county



SWACH Medicaid enrollment by plan



<https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state> and <http://www.k12.wa.us/DataAdmin/Dropout-Grad.aspx>. Focus on attendance shared by local school districts, e.g., <http://vansd.org/attendance-matters/>, <http://vansd.org/student-welfare-attendance/attendance/>, Evergreen School District Foundation’s Attendance Awareness Month, etc.

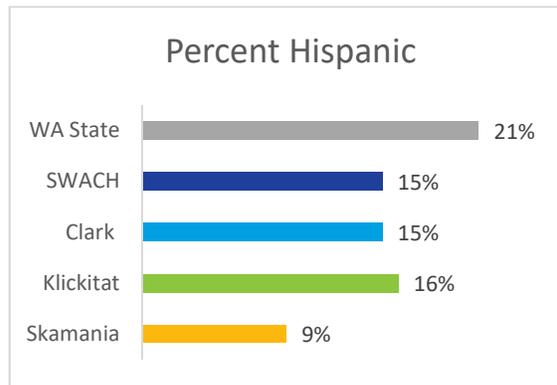
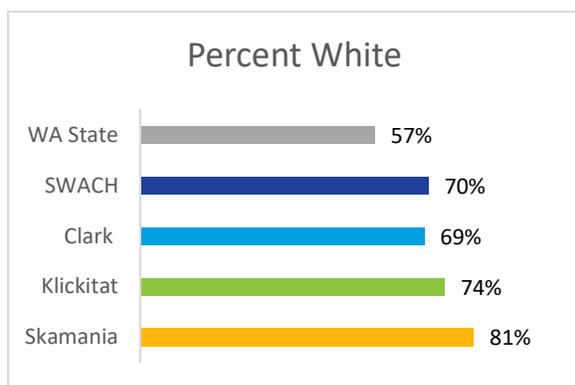
¹¹ Only 36.6% of students in Evergreen School District, and 31.8% in Vancouver School District are ready for kindergarten, compared to 47.4% statewide. Kindergarten readiness drops to 16.9% in Goldendale District. Oct 2016 data, from Office of Superintendent of Public Instruction. Online at <http://www.k12.wa.us/DataAdmin/PerformanceIndicators/Kindergarten.aspx>.

¹² Arrest data from the DSHS County Risk Profiles <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>; additional context provided by Clark and Klickitat county sheriffs’ offices.

¹³ Medicaid enrollment data from Apple Health enrollment reports, September 5, 2017. Available online at <https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports#apple-health-enrollment-reports> and [Healthier Washington Data Dashboard. https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard](https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard)

¹⁴ Medicaid enrollment data from Apple Health enrollment reports, September 5, 2017. Available online at <https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports#apple-health-enrollment-reports>

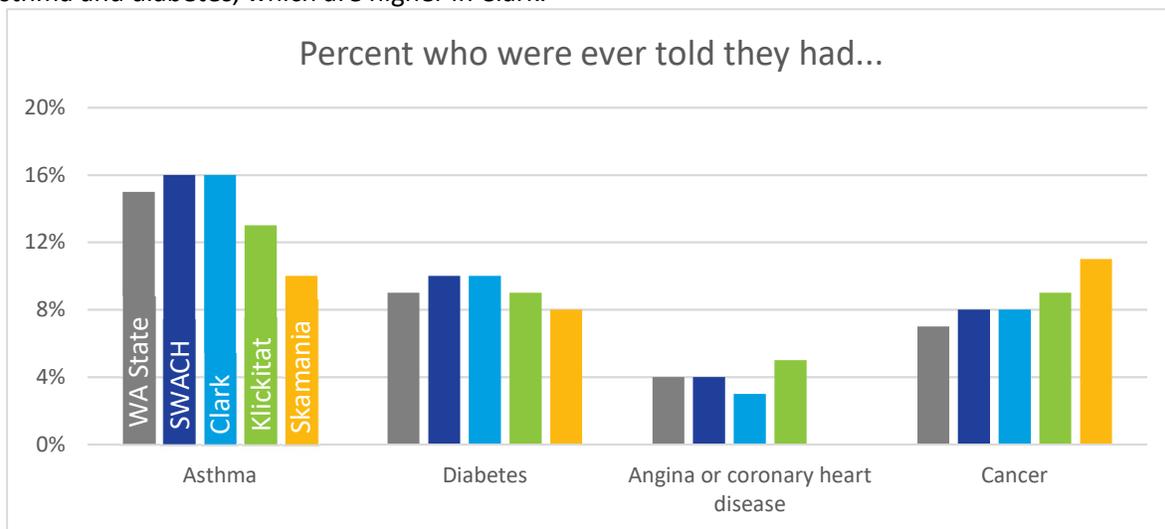
¹⁵ Medicaid demographic data from Healthier Washington Data Dashboard, Oct 1, 2015 – Sept 30, 2016. Available online at <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>



Medicaid Beneficiary Population Health Status

Prevalence of Chronic Conditions

SWACH’s general population has similar, or just slightly higher rates of physical health / chronic conditions than statewide, although there is underlying county variation (see table below). In general, rates of chronic conditions are higher in Klickitat and Skamania than in Clark, with the exception of asthma and diabetes, which are higher in Clark.¹⁶



Angina data for Skamania suppressed due to small numbers.

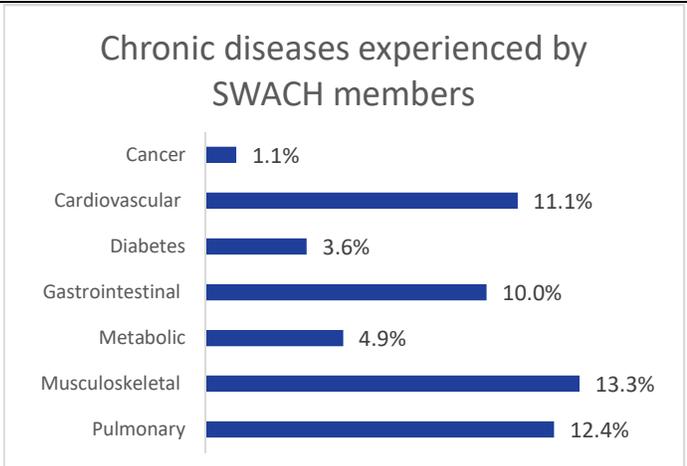
Looking more specifically at the Medicaid population, the prevalence of asthma, diabetes, and depression (based on diagnostic coding) is slightly lower in SWACH members than statewide, with some potential disparities suggested (e.g., American Indian / Alaska Native and Vietnamese-speaking members have the highest rates of diabetes, women have higher rates of depression, etc.).¹⁷

¹⁶ 2014-2016 Behavioral Risk Factor Surveillance System survey data, provided by Clark County Public Health on behalf of Clark, Klickitat, and Skamania Counties, October 4, 2017.

¹⁷ Diagnosis rate data from the Healthier Washington Data Dashboard, July 2015 – June 2016. Similar patterns hold for the updated measurement period, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

Additional data provided by HCA indicate that cardiovascular diseases, gastrointestinal diseases, pulmonary diseases, and metabolic diseases are some of the most frequent chronic conditions experienced by SWACH members.¹⁸

Measures of disease management indicate that SWACH Medicaid members experience similar quality of care to the statewide Medicaid population. SWACH is the highest performing ACH on measures such as antidepressant medication management and medication management for people with asthma, but falls slightly below the state average on measures such as the comprehensive diabetes care composite.¹⁹



Regional performance does mask some underlying geographic variation: for example, Klickitat’s rate for antidepressant medication management (acute) is 47%, compared to 56% in Clark, and 55% for SWACH; Klickitat’s rate for comprehensive diabetes care: eye exams is 8%, compared to 37% in Clark, and 35% for SWACH. Regional performance may also mask potential racial and ethnic disparities: American Indian / Alaska Native and Spanish-speaking members have lower rates of eye exams; multiracial members have the lowest rates of HbA1c testing; Black members have lower rates of antidepressant medication management (acute), etc.²⁰

¹⁸ Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data based on CDSP diagnostic grouping, through June 2016.

¹⁹ Quality measure data from the Healthier Washington Data Dashboard, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

²⁰ Quality measure data from the Healthier Washington Data Dashboard, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

Prevalence of Behavioral Health Conditions

According to ACH profiles provided by DSHS, approximately 25% of the SWACH population that is jointly served by HCA-DSHS were diagnosed with a mental illness in the last 24 months, with depression and anxiety disorders being the most prevalent. 18% of the population were diagnosed with a serious mental illness, and just under 10% had at least one indicator of substance use disorder treatment need (6.7% have co-occurring mental health and substance use disorder diagnoses, compared to 7.7% statewide).²¹

Additional data provided by HCA confirm that just under 10% had at least one indicator of substance use disorder treatment need. The data also provide additional insight into co-occurring

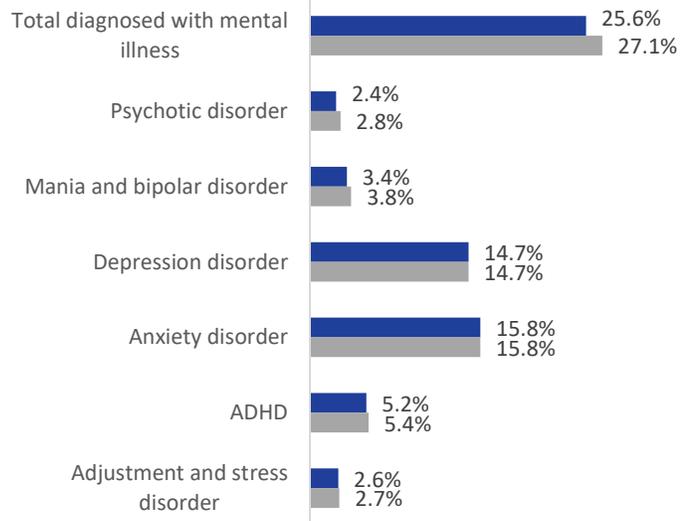
conditions: approximately 5.7% of SWACH Medicaid members have co-occurring mental health AND substance use disorder treatment need and approximately 4.5% have co-occurring mental health AND substance use disorder treatment need AND one or more chronic condition.²²

Despite nearly a quarter of the population having some mental health diagnosis in the past 24 months, SWACH’s treatment penetration rates are low (and have been declining over the past three years).

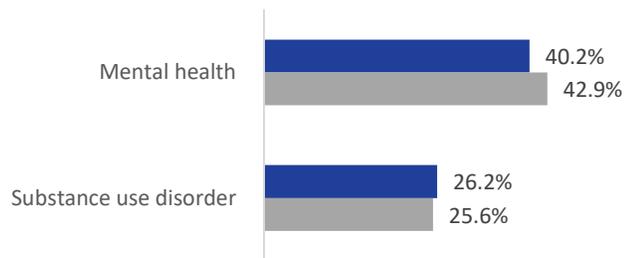
SWACH is the lowest performing ACH for mental health treatment penetration.²³

SWACH also has low rates for Medication Assisted Therapy for individuals with opioid use disorder: only 8% access MAT with buprenorphine, and 11% MAT with methadone.²⁴

Percent of Medicaid members diagnosed with a mental illness for SWACH and WA State



Treatment penetration rates for SWACH and WA State



²¹ DSHS RDA ACH Profiles for Southwest WA, FY 2016. Available online at <https://www.hca.wa.gov/assets/program/SW-wa-future.xlsx>

²² Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data through June 2016.

²³ Penetration rate data from DSHS 1519 reporting available online, <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0> as well as historical measure performance data provided by HCA on September 7, 2017.

²⁴ RHNI “starter kit” data provided by HCA, April 25, 2017. *ACH Project Plan Template (October 16, 2017)*

There are approximately 14,000 Medicaid opioid users in the SWACH region. The majority (87%) do not have a cancer diagnosis, and are non-Hispanic, white members (76%). 20% are considered heavy opioid users, and 18% chronic users.²⁵

Health Behaviors

Population health data indicate that risky health behaviors, particularly tobacco use, are common across the SWACH region. The 2016 Healthy Columbia Willamette CHNA identified cigarette smoking, alcohol, and marijuana use as specific issues for teenagers, as well as cigarette smoking among pregnant women.²⁶ Maternal smoking during pregnancy in both the general population and Medicaid is higher across the SWACH region than statewide, and highest for Medicaid in Klickitat and Clark (17.4% and 16.9% respectively).²⁷

Adult current smoking rates range from 17% in Clark to 25% in Klickitat, compared to 15.6% statewide, and the rates of 10th and 12th graders who smoked cigarettes in the past 30 days were higher across the region than statewide, and highest in Klickitat specifically.²⁸ Healthy Youth Survey data also indicate that 26% of 12th graders in Klickitat County experience binge drinking, compared to 16% in Clark and 18% statewide.²⁹

Vital Statistics

The 2016 Healthy Columbia Willamette CHNA identified the leading causes of morbidity and mortality in Clark County (general population) and prioritized based on racial and ethnic disparities, gender disparities, worsening trends, worse rate at the county level when compared to state, a high proportion of the population affected, and severe health consequences. These include:

Morbidity	Mortality ³⁰
Asthma in adults	Alcohol-induced
Bladder cancer incidence	Alzheimer’s disease
Chlamydia incidence	Breast cancer among women
Chronic Hepatitis C incidence	Chronic liver disease and cirrhosis
Depression in teens and adults	Diabetes
Kidney/renal pelvic cancer incidence	Drug-induced
Lung, Trachea, bronchus cancer incidence	Heart disease
Melanoma (skin) cancer incidence	Lung, trachea, bronchus cancer
Obesity/overweight in teens and adults	Lymphoid, hematopoietic, related tissue cancer
Preterm births	Non-transport accidents (falls, unintentional poisoning)
Thyroid cancer incidence	Suicide

²⁵ Ibid.

²⁶ <http://www.q-corp.org/sites/qcorp/files/HWCW%202016%20Community%20Health%20Needs%20Assessment.pdf>

²⁷ Maternal smoking during pregnancy by county, 2015. Washington First Steps Database <https://www.hca.wa.gov/about-hca/reproductive-health>

²⁸ Adult current smoking from 2013-2015 Behavioral Risk Factor Surveillance System survey data; adolescent cigarette smoking data from 2016 Healthy Youth Survey. <https://www.askhys.net/>

²⁹ 2016 Healthy Youth Survey. <https://www.askhys.net/>

³⁰ Deaths are categorized according to the underlying (or primary) cause of death on the death certificate.

2015 vital records data indicate that leading causes of death are similar across Clark, Klickitat, and Skamania counties: malignant neoplasms, followed by heart disease.³¹

Utilization

SWACH Medicaid members have lower rates of Emergency Department (ED) utilization than statewide (39 visits per 1,000 member months compared to 51, and 42 visits compared to 54 statewide when mental health and chemical dependency visits are included).

However, regional performance masks potential disparities: ED utilization rates are highest in Klickitat, and higher for American Indian / Alaska Native and Black members, as well as Arabic-language speaking members.³²

Of these ED visits, 16% were for conditions that could have been managed in primary care settings (just below the statewide average: 17%). These potentially avoidable ED visits were consistent across the SWACH region, although higher for women, Asian and Native Hawaiian / Pacific Islander and Multiracial members, and Spanish-speaking members.³³

In 2015, a Washington Health Alliance report looking at potentially avoidable ED visits found that the rate was higher for Medicaid members living in Skamania and Klickitat, which may be partially due to the geographic distance to access services.³⁴

In addition to geographic distance to providers, SWACH has known inadequacies in access to behavioral health and primary care services. See access to care section below.

Top reasons for potentially avoidable ED visits among Medicaid members:

- Respiratory infections
- Earaches
- Urinary tract infections
- Headaches
- Back pain

Providers Serving the Medicaid Population

³¹ Washington Tracking Network, Leading Causes of Death by County Age-Adjusted Rate per 100,000, 2015.

³² Utilization data from the Healthier Washington Data Dashboard, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

³³ Potentially avoidable ED visits data from the Healthier Washington Data Dashboard, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

³⁴ Right Care, Right Setting: A Report on Potentially Avoidable Emergency Room Visits in Washington State, January 2015. Washington Health Alliance. <https://wahealthalliance.org/wp-content/uploads/2015/01/Right-Care-Right-Setting-Avoidable-ER-Visits.pdf>

<p>The SWACH region includes:</p> <ul style="list-style-type: none"> Two federal designated rural health clinics (Klickitat Valley Health Family Medicine and NorthShore Medical Group) and one federally qualified health center (Sea-Mar, multiple sites across region) One tribal health clinic (Cowlitz). The clinic, which is physically located within SWACH, is an outpost of the larger clinic located in Longview and served fewer than 500 Medicaid members in 2016 Four hospitals (two in Clark County, and two critical access hospitals in Klickitat County) 	Hospital	% of SWACH Inpatient Admissions	% of SWACH ED Visits
	PeaceHealth SW Medical Center	44.9	41.6
	Legacy Salmon Creek	32.4	38.2
	Legacy Emmanuel (OR)	6.1	2.5
	OHSU (OR)	3.7	0.8
	Providence (OR)	2.0	2.6
	MidColumbia Medical Center (OR)	0.9	1.2
	Klickitat Valley	0.5	3.6
	Legacy Good Samaritan (OR)	0.4	2.3
	Skyline	0.4	2.2

While the majority of SWACH Medicaid member hospital inpatient and ED visits are at facilities in Washington, a small but significant number of admissions and visits occur in Oregon.³⁵ This might be because almost a third of the workforce in Clark and a quarter in Klickitat and Skamania are working outside of Washington.³⁶

It may also be because the health systems serving SWACH often have facilities in both states and patients (particularly in Skamania and Klickitat) may be seen across the river, especially for specialty care.³⁷

All of Klickitat County is a designated medically underserved population, and a portion of southwestern Clark County is a designated underserved area for primary medical care. Klickitat and Skamania counties, as well as portions of Clark are all primary care health professional shortage areas.³⁸ Skamania in particular has a low ratio of physicians and primary care physicians providing direct patient care (see chart below). Additionally, every physician in Skamania is age 55 or older, and therefore, may be closer to retirement.³⁹

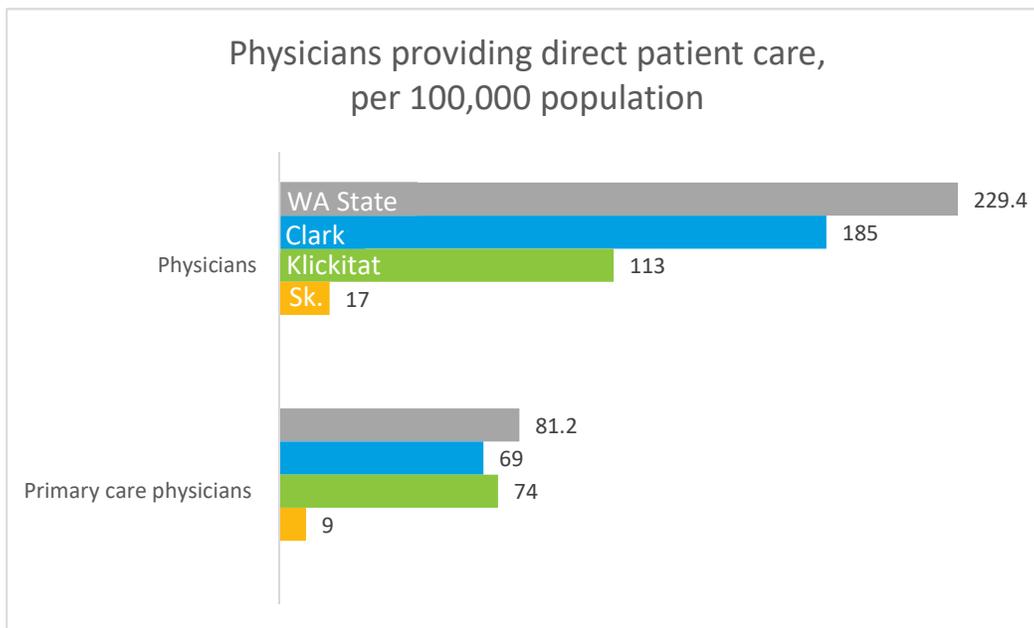
³⁵ 2016 utilization data from Provider Report Outpatient and ED Tables reports, HCA.

³⁶ Percent of workers ages 16 and older who worked outside state of residence, 2015. Commuting Characteristics by County. American Community Survey 5-Year Estimates.

³⁷ Key Informant Interviews conducted with Skamania county residents October 2017 indicated the need for more doctors in Stevenson and how members currently travel to Oregon to receive services.

³⁸ Medically underserved area and medically underserved population, January 3, 2017. Washington DOH. <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/MedicallyUnderservedAreaDesignations>

³⁹ Washington State’s Physician Workforce in 2016. Center for Health Workforce Studies, University of Washington. <http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2015/09/washington-states-physician-workforce-in-2016.pdf>



Crisis behavioral health services are provided by Clark County Crisis Services and Skamania County Behavioral Health. Crisis stabilization services for adults are available through Columbia River Mental Health Services. Catholic Community Services and Daybreak Youth Services provide crisis stabilization services for youth. PeaceHealth SW Medical Center in Vancouver and Telecare Corporation offer inpatient psychiatric beds in the region for adults, while Daybreak Youth Services offers co-occurring inpatient and residential detox services for youth throughout the region.⁴⁰ Klickitat County residents generally receive inpatient services in Yakima County through Comprehensive Healthcare. Lifeline also offers residential and outpatient substance use disorder services, including MAT.

See Appendix 2 (SWACH-Appx-2-Providers-20171116.pdf) for a list of the physical health providers and behavioral health providers that saw at least 500 SWACH Medicaid beneficiaries in 2016, based on provider billing for professional services.

As of 2012, Skamania County also had a low ratio of dentists per 100,000 population: 34, compared to 63 in Clark and 34 in Klickitat. Anecdotal information from Klickitat providers indicate that their Medicaid population generally goes without dental care. The entire SWACH region's dentists-to-population ratio is below the statewide (71 per 100,000).⁴¹ See Appendix 2 (SWACH-Appx-2-Providers-20171116.pdf) for a list of dental providers that saw at least 1,000 SWACH Medicaid beneficiaries in 2016.

Community Based Resources

⁴⁰ Crisis Mental Health Services and Inpatient Psychiatric Care – Capacity, utilization and Outcomes for WA Adults. Dec 2016. Washington State Institute for Public Policy. <http://www.wsipp.wa.gov/Reports/594>

⁴¹ Washington State Dental Association, 2012 Dental Workforce Report. ACH Project Plan Template (October 16, 2017)

There are a variety of community-based organizations in the SWACH region that serve the Medicaid population across a number of domains.⁴² This information has been further categorized by SWACH staff to help inform project planning (see SWACH-Appx-4-Community-Resources-20171116.pdf).

While Council for the Homeless and the Vancouver Housing Authority are serving the region, they are unable to meet demand: 2-1-1 Info statewide quarterly reports indicate that low income housing, rent payment assistance, and emergency shelters were the top three searches on their website, and housing and emergency shelters were 5.9% and 11.7% of the unmet needs in the first part of 2017.⁴³ More specific to the SWACH region, housing services were the top request in Q2 2017, specifically related to rent payment assistance and low income housing. Housing requests represent the largest number of unmet community needs (including potential service gaps for homeless motel vouchers). More than half of 2-1-1 callers in the region are on Medicaid and a quarter report current homelessness.⁴⁴

Nutrition assistance also remains a priority: the Clark County Food Bank distributes 6 million pounds of food and 5 million meals / year, and food pantries and food stamp services are among the top 10 service requests for 2-1-1 callers in the SWACH region.⁴⁵

Transportation, utility assistance, and legal / public safety services were also areas of high unmet community need in the region. The need may be unmet because community organizations are at capacity, or because services do not exist within the community.

Access to Care

SWACH has known inadequacies in access to behavioral health and primary care services. SWACH is the lowest performing ACH on the child and adolescent access to primary care practitioners, and adult access to preventive / ambulatory health services also lags behind state performance. SWACH also has low rates of well child visits for children ages 3-6, particularly in Skamania (46%).⁴⁶

Between 2015 and 2016, Clark County saw a decline of almost 20% in adult access to primary care visits (compared to 5% decline statewide, and a 4% decline in Klickitat County).⁴⁷

⁴² The most complete documentation of available resources is maintained by Southwest Washington 2-1-1 Info. A list of agencies by county and category is available online <https://docs.google.com/spreadsheets/d/1OB62Z-cy3FACHRvuALRv8gmlCuwPcBx0jFSTK0lP7qQ/edit?ts=59e93d88#gid=1986364147>

⁴³ Washington Information Network 2-1-1 Quarterly Newsletter, April – June 2017. <http://211info.org/reports>

⁴⁴ 2-1-1 Info Southwest Washington quarterly report, April – June 2017.

https://static1.squarespace.com/static/5491c902e4b0d409ad77f2e4/t/5981285059cc68fdf7e07fa9/1501636689415/SouthwestWashington_Q4_FINAL.pdf

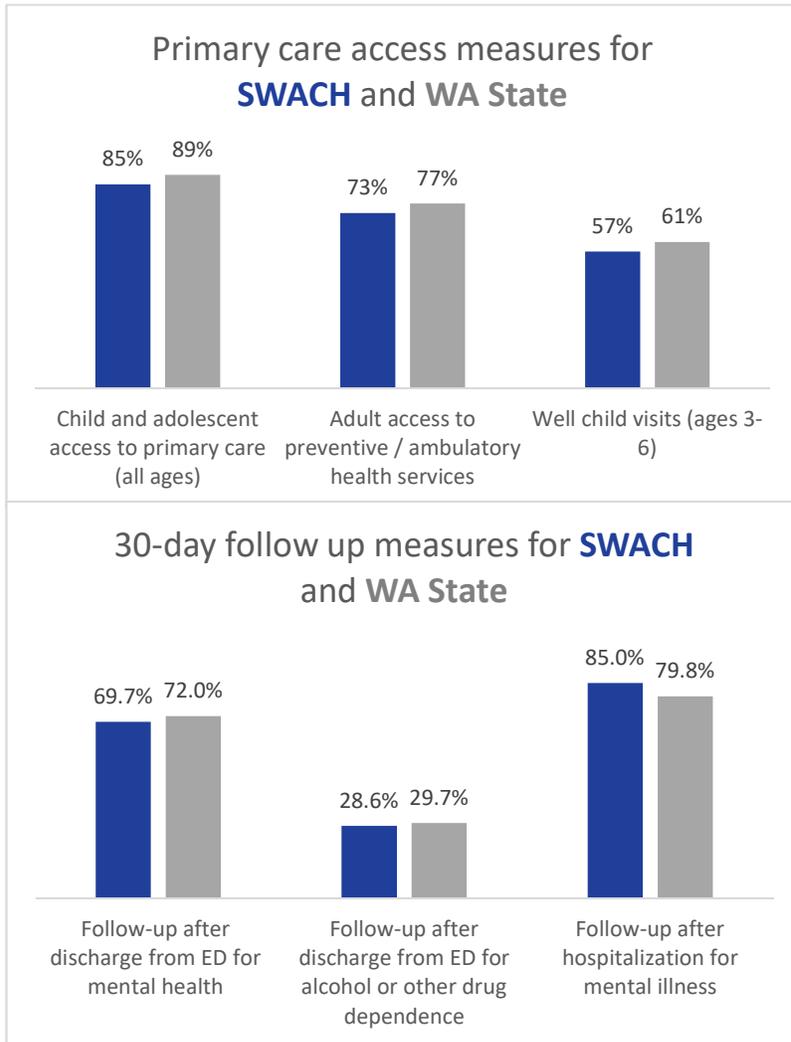
⁴⁵ Ibid.

⁴⁶ Access measures from Healthier Washington Data Dashboard, Oct 2015 – Sept 2016. <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

⁴⁷ 2016 Regional Analysis Report, Qualis Health for Washington Health Care Authority. <https://www.hca.wa.gov/assets/program/eqr-regional-analysis-report-2016.pdf>

Community feedback indicates that some individuals may be avoiding their primary care providers or not making medical appointments because of increased drug testing and changes related to opioid prescribing, as well as the lack of support in navigating the health system (e.g., case managers).⁴⁸ SWACH is also the lowest performing ACH on the mental health treatment penetration measure (40.2% in 2015), and is lower than the state average on measures of follow-up care after emergency department visits for mental illness and alcohol / substance use.⁴⁹

These indicators confirm community feedback, including the survey of Clark residents as part of the 2016 Healthy Columbia Willamette CHNA (access to physical, mental, and/or oral health care was identified as the fourth most important issue that needed to be addressed to make the community healthy). This was echoed in a number of other recent community assessments.⁵⁰ Lack of access to prescribers, particularly for mental health, was highlighted at the community listening session. We heard several experiences of people having to wait more than two months to fill prescriptions, and ending up in jail because they were unable to remain stabilized without their medication.⁵¹



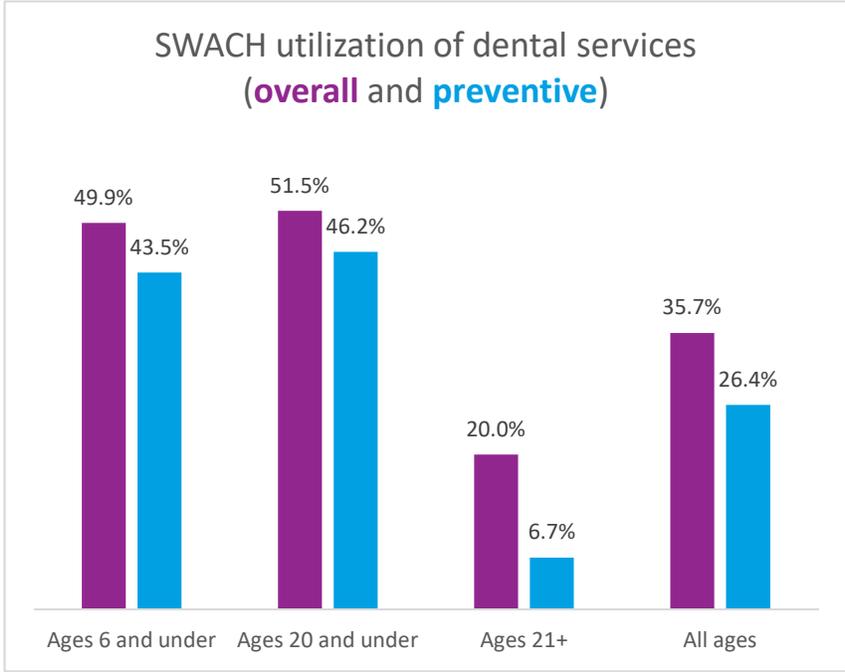
⁴⁸ SWACH Medicaid Transformation Project Community Listening Session, October 23, 2017

⁴⁹ Penetration rate data from DSHS 1519 reporting available online, <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0>. Follow-up measure data for CY 2015, from RDA Measure Decomposition files, provided by HCA July 2017.

⁵⁰ 2016 Healthy Columbia Willamette Community Health Needs Assessment, <http://www.qcorp.org/sites/qcorp/files/HWCWC%202016%20Community%20Health%20Needs%20Assessment.pdf>. The 2015 Clark County CHAN also consistently identified access to healthcare as a priority issue, as did the 2016 Columbia Gorge Regional CHA, which covered Skamania and Klickitat counties (1 in 5 in the region are going without needed physical health care, and 1 in 4 are going without needed dental care). <https://www.clark.wa.gov/sites/default/files/dept/files/public-health/data-and-reports/clarkcha2015.pdf> and <http://cghealthcouncil.org/wp-content/uploads/2017/03/Columbia-Gorge-Community-Health-Assessment-Full-Documents-December-2016.pdf>.

⁵¹ SWACH Medicaid Transformation Project Community Listening Session, October 23, 2017.

Access to dental care is also a known issue in the region for SWACH Medicaid beneficiaries: approximately 50% of children and adolescents (ages 0 – 20) and 80% of adults (21+) had no dental utilization at all in FY 2016, and only a fraction of adults had any preventive services.⁵² Interviews with Skamania residents indicated that people are having to travel to Washougal or Camas for dental care.⁵³ While approximately a third of children ages 6-9 who were at elevated risk received dental sealants, less than one percent of children received fluoride varnish in primary care settings, indicating much room for improvement.⁵⁴



Outline any identified capacity or access gaps between the Medicaid population’s identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs.

In addition to the capacity and access gaps and services described in the Community-Based Resources and Access to Care sections above, there are several other known gaps in the region (described below). SWACH has not fully quantified to what extent providers and partners are meeting all of these gaps and will continue to explore this as part of the current state assessment in early 2018. Known barriers to access include workforce capacity; length of time to access appointments, particularly psychiatric services; transportation; affordability of health care; geographic distance (particularly for more rural areas); hours of operation; lack of culturally and linguistically-appropriate services; and difficulty navigating a bifurcated system.⁵⁵

Culturally-Specific Services

Language and cultural barriers were raised multiple times in a recent community listening session. Community members noted repeatedly that providers don’t “look like us” or speak the same language. One participant mentioned how difficult it is to get basic referral information in different languages, and that people are not accessing available community resources because materials are only available in English.⁵⁶ Conversations with the NAACP also highlighted concerns that there are

⁵² FY 2016 dental utilization data provided by Washington Dental Foundation, April 2017.

⁵³ Key Informant Interviews conducted with Skamania county residents, October 2017

⁵⁴ FY 2016 dental sealant and fluoride varnish data provided by Washington Dental Foundation, April 2017.

⁵⁵ Access to health care, affordable health care, and culturally competent services were identified as prioritized issues through stakeholder and resident interviews, surveys, and listening sessions. 2015 Clark County Community Health Assessment. <https://www.clark.wa.gov/sites/default/files/dept/files/public-health/data-and-reports/clarkcha2015.pdf>

⁵⁶ SWACH Medicaid Transformation Project Community Listening Session, October 23, 2017.

not enough mental health providers of color, and that this is a gap in the community feeling comfortable accessing services. This may explain some of the demographic and language-based disparities in access and quality measures noted above.

Timely Appointments

Washington's 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) statewide reports for Molina and Community Health Plan of Washington (CHPW), the two MCOs with the majority of Medicaid enrollment for the SWACH region, indicate that 74.9% of Molina members and 66.8% of CHPW adult members reported they could get appointments for routine care as soon as they needed, and 71% of Molina members and 69.7% of CHPW members reported they could get appointments to specialists as soon as needed.⁵⁷ The 2016 Columbia Gorge Community Health Assessment survey found that 53% of respondents in Klickitat and 55.5% in Skamania reported they needed specialist care.⁵⁸

Transportation

The same survey found that transportation access was the second most common basic need individuals were going without, particularly for medical care. Ten percent of survey respondents in Klickitat and 19% in Skamania reported they went without transportation.⁵⁹ This is likely a primary driver in the low rates of access to preventive and primary care services, especially in the rural communities.

While medical transportation for Medicaid members in the region is available from the Human Services Council, out-of-area transportation (i.e., if a medical service is not available in the local community) requires pre-authorization by a doctor, with at least 7-14 days for approval recommended.⁶⁰ For Klickitat and Skamania residents, who are more likely to need to travel outside of their local area for services, this is an additional barrier that requires navigation and planning, and may also be affected by cultural or language barriers.

Workforce

In addition to the provider shortages discussed above, the SWACH region is experiencing difficulties recruiting qualified candidates for a number of health professional positions, including registered nurses, nurse practitioners, and licensed practical nurses. For example, SeaMar has leveraged loan reimbursement programs to attract providers, but still face difficulties recruiting candidates. Organizations are also reporting an increased demand for these provider types, as well as medical assistants.⁶¹ Community members have also highlighted the need for more peers and community health workers.⁶²

⁵⁷ 2016 CAHPS Overall Report. <https://www.hca.wa.gov/assets/program/ahmc-overall.pdf>

⁵⁸ <http://cghealthcouncil.org/wp-content/uploads/2017/03/Columbia-Gorge-Community-Health-Assessment-Full-Document-December-2016.pdf>

⁵⁹ Ibid.

⁶⁰ Human Services Council Medicaid Medical Transportation and Health Care Authority Non-Emergent Medical Transportation <http://www.hsc-wa.org/services/medicaid-medical-transportation> and <https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/transportation-services-non-emergency>

⁶¹ Washington State Health Workforce Sentinel Network, April 1, 2017 – May 15, 2017. <http://www.wtb.wa.gov/HealthSentinel/findings-ach-map.asp>

⁶² SWACH Medicaid Transformation Project Community Listening Session, October 23, 2017.

To address workforce capacity, some providers have partnered with medical residency programs in the region to support student development and staffing needs, while other partners are developing new training programs for existing staff or serving as a community placement site for residents. SWACH is working to develop a Residency Placement Workshop to bring together medical and nursing residency programs in the region to develop relationships and more supportive structures for community-based placements to help meet student demand.

ACH Theory of Action and Alignment Strategy

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

The term “health equity,” as used in this Project Plan Template, means reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.¹

Describe the ACH Theory of Action and Alignment Strategy. In the narrative response, address the following:

- Describe the ACH’s vision for health system transformation in its region; include a vision statement and a discussion of how the vision addresses community needs, and the priorities of the whole population.
- Define the ACH’s strategies to support regional health and healthcare needs and priorities.
- Indicate projects the ACH will implement (a minimum of four).

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input checked="" type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

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

- Describe the process the ACH followed to consider and select projects as part of a portfolio approach.
 - What were the criteria for selecting projects?
 - Describe how the ACH applied its whole-population vision for health system

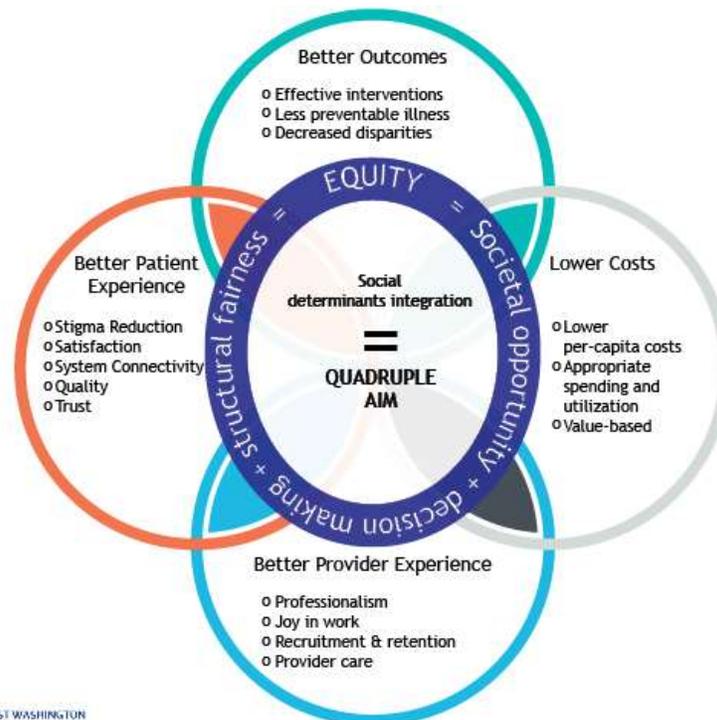
- transformation to inform its project selection and planning.
- Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?
 - Describe how, through these projects, the ACH plans to improve region-wide health outcomes.
 - Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.
 - Describe how, through these projects, the ACH plans to advance health equity in its community.
 - Describe how, through these projects, the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system.
 - Discuss how the ACH addressed any gaps and/or areas of improvement, identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region.
 - Submit logic model(s), driver diagrams, tables, and/or theory of action illustrations. The attachments should visually communicate the region-wide strategy and the relationships, linkages, and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes (*submit as ACH Theory of Action and Alignment Strategy – Attachment A*).

Vision Statement

Aligning with the Healthier Washington priorities, Southwest Washington ACH (SWACH) convenes partners to create sustainable, equitable, and innovative care that continuously improves the overall health and well-being of the communities we serve, striving to create and maintain the healthiest region in the state.

The MTP will provide SWACH the opportunity to convene and support regional, multi-sector, collaborative partners to use regional data to focus on whole person care, addressing the social determinants of health, and rewarding quality and value. This will result in improved outcomes, lower costs, improved health of the population across the region, and a more satisfied, effective workforce, with a specific focus on advancing equity. SWACH will use data to drive policy changes that address up, mid, and downstream issues across the three counties in the region. Addressing workforce issues, adopting and implementing population health management strategies, and supporting providers in shifting to value-based care will provide the infrastructure to support and sustain transformation.

SWACH will evolve into a regional asset, providing long-term coordination and alignment focused on achieving the Quadruple Aim post-Medicaid Transformation Project (MTP).



Source: Adapted from Rishi Manchanda, HealthBegins & Institute for Healthcare Improvement. Updated: 11/09/2017

Strategies to support regional health and healthcare needs and priorities

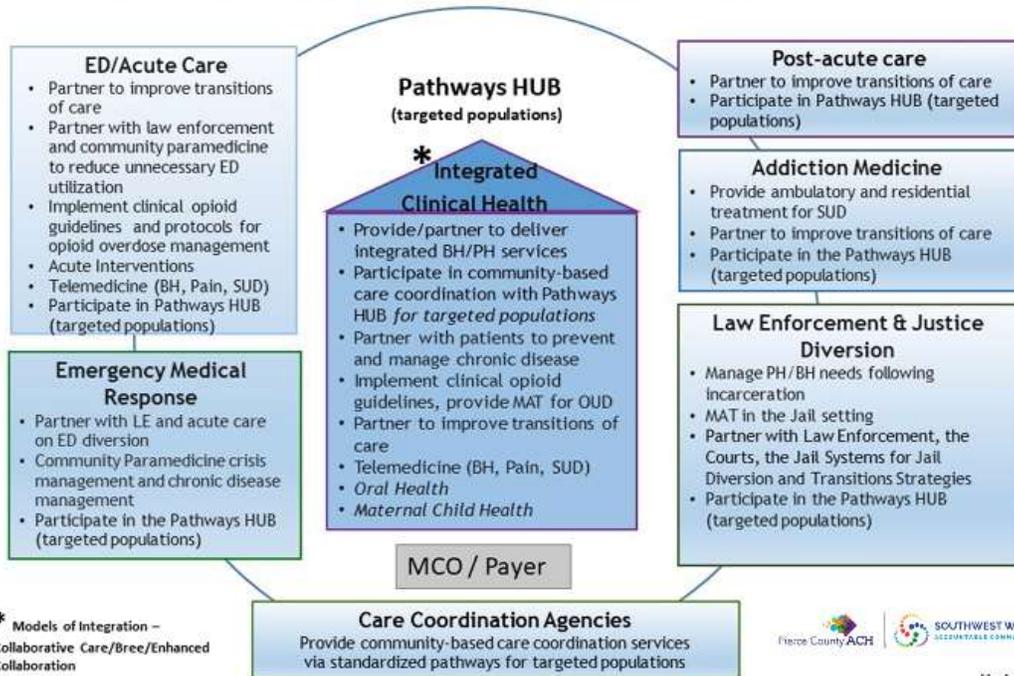
SWACH's overall strategy focuses on transforming systems which affect a large percentage of the population currently experiencing the most profound health inequities and disparities in the region: health care delivery, community social services, law enforcement and justice, and emergency services.

SWACH will:

- Serve as the long-term structure for continued, authentic community and consumer engagement
- Elevate and integrate social determinants of health and equity as critical components of an effective and efficient health care delivery system
- Build a stronger bridge between clinical and community providers
- Make strategic investments in prevention and recovery
- Strive to align MTP work with related efforts and investment flows to maximize impact and achieve results

By building upon its early progress integrating physical and behavioral health care across the region, and developing a community care coordination system, SWACH will create a collaborative framework to address the region's health and healthcare needs and priorities. SWACH will bring regional health care delivery partners, community-based partners, local and state governmental partners, Medicaid beneficiaries, Managed Care Organizations (MCOs), Tribal partners, and other stakeholders together to reexamine how each care delivery and service setting can transform to achieve the quadruple aim.

TRANSFORMING CARE AND SERVICE DELIVERY SETTINGS



Using regional data and the MTP performance metrics as a guide, we will transform care and service delivery settings by working with each individual setting to define the transformation activities and

commitments necessary to articulate the appropriate activities within each setting's walls as well as how each setting will interact with its partner settings across the care and service delivery spectrum.

The transformation activities and commitments will be included as contractual requirements, which SWACH refers to as the *Transformation Rules of Engagement*, for each participating provider working with SWACH on the MTP (See Attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf, "Strategic Aims and Drivers").

Our multi-stakeholder data and learning team, clinical integration committee, community care coordination, and opioid workgroups have used regional data to recommend specific interventions to address access to care, clinical integration, chronic disease management, opioid use and its impact, care transitions, diversion to the best care setting, oral health, and reproductive and maternal and child health. Through our Behavioral Health Advisory Committee (BHAB) and our community engagement and outreach work, SWACH has solicited input and lived experience to validate these recommendations. These recommended interventions will form the basis for our *Transformation Rules of Engagement* which will continue to be refined during the implementation planning process.

Using our MTP and Integrated Managed Care (IMC) incentives SWACH will provide the necessary infrastructure, services, and resources to support care and service delivery setting transformations under the MTP by ensuring alignment and focus on addressing social determinants of health, whole person care, and value-based payment. SWACH believes building a strong, sustainable foundation for transformation using the MTP incentive funding will enable the region to achieve its vision to create and maintain the healthiest region in the state. We intend to use the implementation planning phase to finalize actionable strategies with multi-sector buy-in, that are clearly connected to output, outcome, and impact measures (See Big Dot Metrics in attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf).

Our transformed approach will ensure people receive the best care in the most appropriate setting, from an individual, organizational, and population health perspective, and will provide the mechanism to achieve improved outcomes across the region. By transforming care and service delivery settings, we believe the improved outcomes our approach will demonstrate will be valuable to patients, providers and payers across the spectrum, not just those within the Medicaid system, ensuring the sustainability of these transformations beyond the MTP.

Project Selection Process

The SWACH Regional Health Improvement Plan (RHIP) Council created a two-level project selection criteria model to develop recommendations for the Project Portfolio to the Board of Trustees:

Threshold Criteria:

- Alignment with regional health priorities, ACH mission, values;
- Ability to address documented need without duplication of efforts;
- Impact on Medicaid lives and return-on-investment within 2 - 3 years;
- Ability to spread work and scale project across the region; and
- Readiness to implement the project.

Next Level-Criteria:

Criteria	Key Questions
Health Equity	Does the project reduce health disparities and/or advance health equity? Does it address/support social determinants (underlying community conditions)? Does it support the health outcomes of a group of Medicaid individuals?
Data and Measurement	Will the project use data to define the target population, share learnings, and measure outcomes? Can outcomes be measured with current data sources? What data are needed to evaluate the project's impact? Is the appropriate data and analytic infrastructure in place or available?
Legal	Does the enacting organization have the legal authority? Is future litigation a concern if the project is implemented?
Widespread Support	Is the project controversial? What do key stakeholders think? Is there a good state of readiness (passion, will) and ease of communication (messaging) or is there a reason to delay action?
Practicality	Does the project build on existing efforts? Is there a clear role for SWACH? Is the strategy self-sustaining or does it require ongoing resources (implementation, enforcement)?
Social	Is there a clear connection to improved quality of life/community health and community values? Is the project multi-sector in nature? Are there potential unintended consequences? Is there a clear community engagement strategy?
Earnings Potential	Does the project have a high earning potential based on HCA incentive payment weighting formula?

SWACH's whole-population vision is achieved by policy and system level change being the foundation of transformation across care and service delivery or health system settings. We have ensured this by embedding these components as core criteria (outlined above) for projects selected.

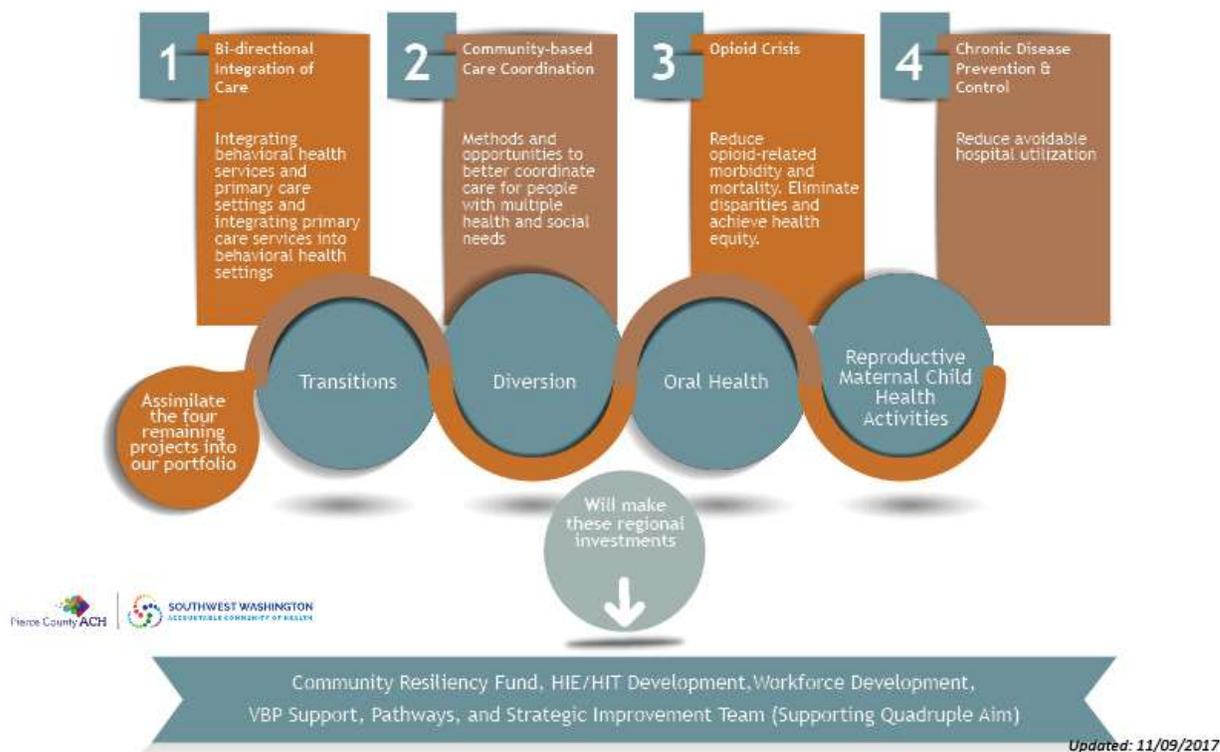
Our committees and workgroups (clinical integration, care coordination, opioid, data and learning) conducted environmental scans to assess the current state of resources and gaps in the region across all eight project areas. These groups evaluated the projects by comparing data from our Regional Health Needs Assessment and the environmental scans against the above criteria and made project selection recommendations to the RHIP Council. The BHAB and our community engagement sessions and key informant interviews provided additional feedback and input to the RHIP Council for project selection. Based upon the regional data, community input, and our governance bodies' desire to maximize the potential for transformation, the RHIP Council originally recommended a six-project portfolio: Integration, Community Care Coordination, Transitional Care, Diversions, Opioids, and Chronic Disease Management and Prevention. The workgroups and RHIP Council also recommended aspects of the oral health project and the reproductive and maternal health project be incorporated into the *Transformation Rules of Engagement* for implementation.

The recent announcement of reduced MTP funds prompted the RHIP Council to recommend a more focused, targeted Project Portfolio. The four areas selected represent foundational initiatives based upon regional health needs and stakeholder input. However, the RHIP Council recommended SWACH, through its project work and other activities, meaningfully address the issues represented by the four project areas not selected: oral health, reproductive and maternal child health, transitions of care, and diversions in the *Transformation Rules of Engagement*.

The Board of Trustees unanimously adopted the recommendations of the RHIP Council.

Shared Interventions, Resources and Infrastructure

As detailed above, SWACH is taking a systems approach, transforming care and service delivery settings to partner more collaboratively and effectively. In this model, our *Transformation Rules of Engagement* will map activities to appropriate care and service delivery settings ensuring significant overlap for shared interventions, resources, and infrastructure.



Proposed Interventions Across All Settings:

- Awareness and sensitivity education and training (cultural, equity, behavioral health);
- Pathways HUB for target populations;
- HIE/EHR strategy to coordinate care (primary care, behavioral health, SUD, ED, EMS, CBOs, etc.);
- Adopt and implement telehealth and mobile services;
- De-escalation training and techniques; recovery oriented care;
- Clinical practice change management and skill building (Strategic Improvement Team);
- Consistent use of two or more approved validated instruments to screen for behavioral health conditions and/or substance use disorder;
- Screen for tobacco use and offer cessation counseling to smokers;
- Commitment to inquire about access and care for oral health and develop referral patterns;
- Commitment to encourage pediatric and adolescent well-child visits;
- SBIRT (Screening, Brief Intervention, and Referral/Provide to Treatment) for common behavioral health conditions and substance use disorders

The above-listed interventions will be shared via the *Transformation Rules of Engagement* and will require all participating providers to adopt as a requirement of the MTP, regardless of care or service delivery setting.

Shared Resources:

- Data Analytics (CORE)
- Learning Lab through Strategic Improvement Team
- Tools and Technical Assistance to support:
 - Science of Improvement
 - Facilitation, Coaching, Training, Consultation
 - Accountability training
 - Performance Technology
 - Change Management
 - Population Health Management (HIE/HIT)
 - Workforce Development strategies
 - Contracting / Billing / VBP
 - Communication strategies
 - Care of the Provider education and strategies
 - Policies and Procedures
 - *Transformation Rules of Engagement* deployment
 - Self-monitoring and reporting
 - Pay for reporting tools and capabilities (worksheet and electronic reporting questionnaire/survey with metrics and definitions)

Shared Infrastructure:

- ACH Staff
- Data Analytics Platform
- Pathways HUB
- Practice Transformation Hub
- Strategic Improvement Team (Improvement Advisors – clinical and non-clinical)
- Population Health Management System
- Self-monitoring and reporting tools

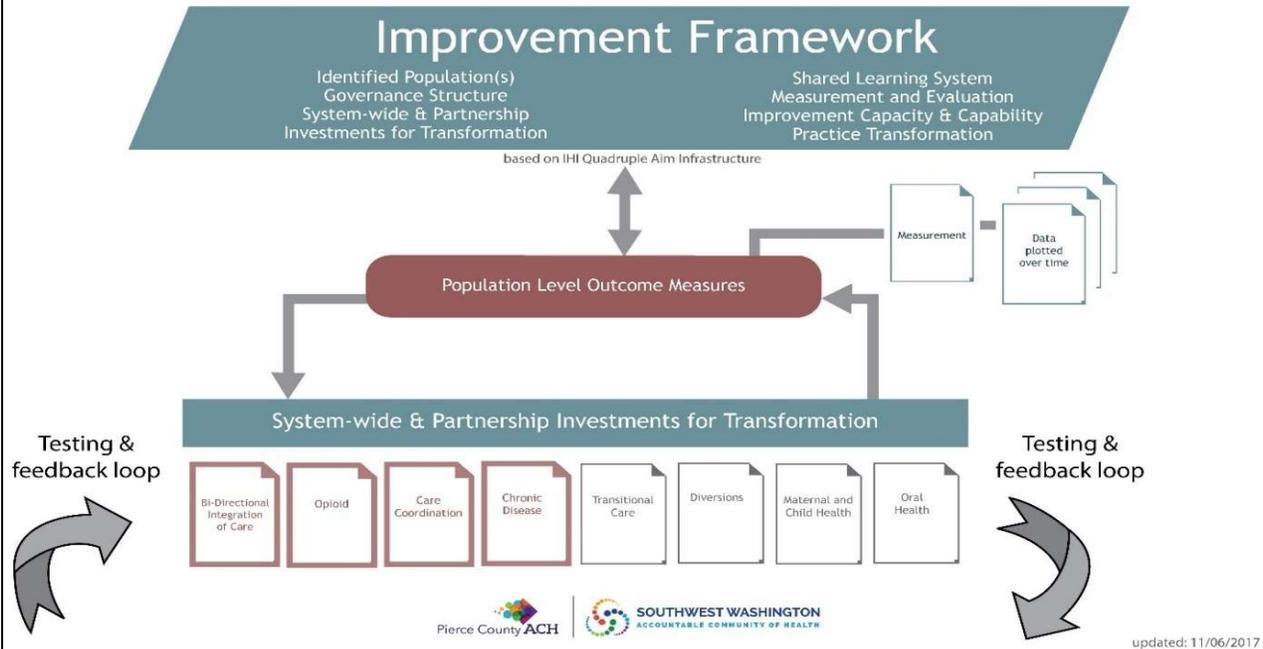
Shared resources and infrastructure will be provided by SWACH. These services will be funded through the designated Systems Capacity Building (SCB) Fund. SWACH staff and sub-contracted service providers will be assigned to partnering providers post-contract execution, as appropriate.

Improvement to region-wide health outcomes

By tailoring the project toolkit approaches of the selected projects to address SWACH's regional needs, SWACH will develop targeted strategies focused on improving region-wide health outcomes. Using our self-monitoring and reporting tools, partnering providers will work with strategic improvement advisors, supplied by SWACH, on quality improvement cycles to drive toward the outcome measures. Monthly, we plan to track our Big Dot Metrics (See Attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf, "Strategic Aims and Drivers") to benchmark progress against state-level measures. Our systems approach will allow SWACH to work with partnering providers to target activities appropriate to each care and service setting, focusing on meeting or exceeding MTP performance metrics as demonstration of improved outcomes.

Improvement to region-wide quality, efficiency, and effectiveness of care processes

SWACH plans to use an improvement framework based upon the IHI Science of Improvement Model and has been partnering with Pierce County ACH to develop the strategy to support continuous quality improvement capabilities and capacity within the partnering provider organizations. SWACH plans to use a Strategic Improvement Team (internal ACH resource) and a Quality and Continuous Improvement Committee (external resource made up of quality improvement experts from regional partnering providers) to ensure improved region-wide quality, efficiency, and effectiveness of care processes. The improvement framework ensures the testing and feedback loop supports the progression toward improved population level outcomes.



The Strategic Improvement Team will:

- Build science-based improvement capability at provider, team, clinic, and system levels;
- Ensure quality improvement knowledge and skills training are provided to participating providers and health care workforce;
- Ensure the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
- Ensure shared learning system is accelerating implementation, spread of work, and increase of innovative approaches to improving health outcomes;
- Provide a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results;
- Ensure participating providers and partners have the tools they need to achieve outcomes;
- Ensure participating providers are proficient at reporting on ACH and MTP-level reporting requirements;
- Ensure participating providers have pay for reporting tools and capabilities in place (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and report on a monthly, quarterly and annual basis; and

- Ensure capture of various partners' data including administrative data, and data from MCOs, CCS (Pathways) platform and Chronic Disease, etc. and compile (with CORE's oversight) for regional dashboard.

Improvement Advisors will consistently work to improve the quality, efficiency, and effectiveness of care while moving partnering providers toward independence by supporting their modified roles and practice changes to ensure sustainability of the changes. The change management processes deployed will transition the partnering provider from dependence on the Improvement Advisor to independence by building capacity within the participating providers' organizations. By building capacity, the participating provider will have a plan to move away from higher levels of support from the Improvement Advisor so that the provider, over time, will implement new concepts, models, and techniques internally with their own, in-house improvement experts building capacity and long-term sustainability.

SWACH will also seat a Quality and Continuous Improvement team, comprised of multi-sector stakeholders with backgrounds in quality and clinical quality improvement (Lean, Six Sigma, Science of Improvement, Kaizen, etc.) to vet the work of the SWACH Strategic Improvement Team and the products emanating from the team's work to ensure alignment with the regional vision and acceptance from the partnering providers.

Advancing Health Equity

SWACH intends to address health equity through a multi-pronged approach including the implementation of the MTP projects themselves.

As demonstrated by our merger with the Health Living Collaborative of SW Washington (HLC), SWACH understands the importance of advancing health equity and the impact it will have in the success of our work. HLC is a community-driven coalition that works together on upstream initiatives that promote health equity and strengthen communities. Some of the sectors HLC's 60+ partners represent are health care, public health, social services, education, a tribal nation, housing services, and transportation.

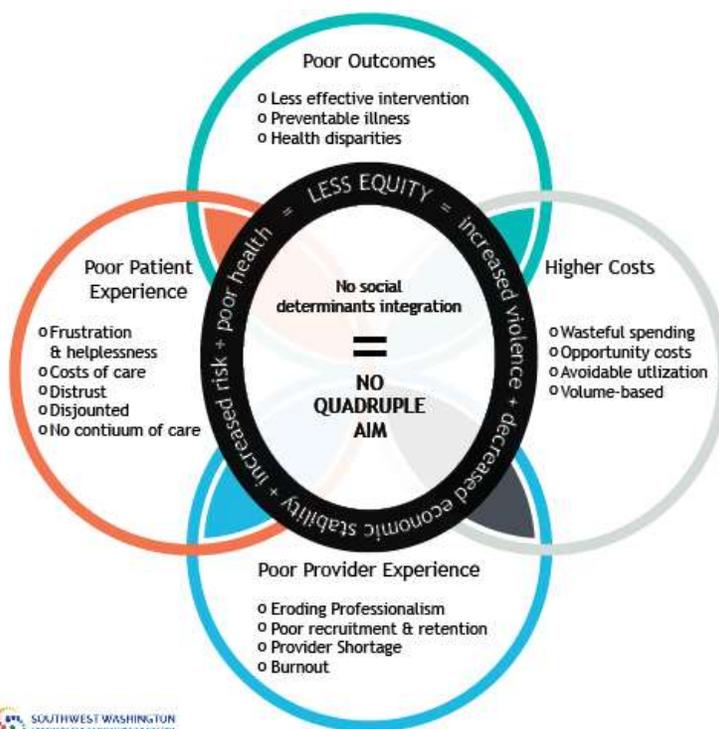
To ensure individuals facing the greatest health disparities inform the community needs assessment and improvement opportunities, SWACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of SWACH Medicaid members. Through our community engagement efforts across the region, we have been able to provide authentic community input and lived experience to inform discussions and decisions regarding project selection, target populations, and selected approaches.

As SWACH has made preliminary decisions regarding target populations for its selected projects, intentional focus on the opportunity to advance health equity has been central. We understand that without the quadruple aim we will not achieve equity. One of the leading criteria applied when choosing target populations and required project elements has been, and will continue to be, advancing health equity. We will continue to review if proposals address the social determinants of health. SWACH posed three questions before proposing target populations and strategies:

- Does the target population disproportionately experience poor health outcomes?
- Are there subgroups within the population that experience disparities?
- Is there a gap in existing services that could effectively address these outcomes?

SWACH will use data wherever possible to accurately measure impact across demographics. By looking at data for Clark, Skamania, and Klickitat Counties, and their Medicaid beneficiaries, SWACH is targeting efforts that will have the greatest impact on health equity. This emphasis on equity will continue through project planning and implementation.

SWACH’s Community Pathways Hub is expected to be an additional thread across all demonstration projects that contributes to advancing health equity. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries’ access to culturally and linguistically responsive care. When SWACH created its Request for Proposals (RFP) for Care Coordination Agencies (CCAs), it required potential Hub partners demonstrate a commitment to health equity. Furthermore, the ACH invited Community Health Workers to be members of the RFP review team to ensure community perspective informed the CCA decision-making process. As a result, the three successful CCAs (SeaMar, Council for the Homeless, and Community Voices are Born) chosen for the initial Pathways Hub pilot are trusted community partners with deep experience in supporting the diverse cultural, linguistic, and geographic needs of SWACH Medicaid members.

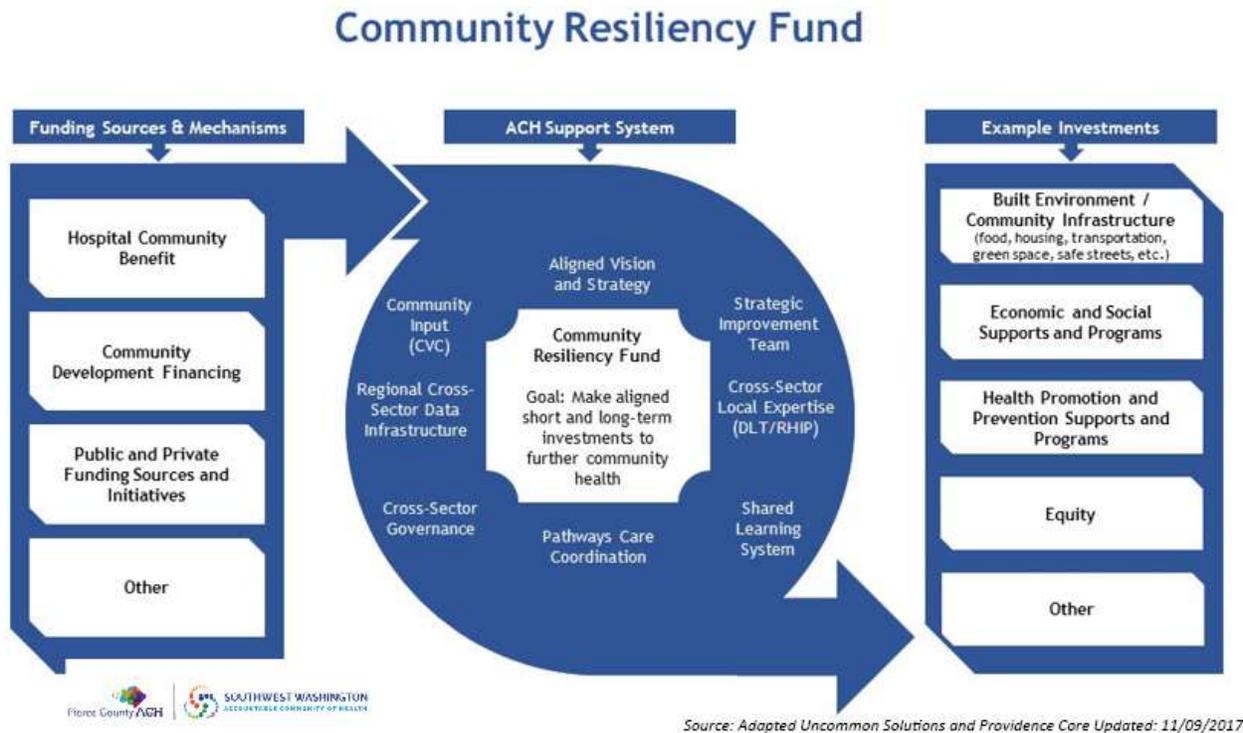


Source: Adapted from Rishi Manchanda, HealthBegins & Institute for Healthcare Improvement. Updated: 11/09/2017

SWACH is also working to deepen its impact on health equity through MTP activities. We plan to work toward ensuring:

- Community trainings in multiple languages and across diverse cultural and geographical community sites;
- A trauma-informed lens is applied to transformation settings;
- Workgroups, committees, and governing bodies receive training on diversity, equity, and inclusion;
- An equity lens is developed and applied to policies/procedures/systems;

- Cultural humility and trauma informed care are incorporated as essential components of the Strategic Improvement Team’s work; and
- Diverse community partners define the needed resources to strengthen community resilience and that these needs are addressed through the Community Resiliency Fund.



Role and business model as an integral, sustainable part of the regional health system

SWACH views itself as an integral, sustainable part of the regional health system. As a neutral party, with the ability to add value in ways other health system players cannot, SWACH is well positioned to:

- Convene care and service delivery partners, payers, governmental agencies, Tribal nations, and patients to transform the regional health system to deliver whole-person, integrated care;
- Identify and leverage other dollars for braided funding opportunities;
- Support care and service delivery partners with financing, workforce development, regional population health management systems, and assistance in transitioning to value-based contracting;
- Partner with consumers by engendering trust and amplifying the voice of those most impacted;
- Focus on social determinants of health through education, communication, and connectivity with and throughout the care and service delivery settings;
- Implement strategies to address social determinants of health;
- Support learning and shared decision making to identify policy challenges and barriers and impact change; and
- Enhance experience, quality, and value for health improvement.

SWACH will pursue multiple avenues to develop a sustainable business model to continue its role post-MTP. SWACH expects to see diversified revenue streams from:

- Pathways HUB
- Strategic Improvement Services
- Service Line Contracting
- Shared Savings
- Philanthropy
- Grants
- Partners outside the Medicaid market

We believe success during the MTP will cement our value to the regional health system and provide for new and innovative opportunities in the future.

Phase II gaps and/or areas of improvement

Feedback on our Phase II Certification application indicated a lack of clarity on RHIP Council project selection process and the role of the Board. The process for project selection is detailed above, as is the role the Board played in approving the RHIP Council recommendation for our project portfolio. We believe we expanded upon our priorities and how we will use the MTP to drive achievement of those priorities.

Governance

Describe the ACH's governance structure. In the narrative response, address the following:

- Describe how the ACH's governance provides oversight for the following five required domains:
 - **Financial**, including decisions about the allocation methodology, the roles and responsibilities of each partnering providers, and budget development
 - **Clinical**, including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers
 - **Community**, including an emphasis on health equity and a process to engage the community and consumers
 - **Data**, including the processes and resources to support data-driven decision-making and formative evaluation
 - **Program management and strategy development**, including organizational capacity and administrative support for regional coordination and communication

- If applicable, provide a summary of any significant changes or developments related to the governance structure (e.g., composition, committee structures, decision-making approach) and decision-making processes since Phase II Certification, including a rationale for changes.
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to its governance structure and decision-making processes.
- Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.
- Submit a visual/chart of the governance structure (*submit as Governance – Attachment A*).

ACH Response

SWACH is a Washington state non-profit corporation, with a 501 3 (c) designation from the Internal Revenue Service. The corporation's governance structure represents an intentional design created to fulfill fiduciary and legal obligations and sustain successful relationships and accountability among diverse partners beyond the Medicaid Transformation Project (MTP). Governance bodies are comprised of representatives from health care delivery providers, community-based organizations, local governmental agencies, Managed Care Organizations (MCOs), and community members who are guided by a community-driven, region-wide vision for sustainable, equitable, and innovative care.

Cognizant of the need for both legal accountability and governance of the non-profit organization, as well as the need to meet MTP requirements, the SWACH governance structure provides for both, while meeting all Standard Terms and Conditions (STCs) under the MTP. The Board of Trustees (Board) is a policy board with ultimate fiduciary accountability for the organization. The Board has delegated the operational work for the MTP to the Regional Health Improvement Plan (RHIP) Council. The RHIP Council has been tasked with reviewing the recommendations of subject-matter specific workgroups, community input, and staff recommendations, and developing MTP recommendations to the Board. This structure allows the RHIP Council members to fully represent their constituencies, sectors, and counties to ensure the MTP activities are feasible and have the required buy-in and commitment of partners to be implemented successfully. Furthermore, this allows the Board to avoid many conflict of interest issues by allowing members to serve as individuals, not as representatives of constituencies.

The interconnected governance structure depicted in the attached diagram is comprised of the following bodies: Board, with an Executive Committee and Finance Committee; RHIP Council, Data and Learning Team (DLT), Behavioral Health Advisory Board (BHAB), Clinical Integration Committee, Community Care Coordination and Opioid Workgroups, and the HLC Policy Committee (See SWACH-Att-2-Governance-Structure-20171116.pdf). The Board will be seating an Incentive & Investments Committee, a Quality and Continuous Improvement (QCI) Committee; an HIE/HIT Task Force; and an HLC Committee in early 2018.

Board of Trustees: The Board has fiduciary duty and full accountability for all decisions of the corporation, and trustees serve as individuals in a traditional nonprofit board capacity. The Board meets monthly in open meetings.

- **Executive Committee:** The Board has authorized its Executive Committee, comprised of the Chair, Vice Chair, Secretary, and Treasurer, to conduct corporation business requiring timely action between Board meetings.

- **Finance Committee:** The Board has delegated review of financial transactions to the Treasurer and the Finance Committee. The Treasurer and CFO review the Finance Committee meeting topics and financial statements with the Board at the monthly meetings.

Regional Health Improvement Plan Council (RHIP): Cross-sector, cross region members from the health care delivery system, including physical, behavioral, and oral health, MCOs, early childhood, K-12, and post-secondary education, housing, criminal justice, public health, and community stakeholders. The RHIP Council captures local expertise, and the work currently underway in the region, to give a cohesive view of the regional picture. The RHIP Council receives input and recommendations from the community, BHAB, DLT, and Workgroups from which it develops recommendations to the SWACH Board.

- **RHIP Cabinet:** The RHIP Council has a Cabinet comprised of Co-chairs and two additional RHIP Council members who review agendas and communications between RHIP Council monthly meetings.

SWACH encourages sector representatives to share information amongst themselves and to bring concerns and questions to the RHIP Council for discussion. We hold open meetings and include all meeting participants in discussion. We endeavored to include all interested parties and not limit membership by sector. For example, the two contracted MCOs, Molina Healthcare and Community Health Plan of Washington, both have RHIP Council representation, and the other three MCOs not contracted in our region are invited to attend our meetings and participate in discussion. Only Council members vote, but other sector representatives are present to share their perspectives. We have used the same approach with our hospital systems, physical health providers, behavioral health providers, education sector partners, community organizations, etc.

Behavioral Health Advisory Board (BHAB): The BHAB, comprised of 50% consumers, many of whom have behavioral health diagnoses or family members with behavioral health diagnoses, is a source of rich community wisdom. Board members utilize Medicaid, Medicare, and Veteran’s Administration benefits, commercial insurance, and some are uninsured, and all provide direct feedback on behavioral health and substance use care delivery issues and barriers. In addition to guiding the distribution of block grant funds, the BHAB provides deep, authentic, lived experience as a lens for SWACH’s work.

Clinical Integration Committee: Comprised of a group of leaders and providers that provide behavioral, physical and general health care in SWACH and understand the key components and barriers of healthcare transformation. The Workgroup uses regional data and expertise to recommend specific interventions and shared learning to collectively understand system and policy barriers or innovations to address access to care, clinical integration, chronic disease management, opioid use and its impact, care transitions, diversion to the best care setting, oral health, and reproductive and maternal and child health.

Community Care Coordination Workgroup: Comprised of a broad set of stakeholders and partners including: physical health providers, hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, and the criminal justice system. This workgroup has supported the environmental scan and community mapping exercises to identify potential areas of overlap or duplication as part of the Pathways HUB planning process.

Opioid Workgroup: Comprised of multiple partners engaged in opioid-related work or expertise throughout the region. These include physical health providers, hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, and the criminal justice system. The Workgroup's function has been to leverage existing efforts and expertise, fill gaps, avoid duplication, and target areas that require additional focus and resources to address the prevention and treatment, from an individual and health system perspective, of opioid use, addiction, treatment, and recovery.

HLC Policy Committee: Provides overall analysis and leadership on policy and system change strategies. Its work will include making recommendations to HLC partner organizations and building support for the policy agenda. This committee's work focuses on organization, local, and state level policy. To date, the policy focus areas are: health, prevention, equity, and affordable housing. The committee is comprised 9-13 organizational and community partners, CHWs, and community members. We plan to have cross-membership between this committee and the RHIP Council to ensure policy considerations are included in SWACH work and we can ensure we fulfill our role in communicating policy barriers and challenges.

The HLC Policy Committee has a representative on the WA State Prevention Alliance, focusing on advocating for policies aimed at preventive measures. SWACH is one of the only ACH currently represented on this collaborative, and has a member on the Steering Committee.

Committees in Development (Operational Q1 2018)

Incentive & Investments Committee: Will provide guidance and direction for MTP related funds flow and investment strategies. The Committee will develop policies and guidelines for the use of the Systems Capacity Building Fund, submit recommendations to the Board regarding distribution of funds to partnering providers, and provide recommendations on the management of the Community Resiliency Fund. The Board is currently developing this committee and will make decisions about the composition and formal charge by January 2018.

Quality and Continuous Improvement (QCI) Committee: Will be comprised of clinical transformation experts and leaders from the region and provider organizations, charged with monitoring continuous quality improvement, program management, and overall success of meeting clinical outcomes and care delivery redesign. The QCI Committee will partner with the Data and Learning Team (DLT) and the ACH Strategic Improvement Team to utilize the self-monitoring tools and resources to drive improvement across care settings. The QCI Committee will provide information and feedback to the Clinical Integration Committee and Incentives & Investments Committee.

Health Information Exchange and Health Information Technology (HIE/HIT) Task Force: Will be comprised of CIO/CTOs from partnering providers; this Task Force will support the development and oversight of the population health management system (PHMS) strategy. This group will provide recommendations on infrastructure and technology strategies to the Incentives & Investments Committee for necessary technology planning, purchasing, training, technical assistance, and on-going maintenance and support for participating providers in the PHMS realm.

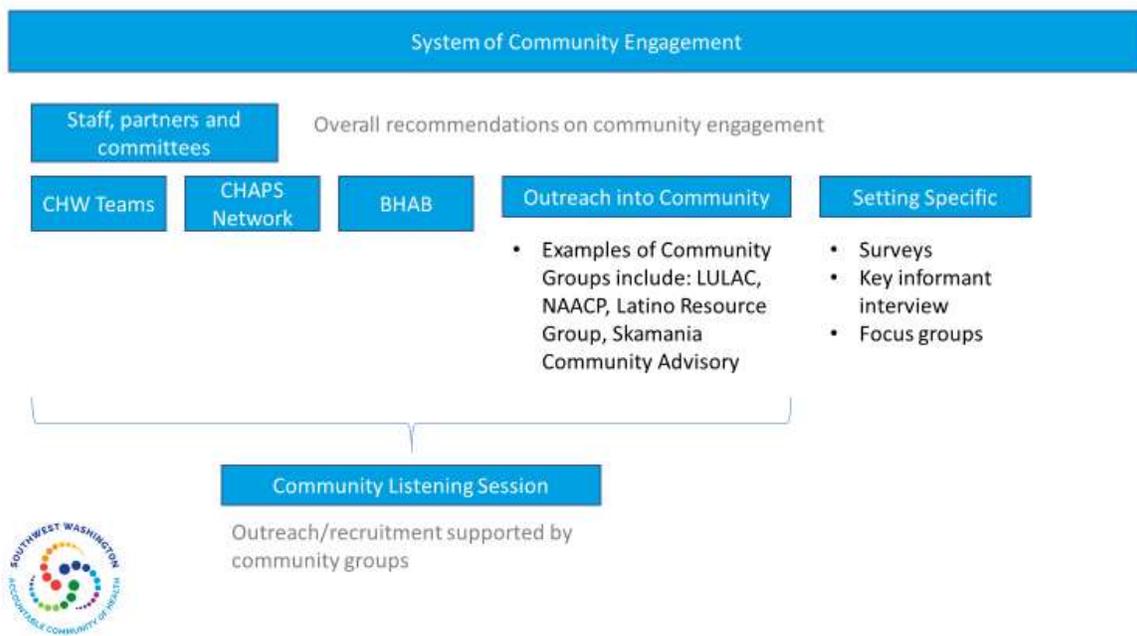
HLC Committee: Provides overall direction to HLC. This includes providing recommendations on community engagement efforts. The group will be comprised of 7-13 members from cross-sector organizational partners, community and advocacy groups, CHWs, and community members who represents different ages, disability status, race/ethnicity, and socioeconomic status and are deeply

connected to the community. This committee will ensure HLC work is aligned with MTP work and reaching more deeply into our communities beyond the MTP.

Operational Support Teams:

Data and Learning Team (DLT): Comprised of data and analytic expertise from regional cross-sector partners. The DLT supports data driven decision-making by reviewing and interpreting existing data and reports, identifying data gaps and data sharing needs, and making recommendations regarding project selection and focus, and target population selection, to workgroups and governance bodies. The DLT will look at performance data and share recommendation with the Strategic Improvement Team and the QCI Committee.

Community Engagement System: SWACH’s community engagement strategy stems from our merger with the existing Healthy Living Collaborative of SW Washington. HLC’s Community Health Workers (CHWs) and Community Health Workers and Peer Support (CHAPS) networks are in communities and neighborhoods, working within our most vulnerable and marginalized communities across the region. SWACH has incorporated HLC as the community outreach and engagement arm for our work under the MTP and more broadly across the region.



HLC has developed trusted relationships with its over 60 organizational partners. HLC brings a network of partners who have a history of being solution oriented, collaborative, and effective in addressing health and social issues across our region.

The 40+ CHW and CHAPS network members share their learnings, input, and feedback with our workgroups, committees, and governance bodies to provide authentic, lived experience to enrich the statistical data. The CHW and CHAPS network members are members of the communities from which we seek to learn. We do not ask community members to come to us; we meet them where they are comfortable and safe, which provides for more candid and honest input.

SWACH's Community Engagement Coordinator attends the meetings of other community-based organizations and advocacy groups to share information about SWACH and the MTP and to learn the concerns and issues facing the various constituencies across the region.

HLC's CHW and CHAPS networks support SWACH as host for community conversations with Medicaid beneficiaries who understand firsthand the difficulties in navigating a fractured healthcare system. These networks contribute their expertise to the shared learning and action structure in the same way providers share their perspective and expertise, ensuring a more complete vision of whole person health and validation of activities designed to advance health equity.

Financial

The Board, working with the ACH executive staff and finance committee, develops the annual budget for the organization's fiscal year. Board approved policies govern the authority of ACH staff to make financial commitments without specific approval and when commitments need to be approved by the Board.

The Board is currently developing a process for distributing MTP incentive funding. In accordance with the recommendations from the RHIP Council and SWACH executive leadership, funds flow guiding principles and a high-level allocation methodology has been approved and is more fully articulated in the Funds Allocation section.

An Incentives & Investments Committee will be seated in early 2108 and charged with developing policies for allocating the Systems Capacity Building Fund and the specific criteria by which partnering provider incentives will be distributed.

Partnering Providers will be required to sign a contract with SWACH detailing the specific responsibilities for which they agree to be held accountable and the terms and conditions upon which they will earn incentive payments (*Transformation Rules of Engagement*). Contracts will be clear on the roles and responsibilities of the parties and have breach, cure, and termination provisions. We anticipate contracting to take place in early Q2 of 2018.

Clinical

The Clinical Integration Committee, staffed by an ACH employee who is a behavioral health provider, is comprised of 28 representatives of physical and behavioral health providers, hospitals, and MCOs serving over 90% of the Medicaid population across our three-county region.

Using claims data provided by HCA, SWACH identified the clinical providers across the region serving the Medicaid population and recruited them to join the MCOs on this important workgroup. The Clinical Integration Committee has engagement from providers who work in large, small, urban, and rural settings across all three of the region's counties. The Clinical Integration Committee members are physicians, behavioral health specialists, substance use disorder specialists, integration specialists, payers, and senior administrators responsible for integration efforts within their own organizations. [These committee members were chosen by their organizations as the clinical integration subject matter experts from their organizations.](https://www.southwestach.org/projects/project-one) A full list of the committee members can be found at <https://www.southwestach.org/projects/project-one>.

This group has chosen the clinical approaches for work under the MTP and will have primary responsibility for finalizing the *Transformation Rules of Engagement* for clinical care settings. In

partnership with the ACH Strategic Improvement Team and the QCI Committee, the Clinical Integration Committee will monitor clinical outcomes and the initiatives to improve those outcomes. SWACH may share a Medical Director with Pierce County ACH in the future.

Community

SWACH's community engagement program, the Health Living Collaborative of SW Washington (HLC) is charged with ensuring robust, authentic community and consumer engagement. SWACH received a \$40,000 grant from the United Way of the Columbia Willamette to develop and implement an equity lens for SWACH's work. The HLC Policy Committee will provide oversight for this work and SWACH Vice President of Partnerships, Policy, and Equity will directly oversee the community engagement, policy, and equity work under the supervision of SWACH's CEO. The BHAB will work in partnership with the HLC Committee to ensure additional consumer and lived experience is incorporated into recommendations.

Data

SWACH has contracted with Providence's Center for Outcomes-based Research and Evaluation (CORE) for data measurement and analytics services. CORE scientists and statisticians are supported by data collection experts and experienced qualitative researchers. CORE co-staffs the DLT and provides data interpretation and use guidance. DLT findings are shared with workgroups, committees, and governance bodies for data-driven decision-making. CORE is developing a self-monitoring and reporting system which will enable SWACH to closely track partnering provider performance and provide data for the Strategic Improvement Team and QCI Committee, as well as the partnering providers themselves.

Program management and strategy development

SWACH's CEO is responsible for ensuring appropriate organizational capacity and administrative support for regional coordination and communication across the region. The CEO reports directly to the Board. The Board, in partnership with the CEO sets organizational strategy and holds the CEO accountable for implementing the strategy. The CEO is reviewed annually through a review process which includes evaluations from stakeholders and staff.

Governance Changes

As of October 1, 2017, SWACH officially merged with HLC, making HLC the community engagement, policy, and equity arm of SWACH. The merger terms included the agreement to seat a HLC Committee and HLC Policy Committee to provide oversight and direction to the work of the HLC and inform the work of SWACH. The HLC Policy Committee is seated, and we are currently conducting an open application process and expect to have the HLC Committee seated by January 2018.

Phase II Certification Areas of Improvement

Our Phase II Certification feedback indicated a desire to better understand how organizations/sectors that make up the RHIP Council were identified as having the greatest connection to the region and impact on the ACH meeting its mission and goals. RHIP Council members were initially chosen through an open application process in December 2016. Over 30

applications were received and the selection committee (chosen by the Board) developed and applied selection criteria tied to the organization’s vision, mission, and goals. The selection committee sought representation across sectors and geographies, as well as a broad array of criteria. After selecting the initial members, the RHIP Council noted gaps in the membership and in partnership with SWACH staff, engaged in targeted recruitment to round out the RHIP Council members. Ongoing recruitment and additions will be made throughout the MTP to ensure representatives necessary to our work are engaged and involved.

Oversight of Partnering Providers

Partnering provider participation and performance will be monitored by SWACH staff through the self-monitoring system. In partnership with the Strategic Improvement Team and the Quality and Continuous Improvement Committee, low-performing providers will be engaged in improvement cycles to increase their performance. Providing partners who cease to participate with SWACH will be subject to the termination or breach terms contained in their contract.

Community and Stakeholder Engagement and Input

Describe the ACH’s community and stakeholder engagement and input. In the narrative response, address the following:

- Describe and provide evidence of how the ACH solicited robust public input into project selection and planning (e.g., attachments of meeting minutes or meeting summaries where input was solicited) (*submit as Community and Stakeholder Engagement and Input – Attachment A*). In the narrative, address:
 - Through what means and how frequently were these opportunities for input made available? (e.g., ACH website posting, ACH listserv, surveys, newspaper, etc.)
 - How did the ACH ensure a broad reach and ample response time in its solicitation?
 - How did the ACH ensure transparency to show how public input was considered?
 - How did the ACH address concerns and questions from community stakeholders?
- Provide examples of at least three key elements of the Project Plan that were shaped by community input.
- Describe the processes the ACH will use to continue engaging the public throughout the Demonstration period.
- Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.
- Discuss how the ACH addressed areas of improvement, as identified in its Phase II Certification, related to meaningful community engagement, partnering provider engagement, or transparency and communications.

ACH Response

Our approach is driven by our belief in a community engagement system that is embedded throughout our work. This system enables us to learn and act together with the community; not only to choose, plan, and implement our Transformation Projects, but in all the work of SWACH. We have built a community engagement infrastructure to authentically engage the community in all efforts to address up, mid, and downstream issues across the region to enable all residents to have access to quality care and improved health outcomes in cost effective ways.

SWACH has endeavored to define community engagement with the broadest possible lens. We have done significant outreach to and engaged with the following types of stakeholders across the region:

<p>Health care providers:</p> <ul style="list-style-type: none"> • Primary Care • Pediatrics • OB/GYN • Hospitals • Behavioral Health • Oral Health • Specialty providers • Allied health 	<p>Community-based organizations:</p> <ul style="list-style-type: none"> • Housing • Food • Education • Employment • Legal • Faith • Addiction and Recovery • Child care • Free Clinics • Advocacy • Cultural 	<p>Agencies:</p> <ul style="list-style-type: none"> • Criminal Justice • Corrections • Early childhood development • K-12 Education • Post-secondary education • Public Health • Clark, Skamania, and Klickitat Counties • Transportation • Social Services • Employment • Area Agency on Aging • Developmental Disabilities • WA DOH • WA DSHS 	<p>Public:</p> <ul style="list-style-type: none"> • Community Members • Medicaid Beneficiaries • Community Health Workers • Peer Based Workers/Leaders
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Solicitation of robust public input into project selection and planning

SWACH pursued a multi-pronged approach for soliciting public input on project selection and planning. Cognizant of the differences among our counties and the inevitable variance in effectiveness of any one strategy, SWACH approached soliciting and collecting public input in the following ways:

- Established workgroups and committees were asked to consult with colleagues and partners to bring input and feedback to the group for consideration and discussion. During the project selection and planning process, workgroups and committees were meeting in frequent intervals. Recommendations from the workgroups and committees were included in the project plan recommendations to the RHIP Council;
- The monthly RHIP Council meetings were open to the public, including a public call-in/web conference line, and non-RHIP Council member participants were invited to freely participate in discussions and provide feedback at meetings. Meetings were advertised in the Columbian newspaper, on the SWACH website, and through requests to partners and stakeholders to share meeting information. The project selection and planning recommendations made to the board included community input such as the need to incorporate key elements of the projects not selected in the MTP work;
- The monthly Board of Trustees meetings were advertised in the Columbian newspaper and open to the public, including a public call-in/web conference line, and two opportunities for public comment were provided (one at the beginning of the meeting and one at the end of the meeting). Meetings were noted on the calendar on the SWACH website;

- Behavioral Health Advisory Board (BHAB) meetings provided an opportunity for volunteer community members to share input on the MTP selection and planning process. Particular attention was given to the input regarding culturally specific training for providers;
- Our Community Health Workers (CHWs) and Community Health Advocate and Peer Support (CHAPS) network, on the ground and working within our most vulnerable and marginalized communities across the region on an ongoing basis, ascertained input as seen through the eyes of those utilizing the systems we seek to transform. CHWs and CHAPS then shared this input with SWACH to provide authentic, lived experience that guided our work and enriched the statistical data. The CHW/CHAPS process is a continuous communication loop;
- Our Community Listening Session provided rich feedback and input that was captured and shared with workgroups, committees, and governing bodies for consideration in MTP project selection and planning. This event was heavily advertised through our partners and stakeholders, as well as the Clark County information listserv;
- Key informant interviews were held with community leaders and Medicaid beneficiaries in our more rural and less populated areas of the region (Skamania and Klickitat Counties) with input shared with workgroups, committees, and governing bodies. These interviews corroborated the input we received from BHAB, CHW and CHAPS Network, and listening session;
- Healthy Skamania (a Collaborative group who share the common goal of promoting health and wellness in Skamania County) meetings solicited input and feedback monthly.
- Partners and stakeholders across the region were interviewed for resource assessments, environmental scans, and current state information and their critical input and feedback was shared with workgroups, committees, and governing bodies.

Utilizing these approaches, SWACH achieved broad outreach to clinical care and service delivery partners, community-based organizations, local governmental entities, Tribes, local agencies, advocacy groups, and the public at large. As this was an ongoing process, ample opportunity to provide input throughout a six-month period was provided.

SWACH posted its RHIP Council and Board meeting agenda, materials, and minutes on its website for public viewing. The logic and rationale for decisions can be seen from these materials.

Concerns and questions from community stakeholders were addressed by SWACH staff follow-up to understand the concern/question, and then triaged to the appropriate workgroup, committee, and/or governing body for further discussion. SWACH staff ensured follow-up with community stakeholders.

Key elements of Project Plan shaped by community input

- Opioid Project

Community input provided the direction and strategies for project planning for the required opioid project. The Opioid Workgroup is comprised of representatives from a broad spectrum of community stakeholders including primary care clinics, hospitals, behavioral health settings, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and

community based organizations. Workgroup representatives engaged in a robust process to review, discuss, and prioritize best strategies through which SWACH will address the opioid epidemic in the region. Workgroup members convened five times and engaged in regular email communications over two and a half months to finalize recommendations for SWACH work to address prevention, treatment, OD prevention, and recovery. The Workgroup was aided by data analysis from the Data and Learning team and by lived experiences shared by CHWs, CHAPS network members, and stakeholders working in the addiction and treatment sector. Project planning, chosen approaches and strategies, and initial implementation planning has been done by these community volunteers. The Workgroup's recommendations were adopted by the RHIP Council and approved by the Board.

- Community Paramedicine

Clark County Fire and Rescue, District 12, approached SWACH to share the information and planning they have completed to date around development of a Community Paramedicine Program. Clark College and the Clark Regional Emergency Services Agency (CRESA) have had conversations with District 12 and SWACH agreed to complete an additional environmental scan of the community to refine the scope and identify key partners to aid in planning for a community paramedicine program in Clark County. Workforce development strategies and target population identification were refined by community partners engaged in community paramedicine program planning in Clark County. The input of District 12, Clark College, and CRSEA encouraged the inclusion of Community Paramedicine in project planning.

In interviews to develop an environmental scan of Skamania and Klickitat counties, rural and frontier partners also expressed a desire to develop community paramedicine as a rural solution to diversion from acute settings of care and from jail. Rural community stakeholders expressed concern about transportation and a lack of resources in the rural and frontier areas of the region, resulting in poor access to necessary health care services. The provider partners in the area voiced their support of community paramedicine as the most logical solution for addressing diversion issues and SWACH agreed a community paramedicine program in rural and frontier areas would require a unique plan. Community leaders in Skamania and Klickitat identified the names of key community partners for further interviews and input. SWACH has decided not to pursue Diversion as a MTP, but is committed to including community paramedicine diversion strategies as part of its work in our other project areas, specifically Opioids, Chronic Disease Prevention and Management, Community Care Coordination, and Clinical Integration.

- Community Listening Session Input

SWACH held a successful community listening session attended by community members from varied backgrounds, neighborhoods, and cultures, many who were Medicaid beneficiaries, as well as potential partnering providers and SWACH staff. The community listening session focused on soliciting direct feedback on project selection planning of five transformation projects. SWACH developed a facilitation guide, which included open ended questions to elicit feedback on the project areas. Each participant participated in two small group discussions to provide input on the project plans (Facilitation guide and complete notes are found in SWACH-Att-3-Public-Input-20171116.pdf). The rich feedback was reviewed by SWACH staff and shared with workgroups, committees, and the RHIP Council.

Examples of input incorporated into the project plans:

- The need to provide more culturally specific services;

- Success of peers/CHWs in providing support and connection in ways traditional providers often cannot;
 - Identification of community organization and places where individuals and families receive assistance (this information both provided confirmation and helped to identify new potential partners);
 - Reaffirmed lack of regional Medicaid health care providers is an issue, not only for beneficiary access, but also how this need is overwhelming existing providers (quadruple aim);
 - Identified need for more information from a specialized source for chronic condition(s); and
 - Language barriers prohibit people from getting or properly utilizing care.
- Project Language

During an outreach session with a community advocacy group, SWACH learned the use of the term “Demonstration,” when used with health care, is offensive to the African American community. Given the nation’s long history with medical experimentation on African Americans, the use of this term may be a barrier to engaging this population in our work. SWACH has removed the word demonstration from our vernacular and instead use Medicaid Transformation Project or MTP in our communications and references for all work going forward.

Continued Public Engagement

SWACH intends to continue to use and strengthen the strategies and mechanisms defined above throughout the MTP. We hope to attract non-Medicaid providers to our work to better align with the broader health care system. As we spread our community engagement program through our Healthy Living Collaborative (HLC) program into Skamania and Klickitat Counties, we expect a more robust penetration of CHW and CHAPS network activities. We have Community Listening Sessions planned to occur quarterly with an opportunity to complete an online survey in addition to or in place of attendance to ensure as wide a reach as possible. We plan to have our DLT and Strategic Improvement Team work with our community engagement system to ensure we are including authentic, lived experience in analyzing performance and creating improvement cycles. SWACH will continue to solicit feedback and input on how we can better engage our community stakeholders.

SWACH will also begin an 18-month stakeholder engagement process to define a vision for community health and resiliency for the region. We expect this process to provide rich input and engagement opportunities throughout the MTP.

- Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.

SWACH has worked with county departments in the following ways:

Clark County

- Clark County Public Health
 - Co-leading the DLT with SWACH
 - Critical partner on Chronic Disease Prevention and Control and Opioids Projects
 - RHIP Council Membership

- Present at Public Health Advisory Board Meetings
- Participate in SW WA Regional Health Care Advisory Committee (Clark and Skamania)
- SWACH CEO has met with all County Councilors individually to discuss MTP work
- SWACH Vice President for Clinical Integration meets with Director of Clark County Community Services regularly to discuss Integrated Managed Care
- Corrections department participates in DLT, Opioid Workgroup
- Behavioral Health Capacity Building Committee (Clark and Skamania Counties, MCOs, ACH, BH-ASO)
- Support for Crisis Center

Skamania

- Partner/member Clinical Workgroup
- Partner/Member Community Care Coordination Workgroup
- Board of Trustees member
- Healthy Skamania meetings

Klickitat

- Klickitat County Public Health Department – RHIP Council member

SWACH intends to nurture its relationships with the counties and to find more opportunities to work in partnership. We believe planning for the distribution of the IMC incentive funds will provide a good platform on which to align our vision and work.

Phase II Certification Areas of Improvement

Our Phase II Certification feedback noted a lack of specificity regarding the list of successes for meaningful community engagement. SWACH viewed engagement of community groups (e.g. LULAC, NACCP, Free Clinic, AAA) as evidence of interest and excitement for the work ahead. For SWACH, meaningful community engagement referred to a multi-prong approach that has been enhanced to go deeper into the community. We have utilized community listening sessions and key informant interviews to elicit specific feedback from the Medicaid population. These sessions provided staff and providers an opportunity to hear candidly from the community where individuals felt safe. We received positive feedback from participants stating they felt heard and they wanted the opportunity for more community listening sessions. We intend to have quarterly sessions beginning in January 2018.

Feedback also included a lack of specificity regarding provider engagement activity and input outside of the formal governance structure. SWACH has engaged potential partnering providers, both clinical and community-based, through activities such as:

- Environmental scanning meetings with Clark, Skamania, and Klickitat providers;
- Presentations for local Clark, Skamania, and Klickitat County meetings with stakeholders, providers and community groups focused on their community's health;
- Staff participation with partnering provider efforts such as the Klickitat Valley Health opioid taskforce meeting;
- Participation in Healthy Skamania meetings each month as a conduit between the local provider community, stakeholders, CBOs and the ACH;
- In person 1:1 meetings with potential providers;

- In person 1:1 meetings with allied providers, such as Clark College and Lower Columbia College;
- Participation in efforts of the Washington State Workforce Education Council as a means of engagement with the college deans regarding future workforce needs in health care;
- Presentation to the Clark County Medical Association;
- Presentation to the Area Agency on Aging;
- Meeting with the WA Department of Transportation to discuss transportation issues; and
- Presentation to the Free Clinic of SW Washington

Our engagement efforts have been with potential clinical and community-based partnering providers across all three counties in our region.

Tribal Engagement and Collaboration

Describe the ACH's current tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts. In the narrative response, address the following:

- How are tribal and IHCP priorities being identified, either through the ACH or through tribal/IHCP partners?
- Have those priorities informed project selection and planning?
 - If applicable, provide examples of at least three key elements of the Project Plan that were informed by tribal input.
 - If tribes/IHCPs are not involved in ACH project selection and design, describe how the ACH is considering the needs of American Indians/Alaska Natives in the ACH region
- If possible, provide as attachments statements of support for the ACH from Indian Health Service, tribally operated, or urban Indian health program (ITUs) in the ACH region. (*Submit as Tribal Engagement and Collaboration – Attachment A.*)
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to tribal engagement and collaboration.

ACH Response

Current tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts

Tribal and Indian Health Care Provider (IHCP) engagement and collaboration has been guided by Steve Kutz, Director of Health and Human Services of the Cowlitz Nation and a member of the SWACH Board of Trustees. Steve has served as our primary Tribal representative and connection point with the Cowlitz Nation.

We have struggled to engage with the Yakama Nation. We have been pursuing a formal introduction, but have not yet been offered the opportunity.

We have been in contact with the Northwest Portland Area Indian Health Board (NPAIHB) to request data to align and complement our existing regional data specific to Tribal health needs and disparities.

Through conversations with the Health Care Authority and other educational opportunities, SWACH has identified the following considerations with respect to tribal and IHCP engagement:

- The Federal Trust responsibility and the legal obligation of the federal government to provide health care for all American Indians/Alaskan Natives (AI/AN) and how the MTP intersects and interacts with the relationship between Indian Nations, the state government, and federal government, including the role ACHs play;
- Access to and ownership of tribal and IHCP specific data can be problematic, based on the historical context of how data has been obtained and used to marginalize or eradicate certain populations; and
- Culturally-specific, responsive and authentic behavioral health interventions are critically important, as AI/AN populations see some of the largest disparities in behavioral health outcomes, which arise from intergenerational trauma and high levels of adverse childhood experiences (ACEs)

We understand Tribal communities struggle with capacity issues and we intend to go to these communities, and to support their engagement and involvement to the greatest extent desired the Tribes. SWACH recognizes that we do not have the solution to these challenges and/or considerations, but we will be sensitive and appropriately responsive when planning and implementing MTP plans.

Identifying tribal and IHCP priorities

- SWACH staff has been recruiting Cowlitz Tribal representation for workgroups, committees, and governance bodies to supplement the support Steve Kutz provides. To date, we have received input on tribal/IHCP priorities through contacts with the Deputy Director of Health and Human Services for the Cowlitz Nation, the Program Coordinator for Health and Human Services for the Cowlitz Nation, and the Health Director of the Cowlitz Nation.
- SWACH's community outreach and engagement have identified Community Care Coordination and Chronic Disease Management and Prevention as project areas with overlapping priorities for the Tribe.

Elements of the Project Plan informed by tribal input

- Awareness and Sensitivity Training

All participating partners will be required to complete awareness and sensitivity training to ensure care will be culturally-specific, appropriately responsive, and authentic.

- Community Care Coordination

Members of the Cowlitz Nation struggle with transportation to Clark County for services given the lack of available public transportation. We have noted this and will look to address transportation issues in our Community Care Coordination HUB.

- Chronic Disease Management and Prevention

Data suggests focusing on chronic disease management could improve outcomes for the Tribal population. Our workgroups welcome Tribal input to craft specific activities for the *Transformation Rules of Engagement* to improve the chronic disease management protocols for Tribal members. Also, through our work with the Healthy Living Collaborative (HLC) we have identified that the Cowlitz Tribe

recently lost funding for a diabetes prevention program. We are interested in helping the Tribe utilize the specific approaches of the MTP Chronic Disease Management and Prevention work planned to be implemented by SWACH.

Phase II Certification areas of improvement

Phase II certification feedback noted no area for improvement. One deficiency noted regarded the implementation of the Tribal Implementation Committee, included as part of the Model ACH Tribal Collaboration and Communication Policy, which was adopted by the Board. No designee to the Tribal Implications Committee has been made by the Tribe, however we do have a Tribal representative on the Board, and we rely upon his guidance with respect to Tribal issues. The Executive Committee also endeavors to be aware of specific tribal issues and has not determined any SWACH action to date to have a negative impact or consequence AI/AN populations. We will continue to ask if there is interest establishing a Tribal Implementation Committee, and will formally establish one if a request is made and a tribal representative to the committee is identified.

In addition to Cowlitz, input has been solicited from the Northwest Portland Area Indian Health Board (NPAIHB).

We continue to pursue a relationship with the Yakama Tribe. We have hired a tribal relations consultant, and through her efforts, expect more robust tribal partnership with Yakama and the NPAIHB in addition to Cowlitz.

Funds Allocation

Funds Flow Oversight

Describe the ACH's process for funds flow oversight. In the narrative response, address the following:

- Describe how the ACH will manage and oversee the funds flow process for DSRIP funds (Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds), including how decisions will be made about the distribution of funds earned by the ACH.
- Discuss the roles and responsibilities of, and relationships between, the ACH governance body and partnering providers in managing the funds flow process.
- Describe the ACH process for ensuring stewardship and transparency of DSRIP funds (Project Design funds, Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds) over the course of the Demonstration.
- If applicable, provide a summary of any significant changes since Phase II Certification in state or federal funding or in-kind support provided to the ACH and how the funding aligns with the Demonstration activities.
- If applicable, provide a summary of any significant changes to the ACH's tracking mechanism to account for various funding streams since Phase II Certification.

ACH Response

Management and Oversight of Funds Flow Process

The SWACH Board of Trustees, having the ultimate fiscal oversight of the organization, will make the final decisions on the distribution of all MTP/DSRIP funds. As Board meetings are open to the public,

this information is available by attending these meetings or reviewing meeting minutes posted on the SWACH website. Time is allowed for public comment at all board meetings.

To date, the high-level decisions about the distribution of DSRIP funds have been made by the Board of Trustees. DSRIP incentives will be distributed among four categories:

- ACH Management and Administration
- Community Resiliency Fund
- Systems Capacity Building Fund
- Provider Payments

ACH Management and Administration funds will be distributed to the ACH and managed and overseen by the Board of Trustees via its annual budgeting approval process and expended pursuant to ACH policy. The annual budget is prepared by executive staff, approved by the Board of Trustees, and variance reports will be reviewed by the Finance Committee and Board of Trustees on a regular basis.

SWACH intends to engage in coalition building to formulate a framework for distributing the **Community Resiliency Fund**. With direction of the Board of Trustees, SWACH plans to lead the region to develop a regional vision – a north star which will guide long-term investment to truly impact upstream issues. SWACH intends this work to begin in Q1 of 2019 and continue through the end of Q2 of 2020. This 18-month stakeholder engagement/coalition building process will provide a strong roadmap for the investments necessary to achieve the region’s vision. Given the percentages allocated to the Community Resiliency fund, and the timing of the cash flow, we do not anticipate significant enough funds in this category to implement projects until the end of the MTP.

The Board of Trustees is developing a policy to govern the distribution of the **Systems Capacity Building Fund** and will establish an oversight committee (Incentives & Investments Committee) to implement the policy and oversee all decisions regarding incentive fund distribution. For expenditures related to system capacity building, the committee will review expenditures proposed to be paid from the fund pursuant to the final, adopted policy. The Board anticipates a policy and decision on whether the oversight committee is a Board committee, or committee comprised of non-Board members by January 31, 2018.

SWACH staff will use the current state assessments to identify gaps and determine areas of need for implementation of the selected projects. Staff will validate assessment data with workgroups and committees. This information will be consolidated by the executive staff (CEO, CFO, COO, and CITO) and prioritized for recommendations to the Incentives and Investments Committee. The committee will prioritize and scope expenditures based on the policies and guidance of the Board of Trustees.

SWACH will work with our workgroups, the community, and our governing bodies, using our guiding principles, to further develop how incentives will be distributed to participating providers (Partner Payments).

Once we finalize the Transformation Rules of Engagement, and the ACH-level reporting and performance metrics, we will have the information necessary to design a model to distribute the earned incentives going to providers. Input received thus far has focused on rewarding providers serving large numbers of Medicaid beneficiaries and those meeting and exceeding performance goals.

Roles and Responsibilities for Managing the Funds Flow Process

As with all decisions regarding the MTP, the various governance bodies of the organization will ensure transparency and engagement in managing the funds flow process. The Board of Trustees is ultimately responsible for the oversight of the funds flow process. Information regarding distribution of all funds (ACH Management & Administration, Community Resiliency Fund, Systems Capacity Building Fund, or Provider Payments) will be reviewed by the Board of Trustees. Board meetings are open to the public. Meeting dates and locations, meeting minutes and handouts are posted on the SWACH website, SouthwestACH.org.

The Incentives & Investment Committee will use our funds flow guiding principles (see Funds Flow Distribution section below), to develop policies for the ultimate methodology for incentive payment distribution for approval by the Board. The workgroups, committees, and RHIP Council will provide input and feedback on policy proposals from the Incentive and Investment Committee. The policies will detail the allowable expenditures and methodology for determining those expenditures, timing of distribution of funds, and documentation of accomplishments/reporting required from partnering providers to receive funds. The policies will also include a mechanism for a partnering provider to appeal a funding decision. MTP contracts between SWACH and partnering providers will contain these policies and expectations. Contracts will also articulate partnering providers' rights to be informed of performance issues jeopardizing their receipt of incentive payments or distributions from the SCB Fund.

The Finance Committee of the Board will review the distribution instructions given to the Financial Executor to ensure they are compliant with the Board approved policies.

Stewardship and Transparency

SWACH intends to use our funds flow guiding principles (see Funds Flow Distribution section below), coupled with checks and balances from our oversight committees (see Roles and Responsibilities section above) to ensure proper stewardship of all DSRIP incentive funds.

SWACH will prepare and disseminate biannual reports detailing its success in meeting pay for reporting and performance measures and VBP incentives and the associated amounts of incentives earned. Reports will provide tracking of funds designated and disbursed for the four categories listed above. Budget to actual reports will be provided to the Board in timely and regular intervals. We will also report the amount of incentive payments to each partnering provider. This information will also be available through our web site.

As of October 1, 2017, SWACH has merged in the Healthy Living Collaborative of Southwest Washington (HLC), a community-driven coalition working for upstream initiatives that promote health equity and strengthen communities. HLC has been part of a four-year 1422 Contract with the Washington State Department of Health. October 1, 2017 was the start of the final year of this project, funded at \$370,000. HLC will serve as a Community Lead Organization to coordinate the Healthy Communities Obesity, Diabetes, Heart Disease and Stroke Prevention Program to promote healthy living. While this program is not exclusive to Medicaid participants, it will have cross-over, and SWACH will be braiding some of the 1422 funds to support the development of the Pathways Hub.

The United Way of the Columbia Willamette has also provided HLC with a grant of \$40,000 in support of the mission of improving health and wellness outcomes in the community through authentic community engagement, using an equity lens in the development of the ongoing work, and supporting continuing collaboration among multiple partners.

Please further elaborate on specific staff positions/titles involved in the financial processes for funds flow. For example, include those in charge of developing the budget, paying bills, sending information to the Financial Executor, etc. In addition to the staff position/title, please include information about the fiscal services they provide.

CEO and CFO are primary staff responsible for developing all financial processes for the organization, including funds flow. Input from the entire staff is solicited and evaluated as part of the budget build. The Board has approved the creation of an Incentives and Investment Committee. The CEO and CFO will staff this committee to assist committee members in design and development of appropriate policies and procedures to govern funds flow.

The CFO will work with the Accounting Manager (hired as of December 27, 2017) to prepare an overview of projected payments based upon the criteria set by the Incentives and Investment Committee. The Incentives and Investment Committee will approve projected payments from the System Capacity Building Fund and the direct to provider incentive payments. The Accounting Manager will send the information to the Financial Executor once the Incentives and Investment Committee has approved the payments.

The CEO approves all payments made on behalf of the organization and the CFO and Accounting Manager work together to ensure timely payment of obligations. Our Contracts Manager ensures the CEO and CFO are aware of contractual obligations requiring payment.

The Finance Committee reviews the financial transactions of the company on a monthly basis and the financial statements, including a year to date. budget to actual comparison, and the board approves the financial statements at its monthly meeting.

A Community Resiliency Committee will also be established to govern the policies and procedures, as well as the distribution, of the Community Resiliency Fund. The CEO and VP of Partnerships, Policy, and Equity will staff this committee.

Project Design Funds

Describe, in narrative form, how Project Design funds have been used thus far and the projected use for remaining funds through the rest of the Demonstration.

ACH Response

Project Design Funds

To date, SWACH has used project design funds (in thousands) to:

- Hire staff 330;
- Rent office space 13;
- Purchase office furniture 2;
- Purchase computers and IT equipment 8;
- Rent meeting space 1;
- Travel to meetings 8;
- Pathways HUB (Technical assistance, consulting) 3;
- Procure legal and accounting services 6;
- Procure consulting services 174;

- Conduct community outreach and engagement 26; and
- Implement a communications strategy 5.

The Board of Trustees approved using design funds to fund a pilot and create a training program for implementing EDIE/Pre-manage with three behavioral health provider organizations in Clark County. These funds will reimburse the three organizations for the staff time needed for training and shared learning workgroup commitments. The pilot and training will run from November 1, 2017 through June 30, 2018.

The Board of Trustees had originally approved utilizing the \$6M in design funds in a 4:2 ratio: \$4M to the ACH to use for ACH administration expenses and \$2M to be utilized to assist providers in planning for and implementing MTPs, including provider engagement, community engagement, HIT/HIE, training, technical assistance, workforce development, and pilots. Upon the recent disclosure regarding the decrease in DSRIP funding, the Board approved a 5:1 ratio, with \$5 M to the ACH to be used throughout the MTP timeframe, and \$1M for planning and implementation to partnering providers.

Funds Flow Distribution

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

- Describe how Project Incentive funds are anticipated to be used throughout the Demonstration. Provide a narrative description of how funds are anticipated to be distributed across use categories and by organization type. (*Refer to the Funds Distribution tabs of the ACH Project Plan Supplemental Data Workbook for use categories and organization types to inform the narrative response*).

ACH Response

Funds Flow Distribution

Three factors have influenced SWACH’s Funds Flow Distribution model:

- Delivery System Reform Incentive Payment (DSRIP) Definition
- Guiding Principles
- Lessons Learned

DSRIP programs are part of Section 1115 waivers and work by providing funding to states to support providers in changing and improving care delivery to Medicaid enrollees.

- Under DSRIP programs, payments to providers are linked to performance on certain quality and cost metrics, focusing on infrastructure development, delivery system design, population health management, and clinical outcomes.
- The focus of early years of DSRIP programs is typically on **infrastructure development and system design, and the metrics are often process-based**.

- In later years, the focus shifts to **outcomes-based metrics that assess clinical or population health improvements.**⁶³

With input and direction from its workgroups, the community, and governance bodies, SWACH developed funds flow guiding principles.

Guiding Principles:

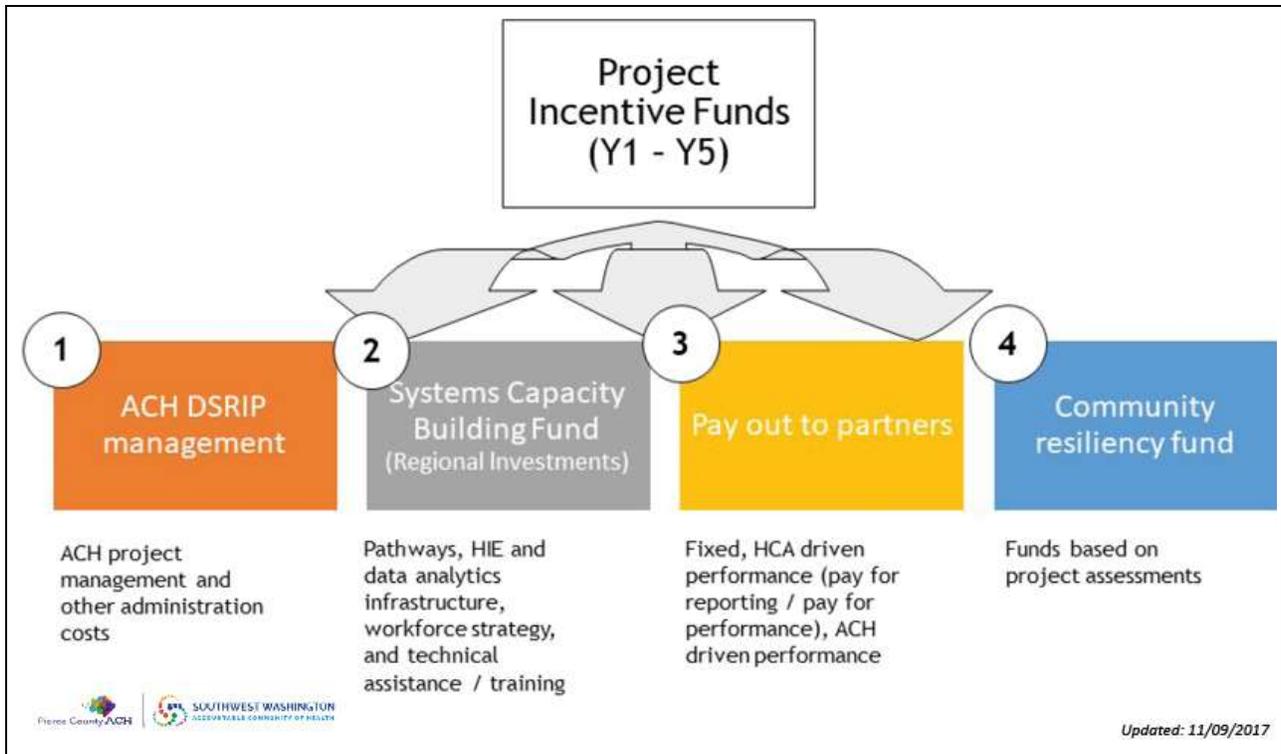
- Equitable
- Sustainable
- Transformative
- Transparent
- Locally Responsive

SWACH also met with four Participating Provider Systems (PPSs) currently implementing a Medicaid DSRIP project in New York state. In sharing lessons learned, these PPSs were consistent on several points:

- Funds required for infrastructure and capacity building and system design should not be distributed directly to providers, but paid by the DSRIP management organization (PPS in NY, ACH in WA);
- It is extremely difficult to estimate the needs and expenses of the work ahead (the known unknowns) while in the planning phase; and
- Ensure funds will be available for costs not currently anticipated because there will be many (unknown unknowns).

Based upon the DSRIP definition, the guiding principles, and the learnings from New York, SWACH has developed a framework for funds flow process for distribution, approved by the Board of Trustees, that initially allocates funds to one of four categories:

⁶³ Kaiser Family Foundation, Issue Brief: “An overview of Delivery System Reform Incentive Payment (DSRIP) Waivers,” Sept 2014 <https://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.



The specific percentages of total incentive dollars proposed across the 5-year MTP projects are illustrated in the table below.

Category	Y1	Y2	Y3	Y4	Y5
ACH DSRIP Management ⁶⁴	10%	10%	10%	10%	10%
Community Resiliency Funds ⁶⁵	10%	10%	15%	20%	25%
Systems Capacity Building ³	60%	60%	50%	40%	30%
Paid out to Partners ³	20%	20%	25%	30%	35%

Project Management and Administration

SWACH will supplement the planning and design funds with a consistent percentage of project incentive funds each year of the MTP. These funds will continue to support the administrative expenses of the ACH, including:

⁶⁴ 10% of maximum dollar amount of all incentives available each year

⁶⁵ Percentages of earned dollar will be allocated based on the funds remaining
 ACH Project Plan Template (October 16, 2017)

- Project management;
- Staff support for workgroups and committees;
- Staff support for governance bodies;
- Pathways HUB administration;
- Support for workforce development;
- Support for population health management;
- Support for value-based contracting;
- Community engagement; and
- Communications.

Provider Engagement, Participation and Implementation

Given the New York DSRIP learnings, SWACH has designed a framework that ensures providers will have MTP and transformation costs covered to the greatest extent possible. Instead of disbursing funds meant to cover infrastructure costs directly to partnering providers for these expenses, SWACH's System Capacity Building Fund will pay for these expenses to ensure we have engaged providers, participating fully, who can implement the *Transformation Rules of Engagement* and be high performers in the pay for reporting and performance incentive program. SWACH will pay for costs directly, reimburse partners for costs incurred, or provide funds with very specific parameters for their expenditure. One of the lessons learned for the NY PPSs was once funds are provided to a partner organization, it is hard to ensure those funds will be used for the intended purpose and not just rolled into their general budget.

SWACH will work with partnering providers to help them understand their roles based upon their care or service delivery setting, assess their resources, identify their gaps, and suggest options for solutions. These costs will be estimated organization by organization, and each partnering provider will have their needs covered based upon the policy governing the use of System Capacity Building funds approved by the Board of Trustees.

SWACH intends to use the Systems Capacity Building Fund to support partnering providers in the following areas:

- Care and service delivery setting transformation training, coaching, facilitation, and technical assistance;
 - Change management
 - Revenue cycle management
 - Supply chain management
 - Intake/discharge protocols
- Strategic Improvement/quality improvement activities
- Population health managements systems (EHRs, HIE, etc.);
- Value-based payment technical assistance and preparation;
- Workforce development, including salary reimbursement;
- Assistance with lost revenue; and
- Support in training and education on preventing provider fatigue.

Provider Performance and Quality Incentive Payments

SWACH's funds flow framework will distribute pay for reporting and performance incentives to partnering providers based upon the model approved by the Board of Trustees. SWACH (in partnership with two other ACH's) engaged KPMG Management Consultants (KPMG), based upon their previous experience working with DSRIP programs and MTPs in other states, to develop a model for the allocation Project Incentive Funds to partners including traditional Medicaid providers, non-traditional Medicaid providers and Tribes. This model is in development and will look at paying incentives based upon factors such as level of engagement and participation, level of success with both MTP and ACH-level criteria and number of Medicaid lives served. Funds paid to partnering providers under this category will come with no expectation for specific use once received by a partnering provider, although it is our hope partnering providers will use these incentive funds to offset any costs or expenses not covered by payments from the Systems Capacity Building Fund and to continue transformation efforts post-MTP.

Funds will be distributed by organization type based upon the final algorithm of the funds flow model. Currently, the distribution by organization type proposed in the supplemental workbook was created based upon estimates for the following criteria:

- Number of partners by organization type
- Number of Medicaid members served
- Ability to influence outcome measures
- Number of projects in which partner will participate
- Level of need

The model assigns a value to these criteria and then allocates available resources according to the algorithm underlying the model.

Once partners have executed contracts, SWACH will have actual data to run through the funds flow model and will adjust the estimates based on actual provider participation and need.

Health Systems and Community Capacity Building

SWACH will also use its Systems Capacity Building fund at a broader level beyond the Provider Engagement, Participation and Implementation payments. This will include state and region-wide workforce development (versus the practice level workforce development referred to above) such as developing a Community Health Worker training program for Pathways, state and region-wide HIE/HIT strategies (versus partnering provider level HIT/HIE investments), and state and region-wide value-based payment activities. We continue to work with our ACH and state partners to define areas where collaboration will bring economies of scale and better outcomes. Collaborating on HIT/HIE strategies, Pathways technology, data collection and analytics, and reporting platforms are areas of interest to SWACH.

- Using the **Funds Distribution** tabs of the **ACH Project Plan Supplemental Data Workbook**:
 - **Funds Distribution – 1**: Provide the projected percent funding of the Project Incentive funds by use category over the course of the demonstration (DY 1 through DY 5 combined). "Project Management and Administration," "Provider Engagement, Participation and Implementation," "Provider Performance and Quality Incentive

Payments,” and “Health Systems and Community Capacity Building” are use categories that are fixed in the workbook. ACHs may enter additional use categories. For each use category (fixed and additional), ACHs must provide a definition and the projected percentage of Project Incentive funds over the course of the demonstration.

- **Funds Distribution – 2:** Provide the projected percent funding of the Project Incentive funds by/for organization type for DY 1. “ACH Organization/Sub-contractors” and four “Partnering Provider Organizations” types are fixed in the workbook. ACHs must define “Other” organizations if the organization type is used. For each organization type, ACHs must provide a projected percentage of Project Incentive funds for DY 1.
- Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
X	

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

YES	NO
	X

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

DATE (month, year)	March 30, 2016
--------------------	----------------

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

DATE (month, year)	February, 2018
--------------------	----------------

- If applicable (*regions that have submitted LOI and implementation is expected*), please describe how the ACH is working within the community to identify how Integrated Managed Care Incentive funds will be used or invested. Identify the process for determining how Integration Managed Care Incentives will be allocated and invested, including details for how behavioral health providers and county government(s) are participating in the discussion. Additionally, using the guidance provided below, describe anticipated use of funds.

(The Managed Care Integration Incentives are intended to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care business processes. County governments are one example of a potential

partnering provider that could receive earned integration incentives, but integration incentives are dispersed by the financial executor, according to an allocation approach defined by the ACHs. Include use categories defined by the ACH for planned funds distribution).

ACH Response

Integrated Managed Care (IMC) Incentives

SWACH is in an interesting position with respect to IMC Incentives. Clark and Skamania Counties were early adopters of IMC, completing the financial integration as of March 30, 2016. Since April 1, 2016, these counties have been financially integrated and behavioral health services have been paid to providers by either Molina Healthcare or Community Health Plan of Washington (CHPW). By February 2018, when SWACH is estimating receipt of the IMC incentives, Clark and Skamania providers will be approaching their second-year functioning in an IMC environment. The counties and behavioral health providers have made great strides in transitioning to IMC, and do not require the same level of technical assistance and training as providers in regions just beginning their transition activities.

As an early-adopter, SWACH has begun work on clinical integration and this is an area where we have identified great need for provider assistance. Many regional behavioral health providers are just implementing electronic health records (EHR). This can be a great asset to our efforts to clinically integrate physical and behavioral health providers, however the success with implementation and use of these records, and assisting providers in gaining access to HIE capabilities will affect our outcomes.

During SWACH's implementation planning period, we will conduct a needs assessment of providers with respect to clinical integration as part of both the MTP bi-directional integration work and the IMC work. This assessment will be done as a two-step process: a provider survey followed by an in-person assessment by the SWACH Chief Information and Technology Officer (CITO). Once the needs assessment has been completed and compiled (March 2018), SWACH will present the results to the HIE/HIT Task Force for input and feedback. Recommendations will be made by the Task Force regarding action steps and the use of the IMC incentive funding distribution. We anticipate these funds supporting providers with training and assistance with EHRs, implementation of Pre-manage/EDIE, costs associated with HIE, and cost reimbursement to cover employee training and loss of productivity during the implementation phases.

SWACH will also review capacity building requests from behavioral health providers in conjunction with the counties, the MCOs, and the BH-ASO.

Klickitat County was designated a transitional county until mid-2017 when they formally moved into the SWACH region for purposes of the MTP. Klickitat has since submitted a letter of intent to be a mid-adopter, and we anticipate its transition in January 2019. SWACH will help the Klickitat providers transition to IMC by providing technical assistance and training on billing and revenue cycle skills, as well as supporting these practices in clinical integration. We are planning a meeting with the county and providers in early 2018 to discuss a plan for assessing providers needs during the transition

period. Our information to date shows only one behavioral health provider in Klickitat County, and we will ensure it has the support it needs to meet the transition timelines.

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

The Medicaid Transformation Project Demonstration requires all ACHs to focus on three areas that address the core health system capacities that will be developed or enhanced to transform the delivery system: financial sustainability through value-based payment (VBP), workforce, and systems for population health management.

The focus areas in Domain 1 require system-wide planning and capacity development to support payment and service-delivery transformation activities. ACHs, in collaboration with HCA and statewide partners and organizations will need to work to use existing infrastructure, and develop sustainable solutions. While regional project implementation will require some level of targeted efforts, ACHs should focus on collective approaches to develop and reinforce statewide strategies and capacity. As a foundation for all efforts within Domains 2 and 3, this collective effort will enhance efficiency, lead to coordinated solutions, and promote sustainability. To the maximum extent possible, ACHs should seek to collaborate with state government and statewide entities, and support partnerships between ACHs, providers, and payers on common topics for all Domain 1 strategies in order to promote efficiencies and reduce costs.

Domain 1 Strategies

- Describe how capacity-building in these three Domain 1 focus areas will support all selected projects.
- Describe the investments or infrastructure the ACH has identified as necessary to carry out its projects in domain 2 and 3.

Value-based Payment Strategies

ACHs should use the statewide and regional results from the 2017 MCO and Provider VBP Surveys, and other engagement with partnering providers, to respond to the questions within this section.

Describe the ACH's approach to implementing and supporting VBP strategies in all projects. In the narrative response, address the following:

- Describe how the ACH supported and/or promoted the distribution of the 2017 Provider VBP Survey.
- Describe the current state of VBP among the ACH's providers.
 - Has the ACH obtained additional information beyond what the survey included? If so, were these findings consistent or inconsistent with the survey results?
- How do providers expect their participation in VBP to change in the next 12 months?
- For your partnering providers, what are the current barriers and enablers to VBP adoption that are driving change?
- Describe the regional strategies that will support attainment of, and readiness to, achieve

statewide VBP targets, including plans for the ACH to partner with MCOs and provider associations.

- What will be the ACH’s role in supporting providers in the transition to VBP arrangements? What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?

Workforce Strategies

Workforce strategies provide a foundation for creating sustainable community-based and statewide delivery system transformation. ACHs should consider opportunities to invest their resources to ensure sustainable workforce capacity assessment and development by leveraging collaborative activities with Washington’s statewide health workforce resources.

Describe the ACH’s preliminary considerations and approach to adapting workforce strategies across all selected projects. In the narrative response, address the following:

- Describe how the ACH will identify the workforce necessary to support payment and service delivery transformation activities, and assess current workforce capabilities, capacity and gaps.
- Describe how the ACH is considering and prioritizing the advancement of statewide and regional innovations and approaches in workforce capacity development. How will the ACH use existing workforce initiatives and resources, including strategies to support team-based care, cultural competency, and health literacy (i.e., Workforce Training & Education Coordinating Board’s Health Workforce Council, Department of Health’s Office of Rural Health, Health Sentinel Network, Practice Transformation Support Hub, etc.)?

Population Health Management Systems

The term population health management systems refers to health information technology (HIT) and health information exchange (HIE) technologies that are used at the point-of-care, and to support service delivery. Examples of HIT tools include, but are not limited to, electronic health records (EHRs), OneHealthPort (OHP) Clinical Data Repository (CDR), registries, analytics, decision support and reporting tools that support clinical decision-making and care management.

The overarching goal of population health management systems is to expand interoperable HIT and HIE infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support VBP models and care delivery redesign.

Describe the ACH’s preliminary considerations and approach for expanding, using, supporting and maintaining population health management systems across all selected projects. In the narrative response, address the following:

- Describe how the ACH will work with partnering providers to identify population health management systems that are necessary to support payment and service delivery transformation activities, and to assess current population health management systems capabilities, capacity and gaps.
- Describe how the ACH will work with partnering providers, managed care organizations and other ACH stakeholders to expand, use, support, and maintain population health management systems across all projects.

ACH Response

Domain 1 Strategies:

Capacity Building

Capacity building in the three Domain 1 focus areas will support all SWACH selected projects by ensuring partnering providers have the necessary skills and infrastructure to transform care and service delivery settings to offer whole person care in a pay for value environment. The three Domain 1 focus areas are inextricably linked and together will provide a strong foundation for transformation efforts.

For partnering providers to successfully transition from fee-for-service to value-based contracting, provider organizations will require specific capabilities:

- Establish appropriate governance and organizational processes;
- Engage individual providers within their organizations;
- Develop care coordination and management;
- Develop and use technology and data analytics; and
- Develop links to community-based organizations to address the social determinants of health.

Capacity building in the three Domain 1 focus areas will assist partnering providers in developing VBP capabilities and offering whole-person care. For example:

- Investments in population health management systems will provide the capability to capture and analyze data for performance measurement and integrated care, care coordination and management, and links to community-based organizations to address social determinants of health.
- Investments in workforce development will provide a foundation to governance and organizational processes, engaging with individual providers, care coordination and management, use of technology and data analytics, and links to community-based organizations to address social determinants of health.

Investments

SWACH has identified the following investments and infrastructure necessary to carry out the projects in domain 2 and 3:

- ACH Administration
- Awareness and Sensitivity Education and Training (cultural, equity, behavioral health)
- Training, Technical Assistance, Transformation Coaching
- Pathways HUB Technology, Training, Administration
- HIE/HIT/Population Health Management Systems
- Validated Screening Tools and Instruments
- Lost Revenue Support
- Data and Analytics
- Strategic Improvement Team
- Self-monitoring system
- Reporting platform
- Workforce
- Provider Engagement
- Partner Engagement

- Community Engagement
- Communications

SWACH intends to make investments in the above-listed requirements to support our partnering providers in transitioning to a value-based contracting environment where they will be paid for high-value, whole-person, integrated care.

SWACH Domain 1 Capacity Building will support each project as follows:

Clinical Integration

- Assist regional providers to assess, choose, implement, and fund health information exchange functionality that will support the clinical integration models being implemented under the bi-directional clinical integration project.
 - SWACH is working with Qualis Health, Department of Health, and three behavioral health provider organizations on a pilot to provide the EDIE/Pre-manage functionality through Collected Medical Technologies (CMT) to behavioral health providers.
- Assist regional providers to assess workforce needs and identify solutions including, but not limited to, training, technical assistance, coaching, and funding.
 - SWACH is leveraging the EDIE/Pre-manage pilot to develop a training to spread this functionality to the other behavioral health providers in the region. SWACH is covering the staff time and expenses for the three behavioral health providers participating in developing the training.
- Assist regional partnering providers to understand and adapt to value-based contract arrangements including, but not limited to, training, technical assistance, and coaching, assessment of technology to better track and understand patient populations, and coordination with the MCOs to ensure alignment.

SWACH will continue to rely upon the Clinical Integration Committee to provide global guidance on these areas, but will also work with each partnering provider to ensure interventions and solutions are appropriate for the specific needs of each organization.

Community Care Coordination

- Ensure community care coordination solutions are supported through appropriate technological platforms that interface with other population health strategies being implemented across the region.
- Provide necessary training, technical assistance, coaching, and financial support to care coordinating agencies, developing and supporting a workforce to support the community care coordination model. (Pathways Hub).

- Work with MCOs and the Health Care Authority to track and detail the return on investment and savings realized from community care coordination efforts and ensure they are represented in a value-based purchasing model.

Addressing the Opioid Use Public Health Crisis

- Assist regional providers to identify and support technological solutions to increase the use of the Prescription Drug Monitoring Program.
- Assist regional providers to identify workforce gaps and needs and provide training, technical assistance, coaching, and funding to fulfill these needs across the addiction prevention, treatment, overdose prevention, and recovery categories.
 - SWACH is working with our community behavioral health providers to enable nurses to attend a statewide training at SeaTac in January as well as pursuing similar trainings to be done regionally.
- Assist regional partnering providers to identify value-based payment strategies that support the system changes required to address this crisis and to align with MCOs on how these interventions are funded in a value-based environment.

Chronic Disease Prevention and Control

- Assist regional providers to identify, assess, and implement technologies to support use of chronic disease registries, patient attribution, and bi-directional communication between behavioral and physical health providers as part of the health information exchange strategy for the region.
- Assist regional providers in identifying workforce gaps and needs and provide training, technical assistance, coaching, and funding to fulfill these needs, including but not limited to, developing community health workers, peers, and patient education resources.
- Assist regional partnering providers and MCOs in aligning payment strategies focused on preventing and controlling chronic disease, including the ability to recognize savings and return on investment.

Value-based Payment Strategies:

DSRIP is a temporary source of funding to support health care transformation under the MTP. To make transformation sustainable, SWACH must ensure MCOs (as well as other payers - Medicare, commercial plans) are embracing alternative payment methodologies through VBP to financially reward and sustain delivery system changes.

2017 Provider VBP Survey

SWACH supported and promoted the request to complete the 2017 Provider VBP survey by contacting providers in the region serving the Medicaid population and requesting each organization complete the survey in a timely manner. An email request was made to the ACH contact(s) in each organization asking them to forward to the appropriate department in the organization, and our CEO followed up with a phone call. We did prevail upon a few providers to complete the survey; however, the response rate was far below our expectations. Our follow up with organizations not completing the survey indicated a hesitancy based upon uncertainty regarding sharing MCO contracting details and a concern about sharing proprietary information.

The 2017 Provider VBP Survey findings were consistent with what we have been hearing from our regional provider organizations. Access to data, interoperability of data systems, and HIT/HIE appeared as key concerns for providers statewide and regionally. Misaligned incentives and contract requirements also give rise to consternation in the provider community.

SWACH is cognizant that the Domain 1 areas are interdependent; population health strategies need to support success for each project area, but also an increase in provider confidence to move to value-based payment arrangements. Our workforce strategies need to support providers in developing appropriate expertise in revenue cycle management to support value-based contracting.

SWACH intends to work regionally and individually with providers to ensure they can successfully adapt to and adopt value-based contracting strategies.

Current State of VBP Among the SWACH Providers

Providers across the region have been somewhat forthcoming, anecdotally, with respect to their individual MCO contract models. The larger providers seem to already have some VBP contracts in place. Shared savings is the most popular model; bonus for performance was the next most common. There is one large provider with a fully capitated contract for approximately 8,000 Medicaid members. The few medium and small providers with VBP contracts are using a performance bonus model. Smaller practices and behavioral health practices do not have VBP contracts. Community based organizations, traditionally not reimbursed by Medicaid, are uncertain how they will be included in a value-based model. Additionally, behavioral health providers are concerned about value-based contracting given their inexperience with member attribution and appropriate VBP models for this type of care.

The information shared with us from providers tracks consistently with the 2017 VBP Provider Survey.

The Next 12 Months

During our information sessions with providers, we have been reinforcing the VBP targets and the MTP requirements contained therein. Providers understand the MTP requires MCOs to pay 90% of the dollars paid to providers pursuant to VBP contracts, but their comfort level and understanding of how this will impact their practices varies greatly depending on practice size, sophistication of provider organization, and provider type. Behavioral health providers are most concerned with how VBP contracts will work as they are just adjusting to payment through the MCO and have not have experience with member attribution. Over the next 12 months, providers will look to SWACH to act as a convener and educator to help them understand the skills and capabilities they will need to be successful in a VBP environment.

Current barriers and enablers to VBP adoption driving change

Providers have shared a wide range of barriers; the following have been reported most often:

- Lack of interoperable health information systems;
- Lack of cost data to assess contracting arrangements;
- Lack of confidence in attribution of members;
- Lack of interest in accepting risk;
- Inability to adequately understand and analyze contracting arrangements; and
- Misaligned quality definitions and/or measurement, especially between Medicaid, Medicare, and commercial payers.

The MCOs have been the driver of the shift to VBP thus far. SWACH intends to work closely with the MCOs to ensure providers have a better understanding of VBP and the skills, technology, and capabilities necessary to succeed in VBP contracting arrangements.

Regional Strategies to support attainment of, and readiness to, achieve VBP targets

To date, SWACH has been working with regional MCOs and the Washington State Medical Association, the Washington State Hospital Association, and Clark County Medical Association to engage and educate providers regarding VBP and MTP. SWACH intends to undertake the following to pave the road to a successful value-based system:

- Assess regional current state (Feb 2018)
 - State of partnering provider capabilities and readiness
 - Gaps in partnering provider capabilities and readiness
 - Patterns: regional, provider type, provider size, provider payer mix
- Identify provider needs at regional level (March 2018)
 - Common gaps/needs
 - Most pervasive gaps
- Determine feasibility of broad-based solutions (April 2018)
 - Regional Solutions
 - Statewide/Multi-ACH solutions
- Develop strategies and plans to address needs/gaps (May 2018)
 - leverage existing/developing resources
 - leverage MCO and other payer programs
- Leverage DSRIP and other programmatic resources to support efforts (ongoing)
 - ACH will use care and service delivery setting model to establish cohorts of providers based upon assessed VBP capabilities for shared learning
- Develop ongoing assessment mechanism (Feb 2018)
 - Partner with MCOs to develop tracking mechanism
- Monitor progress (ongoing)

ACH's Role in Supporting Providers in transitioning to VBP

SWACH will fill several roles in supporting partnering providers in the transition to VBP arrangements:

- Convener

- Connecting partnering providers with one another, with new potential partners, and MCOs to find regional solutions

- Educator

- Ensure partnering providers are aware of State's VBP targets and different VBP models;
- Ensure partnering providers have access to resources and information on VBP readiness;
- Ensure provider and non-provider partners understand capabilities needed for VBP
- Partner with HCA, MCOs, and others to apprise SWACH on changes and progress to allow SWACH to provide accurate and useful information

- Developer of Regional Strategy

Through implementation of the strategies listed above, and partnership with MCOs, the Practice Transformation Hub, and SWACH's Strategic Improvement Team, SWACH will ensure partnering providers have access to training, coaching and technical assistance to develop the following capabilities necessary for success in a VBP arrangement:

- Governance and Organization
 - a. Leadership buy-in and organizational vision
 - b. Workforce development
 - c. Effective practice management system
 - d. Revenue cycle management
 - e. Performance management
 - f. Legal evaluation and contract management
 - g. Change management
- Provider Engagement
 - a. Staff education
 - b. Provider network identification and engagement
 - c. Referral management
 - d. Engagement with and links to non-physician staff/organizations
 - e. Co-location (if applicable)
 - f. Performance feedback and management
- Care Coordination/Management
 - a. Single point of assessment
 - b. Coordination of care/services across specialties and sites of care
 - c. Development of comprehensive care plans
 - d. Patient engagement
 - e. Evidence-based case management
- Technology and Analytics
 - a. Data aggregation
 - b. Data exchange and interoperability
 - c. Evidence-based population health management systems
 - d. Performance monitoring
- Links to Social Determinants of Health
 - a. Patient social needs assessment

- b. Knowledge of and access to services and organizations
- c. Integration into clinical and care management protocols
- d. Development of value case for addressing social needs
- e. Social services referral staff/ programs

- Advocate for and Champion of Practice Transformation
 - Provide support to and advocate on behalf of partnering providers in context of developing VBP capabilities (e.g., support aligning quality measures or increasing access to data)
- Driver of Sustainable Reforms
 - Support developing partnering provider capabilities without increasing overall system costs
 - Ensure activities are in line with MCOs direction on VBP

SWACH's model of approaching projects as interwoven activities and interventions among and across care and service delivery settings, will align VBP strategies by transforming partnering providers individually as well as collectively, offering opportunities for MCOs to more easily pay for true value. SWACH is very cognizant of the need to set expectations and criteria for performance in line with MCO needs and plans, but also with the expectations of other payers such as Medicare and commercial plans, to avoid burdening providers with non-aligned expectations. Other strategies, such as grouping providers in cohorts, based upon their capabilities and goals, will allow SWACH to align activities and strategies to create opportunities for shared learnings and grow the relationships among partnering providers.

Workforce Strategies:

Preliminary considerations and approach to adapting workforce strategies across all selected projects

SWACH is cognizant of the crucial role workforce training and development will play in successful transformation. Success with the MTP will entail a retraining of the current healthcare workforce to function in an integrated system paying for value rather than services. SWACH approaches MTP work from a care and service delivery setting approach. We will look at workforce needs setting by setting, not project by project. We will look to identify the workforce needs to build more efficient, effective care and service delivery settings, including the changes necessary to meet MTP outcomes for the selected projects, as well as those aspects of care critical to successful transformation outside the four selected projects.

SWACH will need to partner across sectors and care and service delivery settings to transform the current workforce, grow the workforce, both in existing and new roles, train the workforce for transformed care and service delivery, and improve workforce satisfaction to keep providers in their roles.

SWACH will:

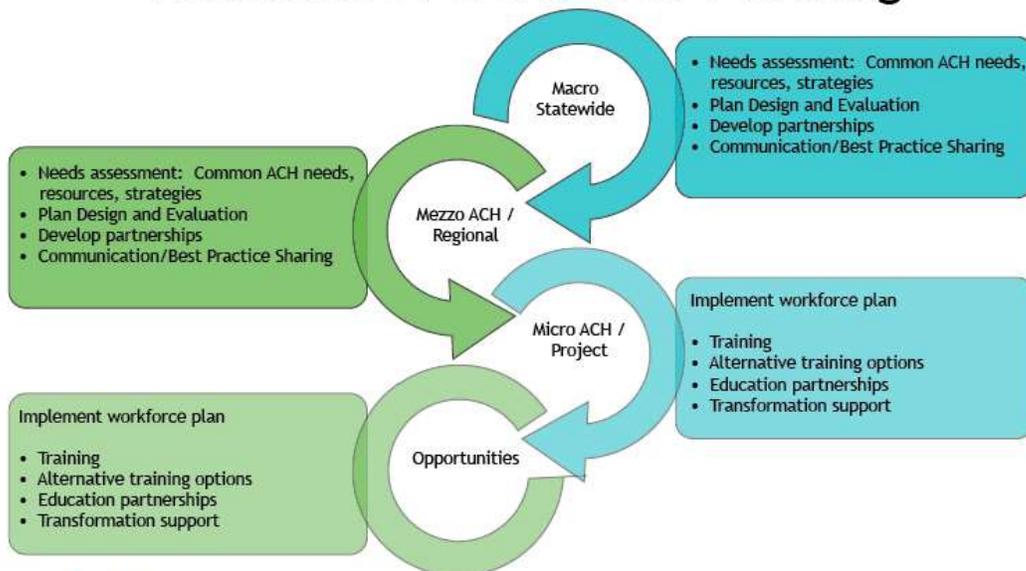
- Convene local resources and support their engagement in SWACH planning and deployment;
- Develop relationships and coordinate with local health facilities, providers, employers, CBOs, MCOs, and other partners;
- Use local expertise and available TA, materials, and templates to develop SWACH specific plans;
- Identify SWACH-specific resource, TA, and curriculum needs, requirements, and plans;
- Develop local deployment plan to address both short and long-term needs; and
- Other actions identified by SWACH/HCA/Workforce SME's/ACH Collaboration.

Identification of Workforce Capacity and Gaps

SWACH will identify the workforce necessary to support transformation activities by:

- Assessment and analysis of current data sources:
 - RHNI
 - Health Workforce Councils
 - Sentinel Network
 - WA Behavioral Health Workforce Assessment
 - Workforce Development Councils – statewide and regional entities, Health Profession

Elements of Workforce Planning



Source: Adapted from Healthier Washington

Opportunity Grants

- UW Center for Health Workforce Studies
 - Health Resources and Services Administration (HRSA) funded Allied Health Workforce Research Center
 - Develop research and analytics of health workforce supply and demand
- Area Health Education Centers

- Recruitment and retention strategies for rural/ underserved populations
- Data support
- Department of Health Workforce Supports
 - State Office of Rural Health
 - Office of Health Professions—scope of practice, qualifications, WA Administrative Code expertise
 - Topic expertise and targeted training resources
 - Community Health Worker training and practice integration
- Allied Health Center of Excellence
 - Connector between industry and the 34 CTC system colleges, Hospital Employee Education and Training (HEET) grants
- Practice Transformation Support Hub
 - Coach clinics and behavioral health agencies to extend social work, RN and other profession skills to practice at top of licensure and adopt team based care
 - Workflow telehealth/telepsychiatry, clinical screening/tracking, care coordination, other new processes
 - Support on issues presenting barriers to practice transformation
- Inventory of Regional Provider Capabilities and Needs
- Compare Regional Needs with Needs of other ACHs to promote cross-region solutions
- Utilize the expertise of our Clinical Integration Committee and other partners and stakeholders to assess potential activities and solutions

Early in 2018, SWACH will conduct a Partnering Provider Assessment which will include a baseline workforce assessment across clinical and community-based care settings for each partnering provider. The Partnering Provider Assessment will deepen our knowledge of workforce capacity and gaps, allowing SWACH to tailor our assistance.

Considering and prioritizing advancement of statewide and regional innovation and approaches in workforce capacity development

SWACH envisions prioritizing and utilizing all available statewide resources for training and technical assistance on integrated, whole-person care, team-based care, cultural competency, and health literacy. This strategy will allow us to make effective use of provided resources and more easily align with the other ACH regions across the state.

SWACH further envisions our Clinical Integration Committee and other clinical partners assisting us in developing customizations to the statewide resources and regional workforce training, and in understanding the level of education and comfort providers have with stigma reduction, trauma-informed care, and the elements of the IHI Workforce Model, “Improving Joy in Work,”⁶⁶ We intend for

⁶⁶ Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at ihi.org)

this framework to improve access to care by reducing provider burnout and keeping our experienced providers practicing in the region.



Source: Adapted from Institute for Healthcare Improvement. Updated: 11/09/2017

SWACH is further prioritizing the advancement of statewide and regional innovations to workforce capacity development by planning for an active role in the statewide workforce forum that will be established for ACHs and subject matter experts. The forum will facilitate collaboration on shared approaches, tools, resources, planning, and deployment across ACHs.

SWACH is currently utilizing tools and guidance provided by workforce subject matter experts and HCA consultant, Manatt, in our regional project and implementation planning. We intend to continue to utilize the tools and look forward to additional tools and guidance emanating from the statewide workforce forum. Our workgroups, Strategic Improvement Team, and Quality & Continuous Improvement Committee will use statewide templates and resources in our regional needs assessment and planning efforts.

SWACH will nurture the strong partnerships we have developed at state and federal levels such as with the Washington State Department of Health in aligning expertise and resources from the Practice Transformation HUB, Transforming Clinical Practice Initiative - Pediatrics (P-TCPI), Office of Rural Health, and Health Living Collaborative and CHW and Peer Support efforts.

SWACH will also pursue strategies intended to be responsive to equity and cultural competency of health workers to increase the diversity among those offering care and services.

Population Health Management Systems:

SWACH's approach to expanding population health management systems (PHMS) across all projects will focus on:

- Identifying, assessing, and educating partners on the technology solutions available to increase the interoperability of PHMS;
- Increasing health information exchange to provide better intelligence for partners across the region for whole person care, integration, quality improvement, and value-based purchasing;
- Implementing care coordination systems to include both clinical and social elements of data to improve whole person health; and
- Improving telecom connectivity in rural areas.

SWACH's approach to using PHMS across all projects will focus on:

- Collecting data for reporting;
- Analyzing data for business intelligence;
- Developing Quality Improvement strategies;
- Health information exchange to support integration and coordination;
- Driving value-based payments;
- Risk stratification for resource prioritization;
- High risk patient identification and action;
- Advancing use of registries;
- Care coordination; and
- Telehealth

SWACH's approach to supporting and maintaining PHMS across all projects will focus on:

- Assessment of critical needs and options
- Vendor procurement, management, and coordination;
- Vendor accountability;
- Partner Technical Assistance;
- Partner Training; and
- Partner Financial Support.

SWACH's approach to population health management encompasses strategies to successfully capture and collect data, analyze data and exchange data, utilizing the most efficient, cost-effective, and wide-reaching technology to accomplish implementing these categories of work. Our approach includes:

- Employment of a Chief Information and Technology Officer (CITO – shared with Pierce County ACH);
- Contract with Providence CORE for data services;
- Establishing an HIT/HIE Task Force comprised of CIO/CTO level participants from participating providers/partners, staffed by CITO;
- Establishment of a Systems Capacity Building (SCB) Fund to provide resources for technology planning, purchasing, training, technical assistance, and on-going maintenance and support for participating providers; and
- Adoption of proven-technology systems that allow for new and innovative strategies.

This approach will ensure interoperable technology that supports the region's transformation work and goals will be identified, procured, and implemented to enable SWACH to successfully achieve outcome metrics.

Next steps for PHMS work:

- Field Assessment (January 2018)
- Convene HIT/HIE Task Force (January 2018)
- Compile Assessment Responses (February 2018)
- Assess Options for PHMS (March 2018)
- Prioritize Recommendations (March 2018)
- Begin Development of Implementation Plan (April 2018)

SWACH encourages HCA to collaborate with the ACHs to develop standardized reporting tools for the MTP. Offering our partners a standard data collection framework will enhance participation and lessen the burden on the providers and the ACHs. It would also offer HCA an opportunity to streamline its reporting requirements to CMS. This will be especially helpful for those providers who cross ACH regions and do not want to have varied reporting requirements. SWACH looks forward to continuing to work with HCA on the HIT/HIE strategic roadmap and to partner on strategic initiatives that will allow us to leverage capabilities in place today, as well as those that will emerge in the future.

Identifying PHMS

SWACH has begun to identify PHMS currently in use in the region through an initial, informal survey of potential partnering providers to ascertain the predominant EHR and exchange technologies in use across our three-county region. Most of our large systems and provider organizations are utilizing Epic as an EHR (PeaceHealth, Legacy, Providence, Kaiser, Vancouver Clinic, and One Community Health). Our largest FQHC (SeaMar) is using separate EHRs for physical and behavioral health (Allscripts and Cerner, respectively). Other providers are utilizing a myriad of EHR platforms, with varied versions of those platforms appearing across the region. To date, other than the prison system, we have not identified potential partnering clinical providers with no EHR capabilities, however we have identified challenges with internet connectivity in our rural/frontier sectors in Skamania and Klickitat Counties. These issues range from no high-speed connectivity to a complete lack of connectivity. These variations require technological solutions which will support interoperability and increased sharing of information to support our system transformation efforts. Additionally, most community based organizations have no capacity to collect or share information electronically.

To date, we have identified the following health information sharing systems in use in the region:

- Care Anywhere (EPIC)
- Care Everywhere (EPIC)
- EDIE/Pre-manage (CMT)
- Clinical Data Repository (OHP)
- Direct Secure Messaging
- Reliance e-Health Collaborative

We have also identified other technologies in use nationally that could serve our region: Carequality and Commonwell.

Next steps include a deeper assessment of partnering providers to ascertain more detailed information, including information on the use and satisfaction of the above-listed systems and providers' views on these systems' capabilities, capacity, and gaps. This assessment will be released in January 2018 with a one-month response window, to allow for follow-up inquiry. Our CITO and the HIT/HIE Task Force will assess responses. Based upon evaluation of the assessment, SWACH may develop a Request for

Information for more detail from the service providers of health information systems currently in use in the region, as well as for other options not currently in use in the region. SWACH intends to play a convener/coordinator role to find the best options for technology solutions and to work with our individual provider organizations to implement these solutions.

PHMS Across all Stakeholders

Successful interoperability and health information sharing requires the commitment of provider organizations expected to use the technology. SWACH is cognizant that success in this area will require a thoughtful and transparent stakeholder engagement process. SWACH intends to convene an HIT/HIE Task Force comprised of CIO/CTO leadership from partnering providers to review the assessment data and evaluate the potential opportunities for robust health information sharing to support implementation of the regional transformation strategies. This Task Force, reporting to the Regional Health Improvement Plan (RHIP) Council will ensure robust partner engagement to understand the benefits and implications of any technology decisions across our partnering provider spectrum. Selection of technologies to increase health information exchange will need to leverage prior investments, align the needs of the providers across the region, regardless of payer mix, and develop strong working agreements for how technology and information will be shared and used.

SWACH understands how vital health information exchange is to our success with the MTP, but also for the spread and sustainability of transformation across the health care delivery system spectrum. It is this core belief which underlies our decision to employ a CITO and to allocate MTP and Early Adopter incentive dollars to the SCB Fund will ensure SWACH can implement the technology approaches necessary to ensure MTP success, including laying the foundation for clinical integration, care coordination, and value-based contracting.

SWACH intends to use the SCB Fund to provide technical assistance, training, and coaching to partnering providers to ensure each organization can fully participate in decision-making regarding HIT/HIE investment and use, as well as successfully implement solutions. Additionally, SWACH recognizes the enormity of the requirements with which our clinical providers must comply: HEDIS, NCQA, MACRA, MIPS, MCO contract requirements, and each organization's individual goals and targets, to single out a few. SWACH will support providers in adopting and using more advanced technology solutions that do not increase administrative burdens.

As an example, SWACH is working with the Department of Health (DOH), Qualis, Collected Medical Technologies (CMT), and three regional behavioral health providers on a pilot program implementing EDIE/Pre-Manage in behavioral health practices. We are using the pilot to develop a training and coaching module for use with behavioral providers across our region, and throughout the state. It is SWACH's hope to be ready to implement the use of EDIE/Pre-Manage within the other behavioral health practices across our region beginning in July 2018. This functionality will allow hospitals to notify behavioral health and physical health providers to share critical information about patients who have been admitted, discharged, or transitioned from a hospital setting. This functionality will support all four of our projects.

Lastly, SWACH is mindful that technology is a fast-paced environment with changes in capabilities, functionality, regulation, and cost occurring daily. SWACH intends to bring a forward-looking perspective to the conversation on HIT/HIE; recognizing new technologies and regulations will continue to emerge throughout the coming years. SWACH wants to assist our region in understanding what is just around

the corner and help it to make the most cost-effective and efficient decisions possible to avoid implementing strategies that will be obsolete before they are fully implemented.

SWACH is watching the emergence of Fast Healthcare Interoperability Resources (FHIR) standards which describe data formats and elements, and an Application Programming Interface (API) for exchanging clinical data contained in EHRs. One of FHIR's goals is to facilitate interoperability between legacy health care systems to make it easier to provide health care information to health care providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems. The Office of the National Coordinator for Health IT (ONC) is piloting models for using FHIR and it is widely believed FHIR will become a required standard for all certified EHR products in the near-term future. Required implementation of FHIR would drastically change the region's approach to HIT/HIE. This technology would increase interoperability and potentially negate the need for health information exchanges or repositories. This could drastically change how providers use and exchange information and SWACH intends to be an education resource for providers on this front to help guide them in technology decision making.

Prioritizing the advancement of statewide and regional innovations and approaches

The more prevalent the HIT/HIE technology, the more beneficial it will be to our work. SWACH will prioritize those statewide and regional innovations and approaches to HIT/HIE that deliver the greatest value to our partnering providers and the region. The HIT/HIE Task Force will provide a forum to analyze assessment responses and filter the data to support decision-making. SWACH understands that the best technology solution is the one that brings the most value to the individual partners as well as the region as a whole.

SWACH intends to use the HIT/HIE Task Force to develop a two-dimensional prioritization methodology; first to prioritize by value of a statewide versus regional solution. Value will include determining a technology's ability to solve the most pervasive problems shared by the most partners across the region. The second element of prioritization will be the cost and feasibility of the solution. SWACH seeks to help providers use technology to drive innovations as well as solve problems, and will continue to use the HIT/HIE Task Force to tease out new strategies for utilizing technology.

Continued involvement with the HCA HIT/HIE strategic roadmap efforts, stakeholder engagement opportunities, and a focus on emerging standards and technologies, will allow SWACH to provide technology solutions to support the MTP and the region well beyond the MTP. SWACH intends to continue to partner and collaborate with other ACHs and will assist in the proliferation of technology solutions that can be shared across the state.

We recognize approaches are continuing to evolve; however, please elaborate on the use of rapid cycle feedback and quality improvement processes for day-to-day monitoring. What processes and roles and responsibilities are anticipated?

We plan for day to day monitoring to be done through the self-monitoring system we are building with the assistance of Providence CORE. This system is envisioned to allow partnering providers to record requested data to demonstrate necessary elements for the pay for reporting and outcome measures. The system will clearly identify the target for each measure, allowing the partnering provider and ACH to monitor progress against expectations. We anticipate working through the final elements of the self-

monitoring system with contracted partnering providers to ensure we are providing a system that meets their needs and expectations before finalizing contracts.

The size and sophistication of the partnering provider will inform whether it uses internal quality improvement staff or will rely upon SWACH provided improvement advisors. Larger, more sophisticated provider organizations are likely to work with their internal teams, while smaller organizations are expected to rely more heavily on SWACH for quality improvement assistance, such as improvement advising, coaching, and technical assistance. SWACH envisions the self-monitoring system providing the basis for identifying issues which can then be addressed through rapid cycle feedback loops of plan, do, study, act (PSDA).

Each partnering provider will be assigned a SWACH staff member as its lead contact who will fill the role of an account manager. The account manager will be tasked with working with Providence CORE to review data from the self-monitoring system and other data sources, and ensure the partnering provider understands the data. The account manager will be responsible for connecting the appropriate SWACH resources with the partnering provider to commence quality improvement planning. CORE and account managers will assess data for use with PSDA cycles, and ensure partnering providers are confident in next steps for quality improvement.

Rapid cycle feedback is just one approach we propose using for quality improvement. Our informal surveys indicated regional partners using various quality improvement models ranging from the IHI, Kaizen, Six Sigma, and LEAN. We anticipate working with our partnering providers to adapt other quality improvement models currently in use across the region and sharing lessons learned with those partners not currently using these approaches.

SECTION II: PROJECT-LEVEL

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

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

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2,

the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
 - Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
 - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
 - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
 - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

Whole person health requires clinical integration of behavioral health and physical health. SWACH will support the region’s collective vision for clinical integration by investing in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes, thus transforming existing relationships and developing a workforce trained to operate in a team-based environment.

Data shows individuals with a serious mental illness have limited access to primary care and are more likely to utilize the emergency department (ED) and inpatient services at higher rates than those without serious mental illness.⁶⁷ Furthermore, on average, this group has increased rates of acute and chronic health conditions and is more likely to die 25 years earlier than the general population.⁶⁸ Our region’s decision to implement an integrated service delivery model supports providing the most appropriate care, at the right time, and in the most appropriate setting for Medicaid beneficiaries. Currently, SWACH Medicaid beneficiaries (adults ages 18-64) with any mental health need, including serious mental illness proxy, substance use disorder (SUD) treatment need, and co-occurring mental illness (MI)/SUD were more likely to have 3 or more ED visits in a 12-month period.⁶⁹ Individuals with co-occurring MI/SUD were most likely to have 3 or more ED visits,⁷⁰ which is why SWACH will focus on

⁶⁷ Lardieri M.R., Lasky G.B., Raney L. (2014). *Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams*. Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions

⁶⁸ Substance Abuse and Mental Health Services Administration. (2014). *Mental and Substance Use Disorders*, Rockville, MD: Substance Abuse and Mental Health Services Administration. www.samhsa.gov/disorders

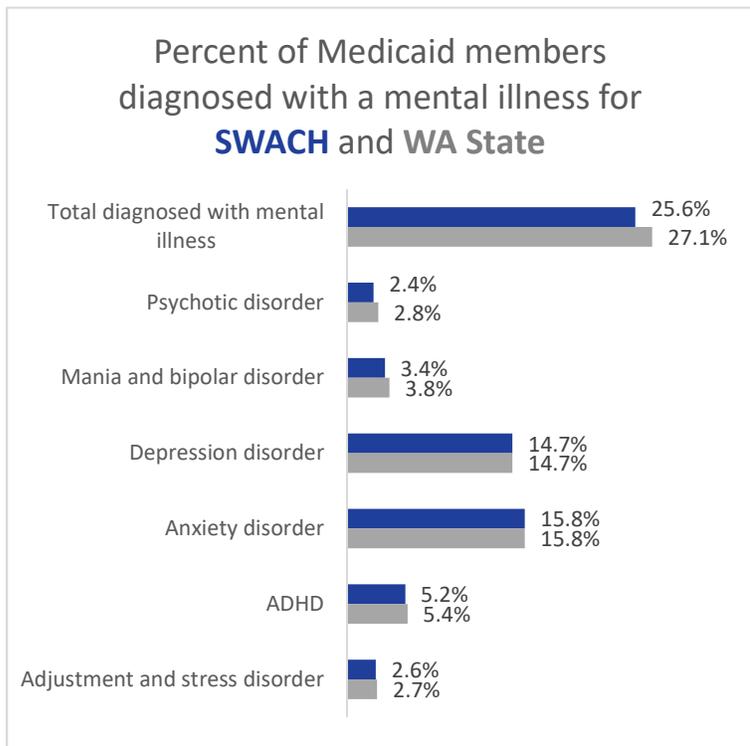
⁶⁹ Measure Decomposition file provided by HCA / RDA, CY 2015 data for SWACH.

⁷⁰ Measure Decomposition file provided by HCA / RDA, CY 2015 data for SWACH. Additionally, Medicaid beneficiaries (adults ages 18-64) with co-ACH Project Plan Template (October 16, 2017)

this sub-group of individuals as one of potential target populations for the bi-directional clinical integration Medicaid Transformation Project (MTP).

According to national data, over 60% of adults with a diagnosable mental health disorder do not receive mental health services⁷¹ and almost 90% of individuals with a substance use disorder do not receive appropriate specialty treatment.⁷²

According to SWACH profiles provided by The Washington Division of Social and Health Services (DSHS), approximately 25% of SWACH Medicaid population being jointly served by Health Care Authority (HCA) and DSHS were diagnosed with a mental illness in the last 24 months, with depression and anxiety disorders being the most prevalent. Furthermore, 18% of the population was diagnosed with a serious mental illness, and just under 10% had at least one indicator of SUD treatment need (6.7% have co-occurring mental health and substance use disorder diagnoses, compared to 7.7% statewide).⁷³



occurring MI/SUD were also more likely to have a hospital readmission within 30 days. In 2016, there were approximately 13,325 admissions for 104,160 Medicaid beneficiaries in SWACH. Approximately 5% of those admissions were for the broad diagnostic category 'mental and behavioral disorders'.

⁷¹ Druss BG, Wang PS, Sampson NA, et al. "Understanding Mental Health Treatment in Persons without Mental Diagnoses." Arch Gen Psychiatry. 2007, 64(10):1196-1203.

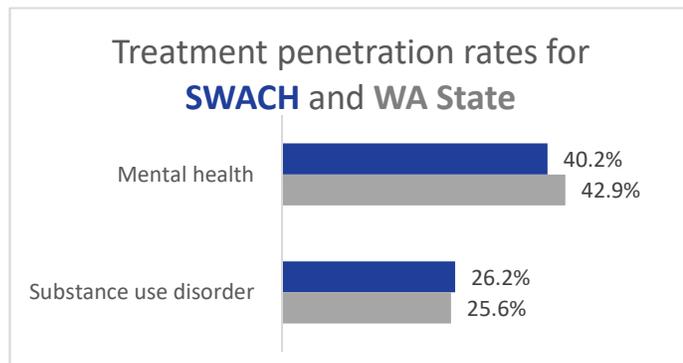
⁷² Levit, K.R. et al. "Future Funding for Mental Health and Substance Abuse: Increasing Burdens for the Public Sector." Health Affairs. Web Exclusive, 7 October 2008, w513-22

⁷³ DSHS RDA ACH Profiles for Southwest WA, FY 2016. Available online at <https://www.hca.wa.gov/assets/program/SW-wa-future.xlsx>

Additional data provided by HCA confirms that just under 10% of SWACH Medicaid population had at least one indicator of substance use disorder treatment need, and provides additional insight into co-occurring conditions: approximately 5.7% of SWACH Medicaid members have co-occurring mental health AND substance use disorder treatment need and approximately 4.5% have co-occurring mental health AND substance use disorder treatment need AND one or more chronic condition(s).⁷⁴

Despite nearly 25% of the population having some mental health diagnosis in the past 24 months, SWACH's treatment penetration rates are low (and have been declining over the past three years). SWACH is the lowest performing ACH for mental health treatment penetration (40.2% in 2015).⁷⁵ Through clinical integration, accessing behavioral health services in the primary care setting will begin to address this rate.

As an early adopter of Fully Integrated Managed Care (FIMC), our region is positioned to enhance the clinical integration of physical and behavioral health already underway because we have cleared the important hurdle of integrating financial models of health care purchasing. Our MTP work will support the goal of clinical integration by using the available incentive funding for planning and implementation of the changes necessary to fully integrate across provider settings.



The bi-directional integration project supports health transformation for the Medicaid population in several ways. By providing integrated services in both Behavioral Health (BH) and Primary Care (PC) settings, timely access to needed services becomes more routine over time. Moreover, early identification of behavioral health conditions leads to earlier treatment; this will have a positive impact on an individual's overall health while also lowering the cost of care. Another key element to integrated care is the ability for providers to communicate health information effectively. SWACH will develop implementation strategies with participating providers to increase their capacity to exchange health information. This will allow the often fragmented care delivery system to more effectively coordinate care among providers, resulting in better quality care for beneficiaries. As clinical practices increase their capability to share information and develop population health strategies that leverage technology, we will develop a road map for providers to increase value to health care purchasers.

SWACH is working collaboratively with other efforts in the region to implement clinical practice transformation. SWACH's collective impact strategy is to build and add value to efforts currently underway in the region. For example, SWACH intends to add financial resources, collaborative partnership development, training and technical assistance, data collection and analytics support, and strategic improvement coaching. SWACH has developed a process to ascertain from providers which practice transformation efforts they are currently implementing in their practices. The information

⁷⁴ Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data through June 2016.

⁷⁵ Penetration rate data from DSHS 1519 reporting available online, <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0> as well as historical measure performance data provided by HCA on September 7, 2017.

will be inventoried and cataloged, and the workgroup and governance structure will determine how SWACH can add value to existing initiatives alongside our MCO partners, Practice Transformation Hum, and Qualis Health to develop and aligned targeted support strategy.

SWACH has developed a working partnership with the Pediatric-Transforming Clinical Practice Initiative (P-TCPi). The regional coordinator for the project has worked directly with SWACH Vice President of Clinical Integration and the Clinical Integration (CI) Committee to leverage both initiatives, collaborate with provider organizations involved in both initiatives, and create a shared learning environment via the CI Committee. SWACH has also been meeting with other organizations who have enrolled their practices in P-TCPi, learning which stages of change they are in and having strategy sessions to align efforts through both initiatives. There are various practices in the region that have implemented elements of integration strategies and SWACH will be developing a matrix of levels of integration based on the SAMSHA Six Levels of Integration to guide strategic plans and support provider movement along the continuum of integration.

In the first part of DY 2, all participating providers will be subject to a comprehensive practice assessment. Through the assessment process, SWACH will learn more about the various projects and partnerships that are in place. SWACH will use this information to inform implementation planning and ensure we are not duplicating efforts.

The CI Committee has committed to supporting the entire Medicaid population in our approach to bi-directional integration. The committee has also expressed their support to address integration in all behavioral health and primary care settings that serve Medicaid, acknowledging that each setting will implement strategies for targeted sub-populations at various stages.

Overview of Medicaid Population in SWACH

Total	Klickitat	Skamania	Clark
Population	21,026	11,339	459,495
% Medicaid	32%	22%	27%
Medicaid Lives ⁷⁶	6,817	2,455	123,608

When considering the target population for Project 2A, all Medicaid beneficiaries are included, currently about 133,000 people, with a focus on sub-populations who have been diagnosed with behavioral health conditions, including mental illness and/or substance use disorder, opioid use disorder and/or chronic health conditions. According to our preliminary analysis, about 4% of the SWACH Medicaid population had an SUD diagnosis, a mental health diagnosis, and at least one chronic condition diagnosis (approximately 5000 people). The Data and Learning team (DLT) will provide further insight and analysis to the CI Committee regarding which specific conditions drive higher utilization of services, provide recommendations to the CI Committee, and provide support to clinical practices through their implementation planning process

SWACH conducted outreach with PC and BH Medicaid providers over the last year, in both our rural and urban communities, as the primary provider types needed for engagement in project 2A. SWACH is also partnering with the hospital systems in the region along with leadership at the two Medicaid health plans that are contracted in the region. We also consider our partners at Qualis Health, AIMS

⁷⁶ Apple Health Enrollment Reports. Measure period May 2017
ACH Project Plan Template (October 16, 2017)

Center and Department of Health (DOH) critical to our alignment efforts in the region to provide technical expertise based on years of clinical change management strategies and national experience integrating clinical settings. The CI Committee liaisons with the other SWACH workgroups and coordinates strategies with each committee/workgroup to develop cross-project alignment. This includes critical community based organizations (CBO) who are deeply involved in the Community Care Coordination project development and are key partners in developing project alignment strategies and implementation strategies.

The PC and BH providers began participating in the CI Committee when it was established in the spring of 2017. While the CI Committee is designed around BH and PC settings and has 28 representatives who serve Medicaid, the committee will leverage the overall SWACH governing structure, that includes a wide cross-sector representation well beyond the clinical setting. The CI Committee charter outlines the committee's responsibility for developing the necessary regional strategies, resources and implementation strategies necessary to move the entire region toward a more capable integrated continuum of services. For the integration of clinical services between BH and PC, having both types of practices involved in the planning, development, training, implementation, monitoring, shared learning, and continuous quality improvement is critical to successfully bridge the gaps between the settings that have historically existed.

Project 2A (Bi-directional Care Integration) is built upon five core concepts of integration that have been identified by the CI Committee and that are fundamental in the evidence-based practices and strategies of the Collaborative Care Model 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 Committee selected five core concepts as the core concepts that SWACH will use to develop the implementation plans and direct resources toward. They include:

- 1) Offering enhanced development of integrated care teams
- 2) Ensuring that 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

Crucial to SWACH's strategy of five core concepts of integration, rather than a specific clinical model, is the implementation of a flexible approach toward integration, allowing providers to build upon their integration efforts that are currently underway. This approach will offer all Medicaid providers, regardless of size or scope, the ability to incrementally increase their capacity to provide integrated clinical services.

SWACH will not be requiring or prescribing that providers chose between the Collaborative Care Model as 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.

SWACH intends to provide support to clinical settings in a variety of ways. SWACH anticipates a variety of integration models at the clinic level, however, the models that are being considered have common elements across all clinical settings. SWACH will provide clinic level technical assistance

along with region wide technical assistance to advance opportunities for organizations to move towards clinical integration. For example, SWACH will provide workflow support, IT technical assistance, workforce development support, trainings, change management support and assistance with transitioning providers towards value based payment arrangements. Moreover, variation across settings is noted as an opportunity to collectively learn effective implementation strategies, identify collective needs for participating providers, disseminate shared protocols and assess financial impact and health outcomes across partners. SWACH intends to convene partners and stakeholders throughout the project timeline to facilitate collective learning. SWACH will also be requiring partnering providers to enter into a contract arrangement that will enable SWACH to monitor progress, identify needs and barriers and collect data in order to deploy rapid cycle change management strategies.

To align the region with a common language around state of readiness and organizational goals, SWACH will utilize the SAMSHA Six Levels of Integration to conceptualize readiness, strategic goals, and progress. The SAMSHA model provides a systemic organizational structure to implement a variety of clinical integration strategies in different clinical settings, for different sub-populations and provider types. Because SWACH is taking a flexible approach toward clinical models of integration, having a conceptual tool to organize the region along a continuum of integration will be useful for supporting change across settings.

Allowing the implementation of key concepts common to both the Bree Collaborative recommendations and the Collaborative Care Model, based on a provider's readiness and consistent with their strategic plans, enables SWACH to support positive movement along the continuum of integration without dictating which integration model a provider must use. By encouraging providers to choose the integration model best suited to their readiness and strategic plans – whether it be the Bree Collaborative or Collaborative Care Model - the ACH can support movement along the continuum of integration. Through building a strong foundation of core concepts, this approach becomes the architectural framework for scalable and sustainable change.

Adding SWACH investments for health information exchange (HIE) capacities, ongoing training and workforce development, collaborative partner development, and financial resources contributes to the scalability and sustainability of integration.

SWACH will be considering the level of impact on target populations and the project outcomes, through a data-driven approach as well as utilizing stakeholder and beneficiary engagement. SWACH will use data to understand the disparities that exist within the region to ensure equity to all project populations. Through our design and implementation stages, SWACH will support regional partnerships and delivery system collaborations and begin to develop strategies to address the variables that contribute to the inequities noted in the data. SWACH has hosted Medicaid beneficiary listening sessions which enabled SWACH to look beyond the data and receive direct input as we consider the potential impact system changes will have on individuals and families.

SWACH is working in partnership with multiple community organizations and community groups to develop an equity lens to inform our overall work. This is an extensive piece of work, supported by additional grant dollars from United Way, Northwest Health Foundation and partner organization funds. We will be bringing in the Center for Equity and Inclusion, a nationally known group, to support the development of this work as well.

Part of our role as an Accountable Community of Health is convening and we plan to continue to share our learning from this process with our partners working on the Medicaid Transformation Project (MTP). SWACH is committed to continuing to offer our equity and social justice 8-hour training sessions for all our partners. Many have already completed this training but SWACH continues to receive growing interest and has identified the need for more training. Our partners have provided very positive feedback about this training.

We realize that developing our equity lens will take time and in the meantime, we plan to use the Center for Racial Justice Innovation's "Racial Equity Impact Assessment Guide" as a set of questions we will bring to our decision-making tables (work groups, RHIP, Board, staff) to inform our work as we take the proper time and process to develop our own equity lens, tools, and community buy in.

Implementation Approach and Timing

Using the **Implementation Approach tabs of the ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:
 - Describe the ACHs general approach to accomplishing requirements.
 - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
 - Specify which evidence-based approach option(s) will be used for the project.
 - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization

- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

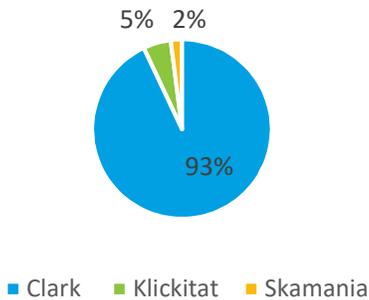
- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented.
Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring there is no duplication.

ACH Response

SWACH has a variety of committees, one of which is the CI Committee. Every member of the committee has made a significant commitment to the CI Committee and the organizations they represent have been dedicated to serving the Medicaid population for many years. The committee is currently represented by 27 individuals who are all Medicaid providers in the community or represent an organization that provides Medicaid services. The following list includes the organizations that are represented, accounting for over 90% of the Medicaid lives covered in the region.

Catholic Community Services	NAMI SW WA
Children's Center	PeaceHealth Medical Group
Community Health Plan of WA	Providence Health and Services
Comprehensive Healthcare	Qualis
Daybreak Youth Services	Rose Medical Group
DOH P-TCPI	SeaMar
Klickitat Valley Health	Skamania County Behavioral Health
Legacy Medical Group	Skyline Hospital and Family Practice
Lifeline Connections	The Vancouver Clinic
Molina Healthcare	

SWACH Medicaid beneficiaries by county



SWACH is developing binding provider participation contracts that will require providers' commitment to serve the Medicaid population. Financial incentives for partnering providers will be tied, in part, to Medicaid lives served, and offering further commitment to serving Medicaid enrollees.

SWACH began an organizational effort to create the CI Committee in the spring of 2017 after meeting with potential providers and their leadership teams. SWACH worked directly with the Behavioral Health Alliance in the region and they self-selected providers to participate on the

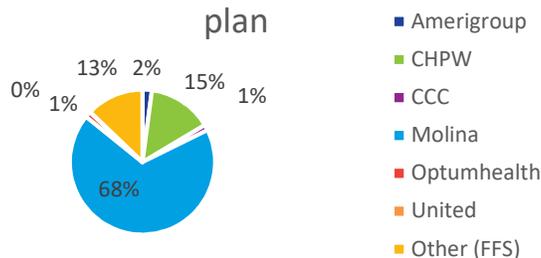
committee and represent the alliance.

The CI Committee developed and approved a charter to help guide the groups work. The Charter stipulates that the objective of the committee is to provide input and guide regional strategies, which ensures that SWACH and its partners can learn, plan, and act collectively to achieve bi-directional clinical integration throughout the regional service area. Pursuant to the CI Committee Charter, the committee's guiding principles are:

- Support planning and implementation of the project through a whole person care lens that is flexible enough to meet needs of all participating providers, sustainable beyond the demonstration period, and values partnerships and collaborations.
- Encourage shared decision- making among all SWACH partners
- Develop projects which address health inequities among residents in the SWACH region
- Promote collaborative, collective processes from multiple organizations and sectors
- Value integrity and agree to uphold all SWACH standards, privacy laws, and other human rights as applicable
- Support the goals of the triple aim of health care reform and the Healthier Washington initiative, including the Medicaid Transformation Project.

The CI Committee has representation from the two MCOs contracted in the region who purchase

SWACH Medicaid enrollment by plan



health care for a significant portion of the Medicaid population. SWACH has developed a coordinated, alignment meeting that convenes each month to ensure that the health plans, our TA partners and SWACH are in alignment, can leverage expertise across domains and strategize collectively about opportunities.

Regional Assets, Anticipated Challenges and Proposed Solutions

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

The SWACH region is in the early adopter FIMC region in Washington. The Medicaid providers in the region now have almost two years of experience in the FIMC payment environment. The experience has provided an opportunity to develop a fuller understanding of an individual's whole person health care needs and an ability to leverage population health data in new and important ways. Bridging the care gap between physical health providers and behavioral health providers, by removing the payment silos, is an important asset of the region that is made possible through integrated managed care funding. Moreover, in October 2017 Klickitat County submitted a binding letter of intent to be a mid-adopter and will join the southwest Washington early adopter counties in January 2019.

Our region is led by innovative and visionary leaders who have deep roots in the community and have been providing evidence based and person-centered care to the Medicaid population with robust dedication for years. The prevailing ethos of the region is collective collaboration, and SWACH views this as a significant asset. These community leaders also have the support of our elected county leaders, who ultimately led the way toward FIMC, and saw the benefits of this transformation years ago. SWACH will build upon the region's leadership, for example to support the development of train the trainer models, best practice change models, and provider champions.

CBOs that serve the Medicaid population are a key asset to the community. The CBOs are instrumental partners in creating the shared regional vision of integrated whole person health. Leveraging the contributions of CBOs in all design and implementation phases of the MTP will increase the clinical practice setting's ability to connect with CBOs and address the social determinants of health needs of the Medicaid population. Agencies that provide housing, employment and peer-run supports, advocacy groups, and population specific support groups, are considered vital partners and the assets they bring to the transformation projects will be critical to the success of the projects.

There are several challenges that the MTP will attempt to address but they will not be addressed through a single project. The ability for providers to implement a real time Health Information Exchange (HIE) is one challenge that the MTP project will address. Another challenge is the development of patient registries to manage populations. The region will pilot the use of EDIE/PreManage with the three largest behavioral health agencies (BHA) beginning in Q4 of 2017. With the support of Qualis Health HUB, HCA's Analytics, Interoperability, and Measurement (AIM), HCA FIMC team, and our managed care partners, the region will establish a PreManage/EDIE HIE Learning Collaborative in 2018 to advance the use of EDIE/PreManage, develop an EDIE/PreManage Roadmap Toolkit and develop strategies to integrate EDIE/PreManage region-wide. The integration of EDIE/PreManage into the healthcare delivery ecosystem will provide an opportunity for clinical settings to share standardized care plans, manage and monitor populations, track individuals across settings and advance existing electronic health record (EHR) capabilities through real time interfaces. With the support of our allied partners, technical assistance can be provided to develop and implement the use of patient registries and electronic clinical information-sharing.

Our community of providers has identified workforce as a priority that needs to be addressed. There are several strategies to address workforce needs. SWACH has developed a Psychiatry/ARNP Workforce Capacity Workshop that includes Washington State University, University of Washington, Oregon Health and Science University, Peace Health Medical Residency Program, key regional Behavioral Health Agencies (BHA) and two managed care plans. This group will leverage SWACH's convening role to increase residency options for students in our region, develop a best practice model for residents working in CBOs and develop creative strategies, such as loan repayment programs, to promote the retention of residents and thus improve access to care. We will also address workforce issues by looking at provider work satisfaction issues to prevent provider burnout.

The CI Committee has identified bi-directional integration models that provide the greatest opportunity for success must include care managers and/or care coordinators. For example, building on Snyder Nardone continuum of integration model, it is known that care coordination is the top priority for transforming healthcare according to the Institute of Medicine.⁷⁷ During SWACH led listening sessions, many beneficiaries echoed the need to have support from their providers navigating a complex health care system. To meet this pending care coordination workforce need, SWACH has engaged the following agencies to develop strategies to help address this issue:

- Allied Health Center of Excellence
- Area Health Education Center for Western Washington
- Clark College
- Lower Columbia College
- Washington Association of Community and Migrant Health Centers
- Washington State Board for Community and Technical Colleges
- Workforce SW Washington

SWACH will continue to develop partnerships and provide shared learning opportunities for the community to develop this new workforce. SWACH presented at the semi-annual Statewide Workforce Education Council meeting sponsored by the Washington State Board for Community and Technical Colleges to advance the needed workforce demands that are on the horizon and create engagement strategies for college programs to meet the upcoming workforce changes.

Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?

⁷⁷ Adams K, Corrigan J: *Priority Areas for National Action: Transforming Health Care Quality*. Washington, DC, Institute of Medicine, 2003.
ACH Project Plan Template (October 16, 2017)

- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.



storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

SWACH's self-monitoring system will allow providers to input data and give SWACH and our partners an early view of progress. This data will allow SWACH to see if providers are falling behind or not meeting requirements early, providing ample time to share the data with them, help them understand the import of the data, and to design rapid-cycle feedback and quality improvement strategies before veering too far off track. This will be more effective with pay for reporting requirements, however, we are working with CORE to develop a system that will allow us to track data elements that will be predictive of overall pay for performance metrics as well.

Our Improvement Advisors will work with provider organizations to assist them in developing the capacity to review their own data and begin to design their own quality improvement projects.

Plan for monitoring project implementation progress, including addressing delays in implementation

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by the Institute for Health Improvement (IHI). This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers. These learning collaboratives will allow regional providers to see trends and work together to determine the underlying cause of these trends.

SWACH Improvement Advisors, in concert with Qualis Health and MCOs will work with each partnering provider to determine the level of support desired and needed. For larger, more sophisticated organizations, SWACH will work with quality improvement teams already working within these organizations. Using data and reports, SWACH will ensure quality improvement personnel know the issues and have the tools to address those issues. If more assistance is requested, SWACH will provide more in-depth support. This support may be in the form of training, technical assistance, or coaching.

For smaller organizations, SWACH envisions being the quality improvement engine for these providers. Based upon provider reported data, and broader data sources, SWACH will provide technical assistance, training, and coaching. SWACH will work with provider organizations to improve their performance with respect to projects, as well as train these organizations to begin to establish their own quality improvement teams and processes .

SWACH envisions needing to be flexible in creating this quality improvement process to meet the varied needs of providers in different sectors, geographies, and stages of maturity. Our own work will require assessment and improvement to continuously meet the needs of our partnering providers.

The comprehensive shared learning system, PDSA continuous improvement process, and CCS platform will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

Our workgroups, committees, and governance bodies will continue to meet to discuss the data and progress of our partnering providers throughout the MTP. SWACH will work with the Quality and Continuous Improvement Committee to ensure all assets are brought to bear when monitoring suggests a project is off course. However, we are aware that there is the possibility that despite best efforts, a strategy may not result in desired outcomes. SWACH is considering charging the Quality and Continuous Improvement Committee with defining when a project may be deemed to require a change in approach versus a quality improvement strategy. SWACH is also open to other ideas from the Quality and Continuous Improvement Committee, our workgroups and committees, the community, and other ACHs to determine whether the data indicates a change in approach is warranted .

If the SI Team and the Quality and Continuous Improvement Committee determine course correction is not possible, they will refer their findings to the RHIP Council for review. The RHIP Council will take a broader look to ensure a possible solution has not been overlooked. The RHIP Council will then recommend to the Board whether changes to the approaches or project should be considered, and SWACH would pursue the appropriate path with HCA.

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform*

initiatives currently in place.

- Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.
- If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.

YES	NO
X	

Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

ACH Response

SWACH will achieve project sustainability through a shared regional commitment to deliver health care through a whole person perspective. As mentioned in the above sections (*project selection and expected outcomes*), SWACH will support this vision by investing in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes, thus transforming existing relationships and developing a workforce trained to operate in a team-based environment.

SWACH will foster the development of a roadmap toward VPB and provide the resources necessary for providers to operate effectively in a value-based payment environment by investing in additional infrastructure and capacities. This will be critical to our sustainability efforts. SWACH has also been partnering with statewide workgroups regarding state Medicaid codes for Collaborative Care to help finance and sustain integrated care. We are working alongside our managed care partners to leverage the billing and coding work that has developed out of SB 5779 along with developments for new billing codes in rural health clinics and FQHCs. We are participating in the statewide Medicaid Value Based Payment workgroup and bringing together partners to develop strategies that provide movement along the VPB continuum from paying for volume to paying for value. Through an aligned strategy with the health plans and scaling successful integration models, by the end of the MTP, our region will be well positioned to provide effective, clinically integrated care which will be measured, in part, by our success in meeting MTP outcomes and progress toward achieving the quadruple aim.

Transformation Project Description

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

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input checked="" type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care

<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
 - Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
 - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
 - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
 - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

Rationale for Project Selection and Expected Outcomes

Although current care coordination efforts in the Southwest Washington region have improved care for many, a community-based care coordination approach has the potential to play a critical role in ensuring individuals with health and/or social needs connect to quality, preventive care and evidence-based interventions and services to improve their overall health outcomes. Expected outcomes will be achievement of the quadruple aim: better care, less cost, better member experience for the target population, and better provider experience.

The siloes and fragmented approaches to care coordination which currently exist often result in duplication of services, ineffective interventions, and uncoordinated care. For example, an individual involved in multiple systems may have 3 or 4 care managers assigned to them – one from each sector of

need (i.e., mental health, housing, social services, or primary care) with no single identified point of accountability; while others may have no care management support and are left to navigate a very complex system on their own.

For those who struggle with the social determinants of health in our region (unmet basic needs, housing insecurity, low income, lack of transportation options, and food insecurity) there are greater barriers to accessing the care and social service supports they need. The following data from the Regional Health Needs Inventory provides information on those who experience the social determinants of health:

- Almost a quarter of children in Klickitat County are living in poverty (24%), compared to 15% of children in Clark, and 16% statewide.
- Unemployment is also higher in Skamania (5.7%) and Klickitat (5.8%) than in Clark (5%), or compared to the state average (5%).⁷⁸
- According to census data, almost 40 percent of Clark County residents spend at least 30% of their income on housing (compared to 33% in Klickitat, and 28% in Skamania),
- In 2015, 3.6% of SWACH Medicaid members were homeless at least one month during the year, and data from the Council for the Homeless' housing hotline indicate an uptick in the first part of 2017 (compared to the first part of 2016) of individuals who are being discharged from the hospital or jail / prison to the streets.⁷⁹
- The 2016 Gorge Wide Food Survey found that 1 in 5 individuals ran out of food and 1 in 3 were worried about running out.⁸⁰ More than a third of students across the region are eligible for free or reduced cost lunch, and more than 20 people per 100 receive food stamps (SNAP).⁸¹

Project Justification, Regional Priorities, Sustainable Health System Transformation

The SWACH Pathways Community Hub project (HUB) seeks to reduce health disparities by providing community-based, culturally competent, and person-centered care coordination for targeted, vulnerable populations in our region. The Pathways Hub Model is an evidence-based and nationally endorsed model for the assessment and coordination of services that are critical for improving health outcomes, including medical (e.g., physical, behavioral, substance abuse and oral health), social, environmental, and educational services.

⁷⁸ Income and employment data from the 2017 Robert Wood Johnson Foundation County Health Rankings and the Washington State Employment Security Department (May 2017), accessed online at <http://www.countyhealthrankings.org/app/washington/2017/overview> and <https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/local-unemployment-statistics>

⁷⁹ Percent homeless data for CY 2015, from RDA Measure Decomposition files, provided by HCA July 2017. Council for the Homeless housing hotline information provided via email exchange with Kate Budd, Council for the Homeless, Oct 24, 2017.

⁸⁰ 2016 Columbia Gorge Regional Community Health Assessment. <http://cghealthcouncil.org/wp-content/uploads/2017/03/Columbia-Gorge-Community-Health-Assessment-Full-Document-December-2016.pdf>

⁸¹ SNAP and free or reduced price lunch data from DSHS County Risk Profiles <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>

The HUB infra-structure 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 community health worker (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. As an evidenced-based, outcomes-focused model, Pathways HUB addresses a regional need; ensuring targeted populations receive assistance connecting to, and appropriately utilizing, services and care.^{82, 83, 84, 85} Community care coordination is a key SWACH strategy that will drive improved health outcomes, health equity, and system savings. These strategies are critical to the sustainability of health system transformation; improved health outcomes, decreases in health inequities, and system savings will support value-based contracting, an underpinning to the sustainability of the MTP work.

The Pathways Hub will further support the sustainability of the health system transformation by serving as the community's driving force for breaking down silos, coordinating needed supports beyond the walls of health care, and advancing improvements in overall health and disparities. The HUB will serve as a core SWACH program, creating cohesion and linkages across Medicaid, including the region's other MTPs. Ultimately the HUB will be available for use with all payers in the region to further support the sustainability of system transformation.

Coordination with Other Efforts

The HUB will help avoid duplication of effort in care coordination and keep individuals from falling through the cracks. To avoid duplication, the Pathways Community Hub model of care will provide "air traffic control," or an overall centralized and standardized system, with processes and resources to track detailed outcomes of those being served, as well as a method to tie payments to outcomes.

The HUB will be the only proposed HUB within the SWACH region. We have shared with partners our intent to be the regional certified HUB and we know of no other entities planning to seek this designation. There is no overlap with any nearby HUB service areas. The nearest existing Hubs are in Hood River, Oregon, operated by One Community Health and the Project Access Now (PANOW) Hub, which operates in Multnomah (Portland), Washington, and Clackamas counties, in Oregon. There are no service area overlaps and the SWACH VP of Community Care Coordination has developed collaborative relationships with these neighboring Hubs. The Hub model also has the unique strength to reach out to Medicaid members who currently do not have a primary care provider and who are not accessing the benefits for which they are eligible. The HUB connects members into systems of care, allowing the individual to identify and prioritize their needs and tie those needs to evidence-based care pathways. The HUB model will promote care coordination across the continuum of health services for Medicaid

⁸² Redding S, Conrey E, Porter K, et al. Pathways Community Care Coordination in Low Birth Weight Prevention. *J Matern Child Health* 2015;19(3):643-50. First online: 20 August 2014. <http://link.springer.com/article/10.1007/s10995-014-1554-4>

⁸³ 4 Zeigler BP, Carter E, Redding S, et al. Care Coordination: Formalization of Pathways for Standardization and Certification. National Science Foundation Grant Award No. CMMI- 1235364. https://www.rockvilleinstitute.org/files/Care_Coordination_Formalization_of_Pathways_for_Standardization_and_Certification.pdf.

⁸⁴ Alley DE, Asomugha CN, Conway PH, et al. Accountable health communities: addressing social needs through Medicare and Medicaid. *N Engl J Med* 2016 Jan 7;374(1):8-11. PMID:26731305.

⁸⁵ Zeigler B, Redding S, Leath B, et al. Guiding principles for data architecture to support the Pathways Community HUB Model. *eGEMs (Generating Evidence & Methods to improve patient outcomes)* 2016;4(1):Art. 1. *ACH Project Plan Template (October 16, 2017)*

beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their whole health.

In an effort to identify current projects and initiatives (either current or planned) within the region; and to engage community and stakeholders in initial Pathways HUB model discussion, SWACH conducted an environmental scan of initial audiences (RHIP Council, existing community based councils and the Care Coordination workgroup) to determine the following:

1. Who does the Community identify as Care Coordinators for various populations and at various touch-points in the continuum of care
2. What programs or initiatives currently exist; which ones are working very well
3. What gaps in access to care still exist
4. "Who was missing" from the Care Coordination resource list (this helped to identify additional referral partners, for example, 2-1-1 and the Educational Opportunities for Children and Families, Clark College, etc.).

Several additional community listening sessions were held to determine where community members were currently preferring to seek care and "what was missing" from the current list of information/resources and initiatives occurring in the region. In addition to the questions above, community members were also asked:

- Do you feel as though your providers, or people that support your health, communicate with you effectively? Do they communicate with each other when you need them to?
- Do you have a Care Coordinator, Care Manager or Health Home or Primary Care Manager assigned to you, or someone you know? If yes, how many do you have? And do you feel as though you are able to communicate all of your concerns to them?

SWACH VP of Community Care Coordination additionally sought input from resources from across the Columbia River, in the Gorge Health Council. One Community Health and Project Access Now are active HUBs in Oregon identified as having an extensive list of resources for those who seek care across the river due to a lack of resource in our state. Information from these HUBs included projects/initiatives which provided support to persons covered by WA Medicaid, as well as those projects/initiatives which have recently reported improved health outcomes (for example, VeggieRx and the reduction of senior social isolation through support of local farmers' markets). Also, in order to avoid duplication with the Health Homes model, SWACH has been working closely with our MCO partners to ensure a bi-directional referral system between Pathways and the Health Home model of care currently being utilized across the state. We believe there are opportunities for Pathways and Health Homes to operate in a complementary manner and look forward to working with our Health Homes Care Coordinating Organizations (regional CCOs participate on our Workgroups and Governance Structures) and MCOs to design an implementation strategy that uses both systems' assets as effectively as possible.

Project Scope and Target Population

SWACH will serve as the Community Pathways Hub, providing implementation training, development of workflows and policies related to HUB operation, and provide critical tools such as the HUB IT platform to track resources, referrals, outcomes, and share information. The HUB IT platform (the Pathways HUB

Connect database), will identify and eliminate duplication of services and allow for the improvement of health outcomes across defined service areas and populations. The HUB will support partnering organizations, or Care Coordination Agencies (CCAs), and referral partner organizations to ensure individuals' health risk factors are addressed through a minimum of 20 standardized Pathways by connecting them to a range of community-based health and social services.

	<u>SUD & MH only</u>		<u>MH, SUD, and 1 chronic condition</u>		<u>MH, SUD, and >1 chronic condition</u>		<u>All SUD & MH</u>	
	N	%	N	%	N	%	N	%
Overall	1,297	1.18	1,349	1.22	3,626	3.29	6,272	5.69
Clark	1,189	1.16	1,257	1.23	3,299	3.22	5,745	5.62
Skamania	73	1.37	63	1.18	206	3.85	342	6.40
Klickitat	35	1.37	29	1.14	121	4.74	185	7.25

Integral community partners were identified through community engagement and an environmental scan process. Partners were identified based upon the number of Medicaid beneficiaries served, types of services offered, and their opportunity to reach beneficiaries experiencing care coordination needs. Once partners were identified, they were invited by SWACH to form a Community Care Coordination (CCC) Workgroup, charged with assisting in the development of CCC project planning, recommendation of initial target population, and identification of potential CCA and referral partners. The CCC Workgroup, with information and support provided by SWACH's Data and Learning Team (DLT), determined the initial target population for the SWACH Pathways Community HUB project:

- Individuals (18+) with multiple conditions

Our working definition for multiple conditions is an individual who experiences a chronic physical health and a behavioral health condition (behavioral health condition is a mental health and/or substance use condition).

Initial data from HCA indicates that as of June 2016, approximately 5.69% of SWACH Medicaid members (or just over 6,000 members) meet this criterion.

Data from HCA Cat 1 Behavioral Health and Chronic Conditions data file, released 9/29/17

The working definition SWACH uses is based on HCA / RDA grouper and diagnostic categories, as outlined in the HCA Cat 1 Behavioral Health and Chronic Conditions data file documentation:

- Physical health diagnosis – SWACH is using the HCA/RDA flag for individuals who have at least one chronic condition, as identified by the UCSD Chronic Illness and Disability Payment (CDPS) model. This includes disease groups such as cancer, cardiovascular disease, diabetes, pulmonary disease, gastrointestinal disease, and more.
- Mental health diagnosis – SWACH is using the HCA/RDA flag for individuals who presented at any point in the prior 24 months with a mental illness diagnosis, using the CDSP model. According to HCA documentation, this group includes diagnoses such as mania and bipolar

disorder, psychotic disorder, depression disorder, anxiety disorder, ADHD, and adjustment and stress disorders.

- Substance use disorder diagnosis – SWACH is using the HCA/RDA flag for individuals who presented at any point in the prior 24 months with at least one instance of need for SUD treatment, based on medical claims, target encounters, and arrest indicators. Additional documentation on SUD available online: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid>

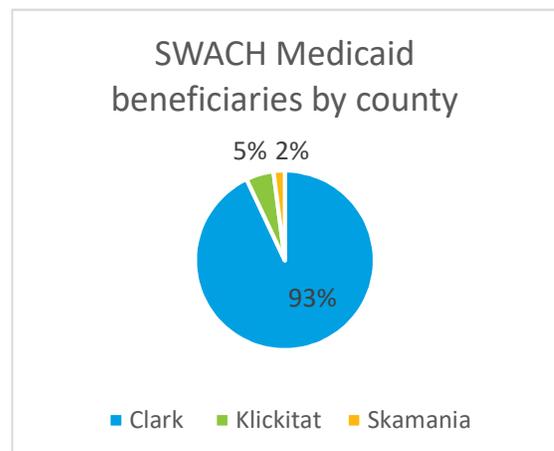
SWACH anticipates refining the population further in coming months as we finalize our target populations, particularly related to physical health diagnoses. We will be exploring narrowing the population from any individuals with physical health diagnoses as identified by the CDSP model to those individuals with specific chronic conditions. We will be looking for alignment with the target populations for other projects, particularly the chronic disease project, and exploring those chronic conditions that have the highest burden in our region (e.g., cardiovascular disease, pulmonary disease, diabetes).

With the help of the CCC Workgroup, SWACH released a Request for Applications to identify potential CCAs who currently serve this population and have interest in partnering to implement the Pathways Community Hub model in the region. Five community partners responded and through a collaborative scoring committee process, three community based agencies were selected: Sea Mar, Community Voices Are Born (CVAB), and Council for the Homeless. These organizations are assets in our region, connected to the identified population, have experience with a CHW workforce and are willing to help find, treat and measure the outcomes for the identified population through the Pathways Hub model. Each CCA will dedicate 2 CHWs and one .5 FTE Supervisor to Pathways model implementation.

SWACH proposes at least 350 individuals to be served by the initial 3 contracted CCAs in DY2. Initial caseload targets will be discussed in collaboration with the 3 pilot CCAs after CHW and Pathways implementation training in January 2018. As the current care coordination model Health Homes (HH) targets a similar acute population, SWACH has engaged Molina and other Health Homes providers to refine the target population using the PRISM score determination as referral criteria and ability of HH to serve as referral partner and develop a bi-directional referral process.

Level of Impact

SWACH intends to begin implementation of the Pathways Community HUB in Clark County, where selected CCA partners have agreed to begin training for implementation and are closest to the largest numbers of the identified target population. Clark is also the largest county, with most covered Medicaid lives (93%). After initial pilot implementation, the HUB plans to extend to additional populations, scaling the model to grow into Skamania and Klickitat, to address the multitude of needs in the rural and frontier areas of our region. As the HUB extends further throughout the region, we are committed to alignment with local, community-based agency partners to expand care coordination services to all regional communities and members.



Equity

SWACH is working in partnership with multiple community organizations and community groups to develop an equity lens to inform our overall work. This is an extensive piece of work, has been funded with additional grant dollars from United Way, Northwest Health Foundation, and leveraged partner organizations' funds. We will partner with the Center for Equity and Inclusion, a nationally recognized organization, to support the development of this work. In our role as a convener, we plan to continue to share our learning from this process with our partners working on the MTP. We are also committed to continuing our equity and social justice 8-hour training for all partners. Many partners have completed this training and we continue to receive growing interest and identified need. Our partners have provided very positive feedback about this training as demonstrated by their desire to train their organizations at large. SWACH realizes that developing an equity lens will take time, however, we plan to use the Center for Racial Justice Innovation, Racial Equity Impact Assessment Guide, as a set of guiding questions to use as a lens for our decision-making tables (workgroups, RHIP, Board, staff) to inform our work as we take the proper time and process to develop our own equity lens, tools, and community buy in.

SWACH is also working to deepen its impact on health equity through project level strategies. One strategy identified through the CCC Workgroup, is to ensure the CCAs contracted with the ACH have the following qualities:

- Able to serve individuals in multiple languages and across diverse cultures
- Utilize a trauma-informed lens in their interactions and treatment of individuals served
- An equity lens is applied to the CCA and HUB policies/procedures/systems (e.g., hiring processes established that enhance diversity and inclusion in the workplace)
- Diverse community partners define the needed resources to strengthen the community referral network

Lasting Impact

SWACH is committed to ensuring all projects are implemented with the intent to provide lasting impact. SWACH Community Pathways HUB will support this commitment by working with the broader network to address barriers to care. The HUB not only works with contracted CCAs to increase connections to care, but also with specific providers of health, behavioral health, and social services to address any identified barriers, improve education for community members, reduce "no shows," and to identify any issue that may prevent a community member from receiving an appropriate intervention or connected pathway to needed social services. The HUB also provides technical assistance to CCAs to address barriers and capacity issues. Reaching out to service providers and addressing issues of quality and barriers is an important aspect of care coordination. Data obtained by the HUB will additionally identify incomplete or partially completed Pathways to inform regional needs and barriers to be addressed by SWACH Community Resiliency funds, or other means identified by our regional partners.

The Pathways HUB is a direct link to Value-based Payments by supporting the target population through pathways that ensure providers and beneficiaries access services appropriately. Pathways ensures payment is based upon outcomes, not services, providing a direct link to value.

Through the implementation of a Pathways Community HUB, SWACH expects to gain deep experience with community-level care coordination, strengthened partnerships across referring entities and care

coordination agencies, and a heightened experience with tracking data and outcome-based payment methodologies intended to create long-lasting system change to improve population health in our community.

Implementation Approach and Timing

Using the **Implementation Approach tabs of the ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:
 - Describe the ACHs general approach to accomplishing requirements.
 - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
 - Specify which evidence-based approach option(s) will be used for the project.
 - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.

- Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented. Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring there is no duplication.

ACH Response

Partnering Providers

Through a regional environmental scan, SWACH has identified and engaged community-based organizations and clinical providers interested in improving community care coordination. Through these efforts, SWACH has developed a Community Care Coordination (CCC) Workgroup, which convenes monthly to aid in the implementation of the SWACH Pathways Community HUB. The CCC Workgroup represents various perspectives to inform health services (e.g., public health, health care providers, payers, community members, behavioral health organizations, and community-based health organizations), as well as other community and sector perspectives (e.g., housing, education, social services, criminal justice, transportation, food security).

As implementation continues, the Community Care Coordination Workgroup will evolve into a Community Advisory Council, which will include at least one representative from the following:

- Community Health Workers, Advocates and Peers serving the region
- Medicaid managed care organizations serving the region
- Health care providers practicing within the region
- Health systems and hospitals operating within the region
- Behavioral health organizations serving the region
- Community-based health organizations

The Community Advisory Council is a requirement for Pathways Community Hub Certification and the SWACH HUB Community Advisory Council will plan to have regular members, with ad hoc members joining as needed to provide input for quality assurance, specific policy discussion, or other issues. The current CCC Workgroup has adopted a charter, with guidelines and principles which support the overall mission and vision of SWACH and is aligned with the principles of Medicaid Transformation.

SWACH has asked the partners listed in the appendix to identify “point persons”, or those persons who provide or oversee Care Coordination in their organization to participate in HUB education and implementation planning. All partners have been engaged in Pathways HUB implementation communication, and many are actively engaged in the SWACH Community Care Coordination workgroup. As partners are still understanding what their potential role in the Pathways model may be, no formal commitments have been attained. However, through an RFA process, three agencies were selected to contract with SWACH as first-round Care Coordination Agencies. SWACH has continued to engage all other providers and community based organizations, as they will either be Referral Partners for the SWACH HUB, or potential Care Coordination Agencies when the model grows (Year 3 or 4). Referral Partners will refer Medicaid enrollees who may be identified as members of the target population to the HUB by way of an MOU with the SWACH HUB. At this time, SWACH does not have details as to the

number of Medicaid served for each Referral Partner as there are many (20) referral pathways and many potential referral partners. Furthermore, SWACH does not currently have specific data/information about numbers served for some of the potential Referral Partners. For example, 2-1-1 would be considered a Referral Partner who may serve the larger community, including Medicaid, however they may not be able to provide us with information about the number of Medicaid lives they serve. SWACH may obtain more specific data and information at a later date, once a partner's role is clarified and an MOU is determined appropriate.

SWACH does have the more specific information for the three providers/community based organizations who will become contracted CCAs:

- Sea Mar Community Health Centers a community-based organization committed to providing quality, comprehensive health, human, housing, educational and cultural services to diverse communities, specializing in services to Latinos. In addition to its core medical, dental, behavioral health and substance abuse services, Sea Mar offers a wide range of social services. These services include care coordination and care management, a Health Homes program, preventative health services, health education and nutritional counseling, Spanish language radio programming, affordable housing, pharmacies, long term care and home care. Sea Mar partners with other health and community organizations across its service area. In all counties it serves, Sea Mar staff represents the organization in a variety of regional efforts addressing health care access on the local level, and participates in regional, state and national community health care collaborations to ensure the needs of its patients and clients are met. Sea Mar served 33,616 patients in Clark County in 2016, and completed 108,996 total visits overall, and 80% of patients served are covered by Medicaid.
- Community Voices Are Born (CVAB): a community-based, peer-run organization committed to sharing hope and empowering individuals. As an organization of people living in mental health and addiction recovery, the heart of CVAB is peer-to-peer support for people wanting to experience healing, recovery and wellness, especially those who are vulnerable or in crisis. CVAB takes a strengths-based approach to holistic beings. CVAB intends to ensure quality community-based peer services of all types are delivered throughout Washington. CVAB supports some of the most vulnerable and at-risk individuals in Southwest Washington. The majority of CVAB participants are individuals working toward or living in recovery (MH/SUD); this includes people who are houseless and un- or under-employed. CVAB serves people from all walks of life, without judgement of who comes through their doors. CVAB serves a Medicaid population (68% of those served).
- Council for the Homeless (CFTH): a nonprofit organization that provides community leadership, compelling advocacy and practical solutions to prevent and end homelessness in Clark County. CFTH provides outreach and navigation assistance to households who are living on the street or in a car/RV to conduct assessments and gather necessary documentation. Community outreach focuses on those who are chronically homeless and unlikely to access assistance through traditional access points. CFTH also provides home visits through its diversion coaching efforts, to ensure housing stability, address any rising crises and ensure the landlord-tenant relationship is stable. Of those served in the last year, 88% self-reported receiving Medicaid through CHPW or Molina.

The SWACH CCC Workgroup also finalized the Care Coordination Agency Application, which was recently released through an RFA process, to engage potential Community Care Coordination Agencies (CCAs) in the region who may be interested in contracting with SWACH to implement the Pathways model. Based on environmental scan criteria, the application process attracted and identified 5 potential CCAs. SWACH convened a guest panel Scoring Committee (consisting of 1 SWACH RHIP Council Member, 1 MCO staff, 2 SWACH staff, 1 Medicaid community member, and 2 referral partners/CCC workgroup members (who did NOT apply to be a Care Coordination Agency)). The Scoring Committee evaluated and prioritized CCA applicants who demonstrated service and connection to Medicaid community members. Additional points were also awarded to those applicants who currently employ Community Health Workers (CHWs) and Peers. Selected CCAs were Sea Mar, Council for the Homeless and Community Voices Are Born (CVAB). All three agencies serve a significant portion of the target population: Medicaid members who experience multiple chronic conditions. By January 2018, SWACH Pathways Community HUB will secure contracts with the 3 selected CCAs which will include a commitment to SWACH's *Transformation Rules of Engagement* and to service of the target Medicaid populations.

Contracts will be secured with HUB referral partner organizations by March of 2018. Ongoing monitoring and continuous quality improvement will also provide oversight of providers to ensure they are serving Medicaid populations and implementing strategies aimed at reaching the desired outcomes for the HUB's targeted Medicaid populations. As the largest MCO in our region, Molina has provided much support in the form of data and learnings from care coordination models currently in place (Health Homes). Collaborating to inform which populations are targeted by Health Homes will help SWACH implement our Pathways Community HUB with target population refinement and bi-directional referral development. This collaboration additionally ensures Health Homes are engaged to appropriately refer community members to the correct care coordination resource. State-wide collaboration with Health Home providers and payors has already resulted in clarification of roles and referral process refinement.

Regional Assets, Anticipated Challenges and Proposed Solutions

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

Assets

SWACH staff have met with Pathway model developers and have gained enhanced knowledge of the

Pathways Community Hub model implementation, often providing technical assistance and shared learnings to other ACHs. SWACH has additionally contracted with national experts, and the model developer, to ensure implementation success. In addition to these organizational assets, SWACH convened a Community Care Coordination Workgroup to help identify regional assets which will play key roles in the implementation of the Pathways Community HUB:

- Currently, there are several outreach and care coordination programs in the region addressing the health and social needs of Medicaid and other low-income populations. The network brings significant expertise in both clinic and community-based care coordination and strategies for reaching at-risk populations. Health Homes partners are engaged and offer much support to implementation, including bi-directional referral refinement and learned strategies.
- Regional stakeholders have been testing pilot projects utilizing shared data systems, such as the EDIE/Pre-manage system, to create mechanisms for shared care planning as well as conducting regular shared case staffing for the highest utilizers of the Emergency Department (ED) in effort to provide more community based services and reduce ED utilization.
- Interoperability of data systems: The Pathways Community HUB model brings with it data technology to support “coordinating the care coordinators” and assuring pathways are complete and outcomes are met. Coordinated Care Solutions (CCS) is the proprietary owner of the data system and assures that the HUB will have interoperability with the numerous other data systems that exist within our region. While the implementation and learning of the Pathways Community HUB data system may add additional administrative burden to providers, SWACH is committed to providing support and is additionally contractually supported by CCS throughout implementation and Y2.
- SWACH is now partnered with the Healthy Living Collaborative of SW Washington (HLC), an organization which has been working for many years to expand a community-based workforce that includes Community Health Workers, Peer Support Specialists, and other community connectors. SWACH plans to strengthen and build upon this network to advance implementation of the Pathways Community Hub model.
- SWACH is also on course to contract with 3 community based Care Coordination Agencies, recently recommended and selected through an open RFA process. The three organizations chosen also represent assets to our region’s implementation of the Pathways Community HUB:
 - **Sea Mar Community Health Centers** a community-based organization committed to providing quality, comprehensive health, human, housing, educational and cultural services to diverse communities, specializing in services to Latinos. In addition to its core medical, dental, behavioral health and substance abuse services, Sea Mar offers a wide range of social services. These services include care coordination and care management, a Health Homes program, preventative health services, health education and nutritional counseling, Spanish language radio programming, affordable housing, pharmacies, long term care and home care. Sea Mar partners with other health and community organizations across its service area. In all counties it serves, Sea Mar staff represents the organization in a variety of regional efforts addressing health care access on the local

level, and participates in regional, state and national community health care collaborations to ensure the needs of its patients and clients are met. Sea Mar served 33,616 patients in Clark County in 2016, and completed 108,996 total visits overall, and 80% of patients served are covered by Medicaid.

- **Community Voices Are Born (CVAB):** a community-based, peer-run organization committed to sharing hope and empowering individuals. As an organization of people living in mental health and addiction recovery, the heart of CVAB is peer-to-peer support for people wanting to experience healing, recovery and wellness, especially those who are vulnerable or in crisis. CVAB takes a strengths-based approach to holistic beings. CVAB intends to ensure quality community-based peer services of all types are delivered throughout Washington. CVAB supports some of the most vulnerable and at-risk individuals in Southwest Washington. The majority of CVAB participants are individuals working toward or living in recovery (MH/SUD); this includes people who are houseless and un- or under-employed. CVAB serves people from all walks of life, without judgement of who comes through their doors. CVAB serves a Medicaid population (68% of those served).
- **Council for the Homeless (CFTH):** a nonprofit organization that provides community leadership, compelling advocacy and practical solutions to prevent and end homelessness in Clark County. CFTH provides outreach and navigation assistance to households who are living on the street or in a car/RV to conduct assessments and gather necessary documentation. Community outreach focuses on those who are chronically homeless and unlikely to access assistance through traditional access points. CFTH also provides home visits through its diversion coaching efforts, to ensure housing stability, address any rising crises and ensure the landlord-tenant relationship is stable. Of those served in the last year, 88% self-reported receiving Medicaid through CHPW or Molina.

Challenges and Barriers

- Siloed systems in a diverse region
 - SWACH region includes a mix of urban, suburban, rural, and frontier communities. The regional needs and providers that serve the communities are both unique and often overwhelmed. Many providers have served their communities with some form of care coordination as part of their service delivery model. The Pathways Community HUB implementation will need to coordinate with and assure there is not duplication with current community resources, while also ensuring the uniqueness of various community providers remains in-tact and access to resources become available as soon as possible through implementation.
- Working in coordination with clinic-based models
 - Pathways Community HUB brings an innovative approach to care coordination that adds processes outside of the clinic walls and engages more deeply with individuals at risk using trusted members of the community who are culturally and linguistically similar. That said, one challenge will be implementing the Pathways Community HUB model in a way that

does not duplicate or interfere with clinic based care coordination but rather enhances it, adds value to the care delivery team, and builds strong, bi-directional partnerships between clinics and community. One component of this is being mindful as to how community-based care coordinators will interact with and collaborate with clinic staff and how accountability will be assured when more than one provider entity is involved. Building confidence in the Community Health Worker workforce is imperative to the potential growth of the workforce, as well as the success of the Pathways Community HUB.

- CCA preparedness
 - SWACH has identified multiple potential challenges that must be addressed to ensure the successful implementation and impact of the Pathways Community Hub model in our region. The first anticipated challenge is the expected learning curve for CCAs who are accustomed to providing care coordination services in a different manner (i.e., not previously using community-level care coordination or Pathways). Participating CCAs will need to learn new ways of assessing data, working with external partners, and getting paid based on outcomes versus services provided. These organizations will also have to adapt to being held accountable by an external HUB organization.

- Data platform and interoperability
 - Another potential challenge for improving outcomes and lowering costs via the Pathways Community Hub model is the very specific HIT/HIE needs of the model. The HUB technology/data platform must allow for accurate and timely documentation for all the Pathway activities. In addition, the data platform must optimize interoperability with statewide and regional data systems to ensure maximal effectiveness in improving health outcomes.

- Finance Model
 - Care Coordination/Pathways is an integral tool of value-based payment and supports the shift from volume to value. However, sustainability is dependent on the state's and Payers' collective willingness to engage in designing a mutually agreed upon funding model for Pathways.

Mitigating Risk and Overcoming Barriers

SWACH will work to overcome these challenges and barriers in several ways:

1. Establishing a Pathways Community Advisory Council

Ensuring the council has diverse representation from the various parts of our region, including partners and community members from rural and frontier areas. Engaging rural and frontier residents to understand their current experience of care coordination will aid in the scaling and expansion planning for the HUB beyond pilot implementation. This engagement will help avoid duplication with current community resources, aid in the coordination with current clinic based

models, while also ensuring the uniqueness of various community providers remains in-tact to serve those in rural and frontier communities.

2. Monitoring growth and capacity of pilot CCAs

SWACH is working with selected pilot CCAs to ensure there are clear expectations and understanding for how the model works, including the specific role of the CCA, value-based payment methodologies, and expectations. This additional step prior to contracting will help to ensure a shared understanding of roles, responsibilities and key model components to ensure a positive working relationship and ability to maximally improve health outcomes. Starting small with an initial pilot will help to gain experience and meaningfully address initial barriers that can be addressed prior to scale-up. This will also allow us to assess community partners' ability to expand beyond Clark County. As the HUB scales to expand beyond Clark County, ensuring partnering providers have the resources needed, strengthening their capacity and identification of new potential CCAs will be crucial to meeting the risks of expansion.

3. Developing the Workforce

SWACH will ensure a well-developed CHW workforce to meet the needs of the rural and frontier areas of our region and provide community and provider education to understand the role of the CHW workforce in community care coordination.

4. Aligning Implementation Efforts

Ensuring implementation efforts are aligned to initiate National Certification as a Pathways Community HUB offers several advantages: A framework for standardizing how community care coordination services are organized, delivered, measured, and financed; Tools, metrics, and mechanisms developed that can be used to monitor, assess, and evaluate various aspects of community care coordination services; and clear demonstration of outcomes and accomplishments. Professional champions and consultants can also provide education and training on the benefits of the Pathways model to the overall system of care.

5. Partnering with other ACHs

Work with partnered ACHs to share learnings of implementation, particularly those who share similar geographical areas.

6. Data platform and interoperability

SWACH has chosen to work with Care Coordination Systems (CCS) to develop the Pathways Community HUB data platform. CCS has already developed a platform specific to the Pathways model and therefore brings tremendous experience to the needs of a new, developing HUB. Additionally, CCS has worked with multiple EHR systems to create some level of interoperability. Work is already underway to create linkages between CCS, EDIE, Pre-Manage, the criminal justice system electronic health system, and beyond.

7. Finance Model

SWACH will continue our efforts with MCOs to arrive at a mutually agreeable and feasible financing mechanism for the Pathways HUB. We will also continue to advocate for the inclusion of Pathways HUB outcome payments in Total Cost of Care so it will be included in premium. Pathways is consistent with paying for outcomes and value – it should be included as an expense covered by Medicaid premium.

Monitoring and Continuous Improvement

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, an Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below (see Figure 1).

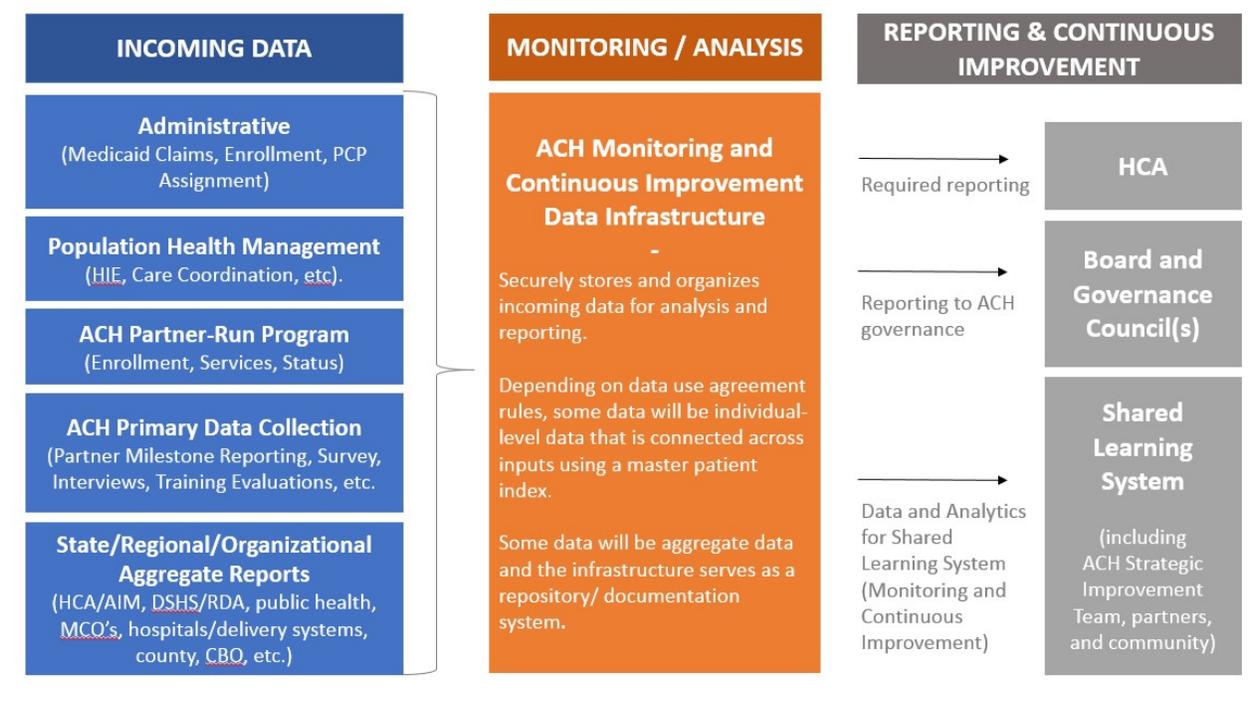
Figure 1. Process for Monitoring and Continuous Improvement

The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the CCC Workgroup and the SWACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

SWACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

SWACH's self-monitoring system will allow providers to input data and give SWACH and our partners an early view of progress. This data will allow SWACH to see if providers are falling behind or not meeting requirements early, providing ample time to share the data with them, help them understand the import of the data, and to design rapid-cycle feedback and quality improvement strategies before veering too far off track. This will be more effective with pay for reporting requirements, however, we are working with CORE to develop a system that will allow us to track data elements that will be predictive of overall pay for performance metrics as well.

Our Improvement Advisors will work with provider organizations to assist them in developing the capacity to review their own data and begin to design their own quality improvement projects .



Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?

- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

ACH Response

Plan for monitoring project implementation progress, including addressing delays in implementation

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of an Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process.

In addition, the Pathways HUB model and data collection tool using the CCS platform will be explicitly developed to allow for real-time assessment of Pathways outcomes and provide SWACH the opportunity for addressing challenges as they arise. The system will be informed by key planning inputs that better position SWACH to invest in and provide supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and ACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the MTP for each project area.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers. These learning collaboratives will allow regional providers to see trends and work together to determine the underlying cause of these trends.

SWACH Improvement Advisors, in concert with Qualis Health and MCOs will work with each partnering provider to determine the level of support desired and needed. For larger, more sophisticated organizations, SWACH will work with quality improvement teams already working within these organizations. Using data and reports, SWACH will ensure quality improvement personnel know the issues and have the tools to address those issues. If more assistance is requested, SWACH will provide more in-depth support. This support may be in the form of training, technical assistance, or coaching.

For smaller organizations, SWACH envisions being the quality improvement engine for these providers. Based upon provider reported data, and broader data sources, SWACH will provide technical assistance, training, and coaching. SWACH will work with provider organizations to improve their performance with respect to projects, as well as train these organizations to begin to establish their own quality improvement teams and processes .

SWACH envisions needing to be flexible in creating this quality improvement process to meet the varied needs of providers in different sectors, geographies, and stages of maturity. Our own work will require assessment and improvement to continuously meet the needs of our partnering providers.

Plan for addressing strategies that are not working or not achieving outcomes

The comprehensive shared learning system, PDSA continuous improvement process, and CCS platform will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

Our workgroups, committees, and governance bodies will continue to meet to discuss the data and progress of our partnering providers throughout the MTP. SWACH will work with the Quality and Continuous Improvement Committee to ensure all assets are brought to bear when monitoring suggests a project is off course. However, we are aware that there is the possibility that despite best efforts, a strategy may not result in desired outcomes. SWACH is considering charging the Quality and Continuous Improvement Committee with defining when a project may be deemed to require a change in approach versus a quality improvement strategy. SWACH is also open to other ideas from the Quality and Continuous Improvement Committee, our workgroups and committees, the community, and other ACHs to determine whether the data indicates a change in approach is warranted .

If the SI Team, Quality and Continuous Improvement Committee, and Care Coordination Advisory Council determine course correction is not possible, they will refer their findings to the RHIP Council for review. The RHIP Council will take a broader look to ensure a possible solution has not been overlooked. The RHIP Council will then recommend to the Board whether changes to the approaches or project should be considered, and SWACH would pursue the appropriate path with HCA.

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

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

YES	NO
X	

Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

ACH Response

Project Sustainability

Strategy for long-term project sustainability

The Pathways Community Hub model is rooted in the principal of payment for outcomes. From the start, SWACH will be working with MCOs, other potential payers, and other agencies to establish sustainable funding for the program and care coordination agencies that will continue beyond the MTP period. Robust reporting and analysis will enable us to demonstrate the direct cost savings achieved by health systems and MCOs and the improved health outcomes of members.

Although we intend the HUB to initially be implemented with a blend of ACH earned MTP dollars, as well as MCO payment, a break-even year is anticipated by year 2 and it is projected the HUB will begin to generate revenue, be self-sustaining, and pay CCAs bonus payments for exceptional performance. In years 3 on, additional revenue earned beyond what is needed to sustain the HUB will be re-invested into community resiliency projects, identified by data collected by the HUB.

Ultimately, HUB certification standards require that contracts with the HUB tie fifty percent of all payments to an individual’s intermediate and final Pathway outcomes. SWACH hopes to be able to achieve this goal by utilizing the Strategic Improvement Team to implement process improvement and change management strategies to support partners to make sustainable change. Providers will also be supported so that they may meet established success measures and outcomes. In addition to achieving self-sustainability by the end of the MTP, the HUB anticipates being in the position to provide system-level data to non-traditional payers and sectors (those outside of healthcare, e.g.

housing, private business, government, etc.) - as the number of incomplete or partially completed Pathways will inform assessment of regional needs and barriers - to pay for care coordination and tracking of Pathways which may be of interest to those entities.

Beyond MTP

The HUB’s ability to blend funding and provide value-based, outcome payments to contracted Care Coordinating Agencies will aid the HUB’s ability to expand to vulnerable populations and address specific issues related to the social determinants of health. SWACH intends to capitalize on the opportunity of the Medicaid Transformation Project funds to aid in the implementation and capacity building of a community asset that will help transform care for Medicaid beneficiaries – and the community at large.

Transformation Project Description

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

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
 - Describe the project’s anticipated target population. How many individuals does the

- ACH anticipate reaching through the project?
 - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
 - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
 - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

2.1 Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.

No magic bullet exists for addressing the opioid epidemic. Programs and services must address the epidemic by weaving together to form an integrated net of prevention for people at risk of opioid abuse and a blanket of support for people struggling with opioid use. SWACH proposes a multi-sector, multi-pronged approach to address the epidemic with a focus on prevention, treatment, overdose prevention and recovery. Opioid strategies will be integrated across SWACH’s concurrent projects of Bidirectional Integration, Community-Based Care Coordination and Chronic Disease Management.

High levels of opioid prescriptions and opioid availability have contributed to an increase in rates of addiction, overdose, and the use of non-prescription street drugs. Since 1999, the amount of prescription opioids in America quadrupled and the number of opioid overdoses in America have closely correlated, quadrupling as well to epidemic levels.⁸⁶ Non-medical use of prescription opioids is linked to increased street drug use and is the gateway for four out of every five new heroin users.⁸⁷ The devastation to human lives aligns with increased health care utilization and costs. Adults with substance use disorder treatment needs are 3.5 times more likely to have three or more ED visits in a year.⁸⁸

SWACH covers geographically diverse urban, rural and frontier populations, all hit hard by the opioid epidemic. Data availability differs across communities. Nationally, death from opioid OD is 45 percent higher in rural areas than urban areas.⁸⁹ Rural counties in our region have seen increases of 221.6% in Skamania and 48.5% in Klickitat of publicly funded treatments involving opioids between 2002 and

⁸⁶ Commission on Combating Drug Addiction and the Opioid Crisis -Report to President 2017

⁸⁷ <https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm>

⁸⁸ HCA / RDA Measure Decomposition file, provided August 2017. Data for CY 2016, adult Medicaid users with 3 or more ED visits in the past year.

⁸⁹ <http://nashp.org/intervention-treatment-and-prevention-strategies-to-address-opioid-use-disorders-in-rural-areas/>
ACH Project Plan Template (October 16, 2017)

2013.⁹⁰ In primarily urban Clark County, opioid related death rates increased by over 40% and opioid related hospitalizations increased by over 200% in the last 10 years.⁹¹

We anticipate SWACH's opioid project will provide long term support for Medicaid members using opioids in the following ways:

- 1) Reduction in amount and duration of opioids prescribed and promotion of alternative pain management strategies with long term impacts of declining rates of Opioid Use Disorder (OUD) and opioid overdose.
- 2) Increased outreach as well as education and treatment access to persons who use opioids through capacity development of peer support services, care coordination, and community based organizations serving as treatment access and referral points.
- 3) Improved care and treatment penetration for persons with OUD through SWACH strategies and projects enhancing cross-continuum collaboration and increasing capacity in clinical settings to manage persons with OUD.
- 4) A reduction in overdoses and ED utilization rates for persons with OUD resulting from increased treatment penetration and naloxone distribution, together with the web of support provided the SWACH project portfolio.

2.2 How will the ACH ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region?

In June of 2017, when SWACH convened an opioid workgroup, no regional opioid taskforce was in place.

SWACH convened the opioid workgroup to guide planning, ensure coordination, avoid duplication and guide implementation efforts for opioid strategies. The opioid workgroup meets monthly at minimum and represents a broad array of settings and stakeholders engaged in opioid work. Opioid workgroup members represent primary care clinics, hospitals, behavioral health settings, alternative or complementary medicine physicians, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations. Workgroup expertise has informed an environmental scan of opioid efforts across the region.

The environmental was organized by approaches and indicated the following.

Prevention

- Efforts to improve opioid prescribing through guidelines have been initiated and appear inconsistent across care delivery settings (e.g. primary care, hospitals, etc.)
- Educational Service District 112 (ESD 112), representing 21 school districts across SWACH's region, administers six community prevention coalitions active across the region supporting community education and drug take-back efforts.
- ESD 112 has prevention/intervention specialists in most schools across the region

⁹⁰ <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

⁹¹ Saving Lives with the Opioid Overdose Prevention Program In Clark County, WAState: WA Type: Model Practice Year: 2016- <http://cabarrus.nc.networkofcare.org/ph/model-practice-detail.aspx?pid=5914#.Wd6-etRVC8k.email>
ACH Project Plan Template (October 16, 2017)

- Ongoing drug take-back programs are inadequate. Some have been discontinued due to cost.

Treatment

- Access to treatment facilities and services is much greater in Clark County than in Skamania and Klickitat, where it is very limited.
- Clark County jails offer counselling treatment to inmates and recently began providing MAT continuation.

OD Prevention

- Naloxone prescription protocols for persons with OUD or patients receiving high doses of opioids are not the norm. Naloxone prescribing appears to vary across care settings and is not happening at all in some hospitals and ED's.
- Clark County syringe exchange distributes naloxone

Recovery

- Clark County has a strong recovery community with various recovery support services and agencies.
- Skamania and Klickitat have very limited recovery and peer support services.

The opioid workgroup identified and prioritized top opioid strategies for SWACH. The process utilized a criteria matrix with six key criteria for project selection and prevention of duplication:

<i>Community Readiness:</i> Will potential partners be ready to take this on?	<i>True Need:</i> Does it connect to a high magnitude of documented need (<i>without duplication or intense competition of existing efforts</i>)?	<i>Impact/Scale:</i> Does it affect a large number Medicaid covered lives and will it provide a return-on-investment within 2-3 years?	<i>Spread:</i> Does it engage across the region?	<i>Actionable:</i> Is it an actionable strategy? Is it ready to be implemented immediately?	<i>Measurements Alignment:</i> Does it support the measurements for which the ACH will be accountable?
----------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------	---------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------

Moving forward SWACH will continue to ensure coordination and prevent duplication:

- Ongoing SWACH opioid workgroup guidance, information sharing, collaboration.
- Klickitat Valley Health Opioid Taskforce to address needs and opportunities specific to rural/frontier communities.
- SWACH to convene advisory groups of setting specific champions to represent six settings: primary care, hospitals, behavioral health, SUD, dental, community. Advisory groups to lead and ensure coordination of setting specific integration of opioid strategies.
- SWACH community engagement team to gain input from regional Medicaid populations ensuring community defined needs are being met and prevent duplication.
- SWACH has convened a Klickitat Valley Health (KVH) Opioid Taskforce.

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. As Klickitat is a two-hour drive from Clark County, the KVH Opioid Taskforce was convened as different from supplementary to the Opioid Workgroup to identify and act on SWACH opioid strategies specific to the rural Klickitat context. SWACH VP of Prevention attends taskforce meetings to consider opportunities and plan SWACH project implementation details specific to the KVH context. The VP of Prevention 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 PMP registration and PMP QIP
- Increasing drug-take back capacity
- Increasing number of MAT providers
- Collaborating with the Comprehensive Health for MAT related counselling treatment
- Creating protocols for naloxone prescription
- Supporting expansion of peer services in community

2.3 Anticipated target population. How many individuals does the ACH anticipate reaching through this project?

The target population is Medicaid clients without a cancer diagnosis who use opioids, particularly those with opioid use disorder (OUD). A subset target population is Medicaid members with a diagnosis of opioid abuse who are *not* receiving medically assisted treatment (MAT).

In 2016, 12,234 Medicaid members in the SWACH region used opioids and who did not have a cancer diagnosis.⁹² 2,288 had a diagnosis of opioid abuse. 81.8 percent of these, 1,872 persons, were not receiving MAT.⁹³

We anticipate that this project will have broad impact as increased regional focus on coordination, collaboration, efficiency and practice alignment will extend beyond the Medicaid population to benefit all persons who use opioids.

What types of partnering providers are involved in the project thus far, and why are they critical to the success of the project?

Thus far, 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, substance use disorder, public health, schools, community coalitions,

⁹² HCA/ Starter Set Data Files/Opioid Tab/Medicaid Users with no Cancer History. FY 2016.

⁹³ HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse / Medically Assisted Treatment-Buprenorphine, Methadone. FY 2016.

managed care organizations, corrections, and community based organizations. Project success requires collaboration across settings and opioid strategies must synergistically weave together in support of whole person care.

- Care delivery providers (primary care, hospital, dental, behavioral health, and substance use disorder settings) are critical for informing integration of clinically based strategies (e.g. opioid prescribing, PMP utilization, MAT initiation and management, Naloxone distribution etc.)
- Community based organizations are critical for community based strategies (e.g. increased access points to treatment, opioid education, recovery support, care coordination, community mobilization etc.)
- Managed Care Organizations are critical for coordination, scale and sustain strategies that will ensure long term project impact beyond the scope and timeline of the MTP.

EMS is not currently part of the Opioid workgroup although SWACH is exploring strategies to address the opioid crisis in partnership with law enforcement and EMS. Considered strategies include:

- Training and education opportunities about opioids and OUD to address stigma, particularly education on addiction pathophysiology that supports understanding of opioid use disorder, not as a choice, but as a chronic disease that that can be addressed through treatment and recovery efforts.
- EMS and law enforcement trained and supplied with leave-behind naloxone kits to support OD prevention.
- Opportunities for inmates in jails to access MAT, both initiation and continuation.
- In conjunction with SWACH's care coordination project, opportunities for EMS to develop community paramedicine capacities which would include paramedicine follow up with OUD affected persons post discharge from jails or hospitals ⁹⁴

Law enforcement agencies are represented in the opioid workgroup through Chief Ric Bishop and Commander Randall Tangen from the Clark County Sherriff's Office and Deputy Sheriff Christian Lyle from the Skamania County Sheriff's Office. SWACH plans continued outreach efforts to engage Klickitat law enforcement through the Klickitat Valley Health opioid taskforce.

SWACH is exploring community paramedicine opportunities and is in the "planning" stage of the PDSA cycle, identifying and meeting with organizations with whom we can partner to share strategies/barriers. We are involved in ongoing meetings with Clark County Fire and Rescue and Clark County's EMS medical director, and we are establishing a relationship with AMR. SWACH is also working with Pierce ACH to share learnings from Tacoma Fire and Rescue's recently established community paramedicine program which will serve persons with OUD and will include leave-behind naloxone kits. SWACH anticipates a phased scale and sustain regional approach to engaging EMS and Fire and rescue with initial efforts focused on Clark County.

SWACH opioid workgroup represented by Medicaid providers and organizations that provides Medicaid services.

⁹⁴ <https://www.ems1.com/opioids/articles/197686048-How-community-paramedics-can-respond-to-the-opioid-overdose-epidemic/>

- • Beacon Health- *Provides behavioral health crisis services to all individuals regardless of income or insurance status*
- Clark County Department of Community Services – *Allocates funds for behavioral health programs to reduce the impact of substance abuse.*
- Clark County Public Health- *Collaborates with partners to prevent disease, runs syringe exchange program*
- Clark County Sherriff’s Office- *Law Enforcement*
- Columbia River Mental Health- *Medicaid provider*
- Community Health Plan of WA -*MCO serving Medicaid population*
- Comprehensive Healthcare- *Medicaid provider*
- Consumer Voices are Born- *Community Based Peer Support Organization*
- Cowlitz Tribal Treatment –*offers SUD counselling treatment accessible to tribal members and Medicaid beneficiaries*
- ESD 112- *Prevention and Youth Services in SW Washington schools administers Drug Free Communities Prevent Coalition, Washington State Community Prevention and Wellness Initiative*
- Exchange- *Faith Based Peer Support Organization*
- Healthy Living Collaborative- *Input from community member Medicaid beneficiaries*
- Klickitat Valley Health- *Medicaid provider*
- Lifeline Connections- *Medicaid provider*
- Molina- *MCO serving Medicaid population*
- North Shore Medical Group- *Medicaid provider*
- Our Klickitat Prevention Coalition- *Prevention education and programs including drug take-back focus*
- Peace Health Medical Group- *Medicaid provider*
- SeaMar Community Health Centers- *Medicaid provider*
- ShareHouse- *CBO serving the hungry and homeless and provides supportive housing with on-site mental health and substance abuse services.*
- Skamania Sherriff’s Office- *Law Enforcement*
- SW Washington League of United Latin American Citizens- *Input from Latin American community and representative is a chiropractic provider and advocate for non-opioid pain treatment.*
- United -*MCO serving Medicaid population*

Not all regional Medicaid providers have representatives on the Opioid workgroup. Outreach efforts to unengaged Medicaid providers are ongoing. By end of Q1 2018 SWACH plans to invite all providers not currently on the opioid workgroup to participate in the opioid project and join the workgroup. SWACH does not currently know exact client counts for all opioid partners and intends to address this as part of the upcoming current state assessment (due Q2 2018).

How did the ACH consider the level of impact when selecting the project’s anticipated target population?

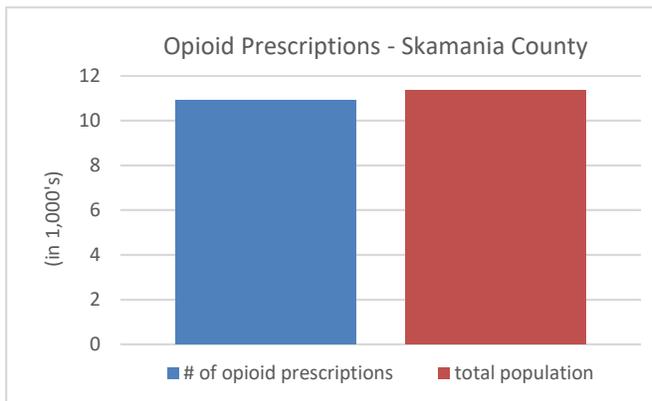
SWACH anticipated target populations are Medicaid clients without a cancer diagnosis who use opioids, with a sub-population of those with opioid use disorder who are not receiving MAT treatment. The project's level of impact will be regional, as the opioid response for these populations needs improvement across all three SWACH counties. The level of impact will also be transformational as, to best serve the target populations, provider partners across the region will need to work toward greater collaboration and integration across care and community settings. As such, the impact of the opioid project at a foundational level will be determined synergistically with concurrent SWACH projects (bidirectional integration, care coordination, chronic disease management) working toward the MTP's overarching goal of system transformation.

To serve the target populations, SWACH selected four related approaches with anticipated impacts at regional and system transformational levels.

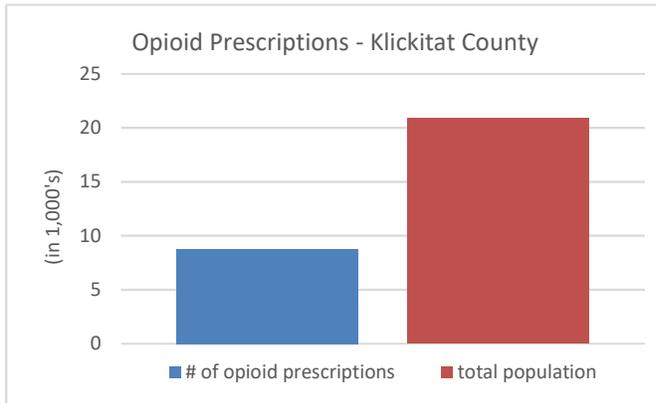
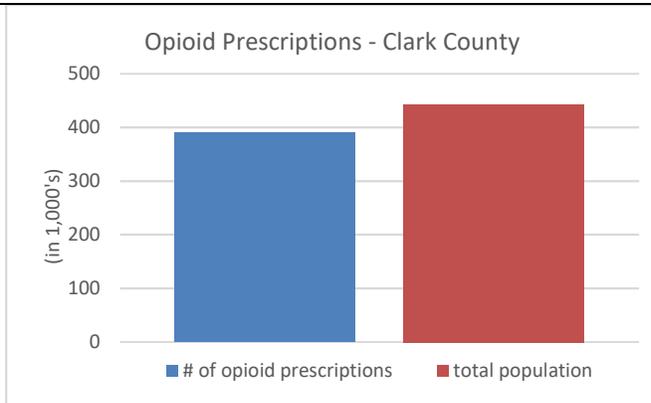
1) Prevention - Improve Opioid Prescribing Practices / Decrease Opioids in Community

Our community has been flooded with opioids. In the SWACH region there were 408,673 unique opioid prescriptions in 2014 as compared to a total population of 475,019 (ratio of 0.9 / person).⁹⁵

In 2014, for example, there were 388,999 opioid prescriptions in Clark County compared to a total population of 442,800 in 2014, almost one prescription for every person (Ratio of 0.88 opioid prescriptions per person). In Skamania there were 10,907 unique opioid prescriptions compared to a population of 11,370. In Klickitat there were 8,767 unique opioid prescriptions compared to a population of 20,849 (see charts below).



⁹⁵ <https://www.doh.wa.gov/Portals/1/Documents/2600/PMPcountyProfiles/630-126-ClarkCountyProfile2014.pdf>
<https://www.doh.wa.gov/Portals/1/Documents/2600/PMPcountyProfiles/630-126-SkamaniaCountyProfile2014.pdf>
<https://www.doh.wa.gov/Portals/1/Documents/2600/PMPcountyProfiles/630-126-KlickitatCountyProfile2014.pdf>



14,066 SWACH Medicaid members use opioids, representing more than one in ten of the region’s 134,745 Medicaid members. Persons prescribed opioids are at increased risk for developing OUD, the likelihood ranging from a threefold increase for acute low dose opioids to a 122-fold increase for chronic high dose opioids.⁹⁶

The general target population is Medicaid members who use opioids. This target population will support prevention efforts for three sectors of the SWACH community.

- Patients who use opioids but do not have OUD.
- Opioid naïve patients who present with pain issues.
- The community at large by decreasing the quantity of opioids in the region.

Training and Technical Assistance

SWACH intends to work with partnering providers to offer training and technical assistance, as well as QI support, that will support implementation of and adherence to prescribing guidelines as well as promote use of PMP. Statewide, only 30% of prescribers and 51% of pharmacists are registered for the state’s PMP.⁹⁷ We anticipate fewer and more appropriate opioid prescriptions will support prevention efforts that affect persons who use opioids, opioid naïve patients presenting with pain, and the larger community through decreased numbers of and access to non-medical use of opioids.

⁹⁶ Washington State Interagency Guideline on Prescribing Opioids for Pain

⁹⁷ Washington State Department of Health. Prescription Monitoring: A Tool in Patient Care. June 15, 2017. *ACH Project Plan Template (October 16, 2017)*

There are an estimated 100 million Americans in chronic pain and pain is the most common thing that providers take care of in clinical setting, yet most clinicians get almost no training on pain or drug abuse.⁹⁸ SWACH intends to work with partnering providers to offer training for medical professionals on pain and drug abuse management as part of the strategy to improve opioid prescribing.

We anticipate trainings will equip providers with increased capacity and confidence in working with OUD affected patients and with chronic pain. We expect providers more informed in managing these conditions will prescribe opioids less and more often consider non-opioid treatment options. This will support prevention outcomes beyond the target population to include opioid naïve patients who present with pain and non-Medicaid patients.

Medication Disposal

SWACH intends to support regional drug take-back efforts. Research shows that patients are often prescribed more opioids than consumed, for example up to three times more opioids than are consumed after orthopedic surgery.⁹⁹ It is hard to know the impact that this has had on the amount of medication available for overuse and diversion, but it is likely to be significant. Sixty-three percent of heroin using clients at the region’s harm reduction center reported using prescribed opiates before becoming heroin addicted.¹⁰⁰

Reports from the department of community services, prevention coalitions, the syringe exchange, and medical providers suggest the SWACH region has insufficient access to medication disposal.

SWACH intends to work with partners to support an increase in drug-take back opportunities in the community. This strategy addresses the target population while also supporting prevention efforts for the community at large by reducing access to excess opioids in the community.

Telehealth

SWACH will support telehealth in underserved rural/frontier counties. Nationally, death from opioid OD is 45 percent higher in rural areas than urban areas.¹⁰¹ In Skamania and Klickitat 2016 student surveys of 8th and 10th graders showed rates of non-medicinal opioid use higher than the state average.

Healthy Youth Survey 2016¹⁰²

30-day (non-medical) use of prescription drugs:

Grade	Klickitat County	Skamania	State
8	6.1%	7%	5.2%
10	15%	8%	7.9%

Reflecting the general increase in opioid usage, between 2002 and 2013 there were increases of 221.6% and 48.5% in Skamania and Klickitat respectively in publicly funded treatments involving opioids.¹⁰³

Telehealth will provide needed support for areas with limited resources and rising rates of opioid use.

⁹⁸ D. Thomas. NIH. National Institute on Drug Abuse. “Do I Need This Pill? Understanding Pain and Prescription Drugs”. DHHS Webinar 12.7.2017. <https://attendeegotowebinar.com/recording/7253667711680756232>

⁹⁹ How Hospitals Can Fight the Opioid Epidemic - *Medscape* - Nov 02, 2017

¹⁰⁰ Saving Lives with the Opioid Overdose Prevention Program In Clark County, WAState: WA Type: Model Practice Year: 2016- <http://cabarrus.nc.networkofcare.org/ph/model-practice-detail.aspx?pid=5914#.Wd6-etRVC8k.email>

¹⁰¹ <http://nashp.org/intervention-treatment-and-prevention-strategies-to-address-opioid-use-disorders-in-rural-areas/>

¹⁰² HYS 2016 askhys.net

¹⁰³ <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>
ACH Project Plan Template (October 16, 2017)

- A) SWACH will support provider adherence to opioid prescribing guidelines, in particular to HCA regulations for opioid prescriptions for Medicaid patients effective November 1, 2017.
- B) SWACH will support PMP usage to inform opioid management. Statewide, only 30% of prescribers and 51% of pharmacists are registered for the state’s PDMP.¹⁰⁴
- C) Nationally, death from opioid OD is 45 percent higher in rural areas than urban areas.¹⁰⁵ SWACH will support telehealth in rural/frontier counties with limited resources and rising rates of opioid use. 2016 student surveys of 8th and 10th graders in Skamania and Klickitat show rates of non-medicinal opioid use in the last 30 days higher than state average. Reflecting the general increase in opioid usage, between 2002 and 2013 there were increases of 221.6% and 48.5% in Skamania and Klickitat respectively in publicly funded treatments involving opioids.¹⁰⁶

Healthy Youth Survey 2016¹⁰⁷

30-day (non-medical) use of prescription drugs:

Grade	Klickitat County	Skamania	State
8	6.1%	7%	5.2%
10	15%	8%	7.9%

- D) Research shows that patients are often prescribed more opioids than consumed, for example up to three times more opioids than are consumed after orthopedic surgery.¹⁰⁸ Very few have any counseling regarding the safe disposal of unused narcotic medicines and there is limited access to medication disposal. It is hard to know the impact that this has had on the amount of medication available for overuse and diversion, but it is likely to be very significant. Sixty-three percent of heroin using clients at the region’s harm reduction center reported using prescribed opiates before becoming heroin addicted.¹⁰⁹

SWACH will work with partners to create greater access for the community to dispose of opioids. Currently there are limited medication disposal sites and two annual drug take back events. Reports from the department of community services, prevention coalitions, the syringe exchange, and medical providers suggest the need for increased drug take back opportunities. A recently installed med safe collection program at Klickitat Valley Hospital, for example, was discontinued because overwhelming response was greater than capacity.

¹⁰⁴ Washington State Department of Health. Prescription Monitoring: A Tool in Patient Care. June 15, 2017.

¹⁰⁵ <http://nashp.org/intervention-treatment-and-prevention-strategies-to-address-opioid-use-disorders-in-rural-areas/>

¹⁰⁶ <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

¹⁰⁷ HYS 2016 askhys.net

¹⁰⁸ How Hospitals Can Fight the Opioid Epidemic - *Medscape* - Nov 02, 2017

¹⁰⁹ Saving Lives with the Opioid Overdose Prevention Program In Clark County, WAsate: WA Type: Model Practice Year: 2016- <http://cabarrus.nc.networkofcare.org/ph/model-practice-detail.aspx?pid=5914#.Wd6-etRVC8k.email>
ACH Project Plan Template (October 16, 2017)

2) Treatment – Expand access to MAT

81.8 per cent of Medicaid members with a diagnosed opioid use disorder in the SWACH region are not receiving MAT.¹¹⁰ Anecdotal reports from providers¹¹¹ suggest that opioid use disorder is under-diagnosed and treatment penetration rates are likely lower than data suggests. Patients receiving MAT cut their risk of death from all causes in half.¹¹²

- A) SWACH will support efforts to increase numbers of MAT providers. Increasing regional capacity for long term management of patients on MAT has been identified as a top priority by the opioid workgroup. Clark County currently has 13 prescribers waived to offer MAT -buprenorphine.¹¹³ In Skamania and Klickitat two prescribers are currently waived to offer MAT- Buprenorphine. Access is lower than the numbers indicate as many waived providers do not prescribe MAT.
- B) SWACH intends to work with partners to increase sites where MAT can be initiated with a focus on EDs, hospitals, jails, and syringe exchanges as prime locations. SWACH anticipates high impact for target populations as these locations see high numbers of people with OUD.
- ED's: Opioid related ED visits in Washington increased 99 percent between 2005 and 2014.¹¹⁴
 - Hospitals: Between 2000 and 2014 the rate of opioid related in-patient hospital stays in Washington increased by 60.1%, the fourth highest increase in the country.¹¹⁵
 - Jails: People with OUD leaving jail without MAT are at higher risk of overdose due to decreased tolerance over the time incarcerated.¹¹⁶
 - Syringe Exchange: The syringe exchange in Clark County served about 1400 individual clients in the last year.¹¹⁷
- C) SWACH intends to increase access points to treatment through capacity development of select community based organizations for outreach and engagement. CBOs whose work overlaps with high numbers of persons with OUD will be prioritized (e.g. child welfare services, WIC programs, housing and homeless agencies).

¹¹⁰ HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse / Medically Assisted Treatment- Buprenorphine, Methadone. FY 2016.

¹¹¹ For example, conversation with CMO of area FQHC 10.19.17

¹¹² <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm57675>

¹¹³ <https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>

¹¹⁴ <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf>

¹¹⁵ <http://www.hcup-us.ahrq.gov/faststats/landing.jsp>

¹¹⁶ <https://www.recoveryanswers.org/research-post/medication-assisted-treatments-for-prisoners-to-reduce-risk-of-death-after-release/>.

¹¹⁷ Clark County Public Health – Syringe Services Program. Kari.Haecker@clark.wa.gov October 2017
ACH Project Plan Template (October 16, 2017)

D) SWACH will support peer services and greater integration of peer support services in the continuum of care. Peer support services overcome barriers of stigma and increase likelihood of connection to treatment.¹¹⁸

3) OD Prevention - Increase Distribution of Naloxone

Ensuring at risk individuals receive take home naloxone and supporting education will reduce overdoses and save lives.¹¹⁹ 2016 Clark County data shows 245 opioid related ED visits and 111 opioid related hospital stays. In that same year there were 40 opioid related deaths by overdose. (Data unavailable for Klickitat and Skamania).¹²⁰ Naloxone rapidly reverses opioid overdoses and keeps alive the chance for a person with OUD to access treatment and recovery. We are not aware of any system-wide approach in our region to ensure all at-risk individuals receive naloxone.

SWACH will work with partners across care and community settings to increase distribution of Naloxone. SWACH will explore opportunities through collaboration across care and community settings including primary care, behavioral health settings, hospitals, ED's, jail re-entry programs, community based organizations, public health, law enforcement, and EMS.

4) Recovery- Enhance the provision of peer based recovery support services

Opioid addiction is a chronic condition and there is need for long term management to support recovery. Peer support specialists can be a cost-effective approach to working with people over a long period of time to help keep their lives stabilized and prevent relapse.¹²¹ Peer support services are effective in outreach, facilitating engagement and connection to treatment. Peers bridge barriers of stigma associated with opioid use and promote a sense of belonging within the community.¹²²

Peer services available through behavioral health agencies are limited in Clark County¹²³ and unavailable in Skamania or Klickitat. Increased peer support services are needed:

- Upstream- increased peer support services for outreach and engagement of persons with OUD on the streets, in courts, in jails.

¹¹⁸ <https://www.elementsbehavioralhealth.com/recovery/benefits-of-peer-recovery-support-systems/>

¹¹⁹ Intranasal Naloxone and Related Strategies for Opioid Overdose Intervention by Nonmedical Personnel: a Review. *Substance Abuse and Rehabilitation*. 11 Oct 2017.

¹²⁰ (file:///C:/Users/eric.scott/AppData/Local/Temp/Temp1_wa_ach_od_quarterly_2017Q1%20(1).zip/wa_ach_drug_quarterly_dash_2017q1.html#dashboard

¹²¹ <http://kbia.org/post/why-peer-support-playing-growing-role-addiction-recovery#stream/0>

¹²² <https://www.samhsa.gov/recovery/peer-support-social-inclusion>

¹²³ Anecdotal from CEO of CVAB 10.20.17

- Within the treatment system – increased peer support services in OUD treatment programs both in-patient and out-patient, in ED’s, in pain management clinics. Integrating peers into care settings such as the ED has been proven successful for engagement in recovery services.¹²⁴
- Post treatment- increased peer support for long term recovery support, connection to the recovery community, life-skills development.

SWACH intends work with partners to establish access to peer support services across care settings.

Opioid Project Expected Impact and Outcomes

Increase in:	Reduction in:
<ul style="list-style-type: none"> • <i>Number of prescribers trained on evidence based prescribing guidelines</i> • <i>Number of prescribers using the PMP</i> • <i>Access to telehealth to support OUD prevention and treatment in rural and underserved areas.</i> • <i>Number of providers certified to prescribe OUD medications</i> • <i>Opioid treatment penetration</i> • <i>Sites providing access to MAT</i> • <i>Community based organizations serving as education and referral sites</i> • <i>Access to and use of naloxone to reverse overdoses</i> 	<ul style="list-style-type: none"> • <i>Quantity of opioids in community</i> • <i>Opioid overdose ED visits</i> • <i>Opioid OD deaths</i> • <i>Prescription-opioid related inpatient stays</i> • <i>High-dose chronic therapy</i> • <i>Concurrent sedative prescriptions</i>

How will the ACH ensure that health equity is addressed in project design?

In addressing the opioid epidemic, SWACH acknowledges that the “War on Drugs” has had disproportionate adverse impact on some communities, particularly those of color. It is important that supportive interventions recommended now not inadvertently replicate that pattern. A central guiding principle of the opioid workgroup, captured in the opioid workgroup charter, is a commitment to equity. Opioid workgroup membership includes the director of diversity for PeaceHealth, the health system serving the largest volume of Medicaid patients in the region.

SWACH partners with multiple community organizations and community groups to develop an equity lens to inform overall work. For this extensive piece of work, SWACH brought in grant dollars from United Way, Northwest Health Foundation and leveraged partner organization funds. SWACH will be bringing in the Center for Equity and Inclusion, a nationally known group, to support the development of this work.

¹²⁴ <http://www.addictionpolicy.org/single-post/2017/02/02/AnchorED-Rhode-Island>
 ACH Project Plan Template (October 16, 2017)

As we take the proper time and process to develop our own equity lens, tools, and community buy in SWACH plans to use the Center for Racial Justice Innovation, Racial Equity Impact Assessment Guide, as a set of questions we will be bringing to decision-making tables (workgroups, RHIP, Board, staff) to inform the SWACH work.

To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH's region's Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.

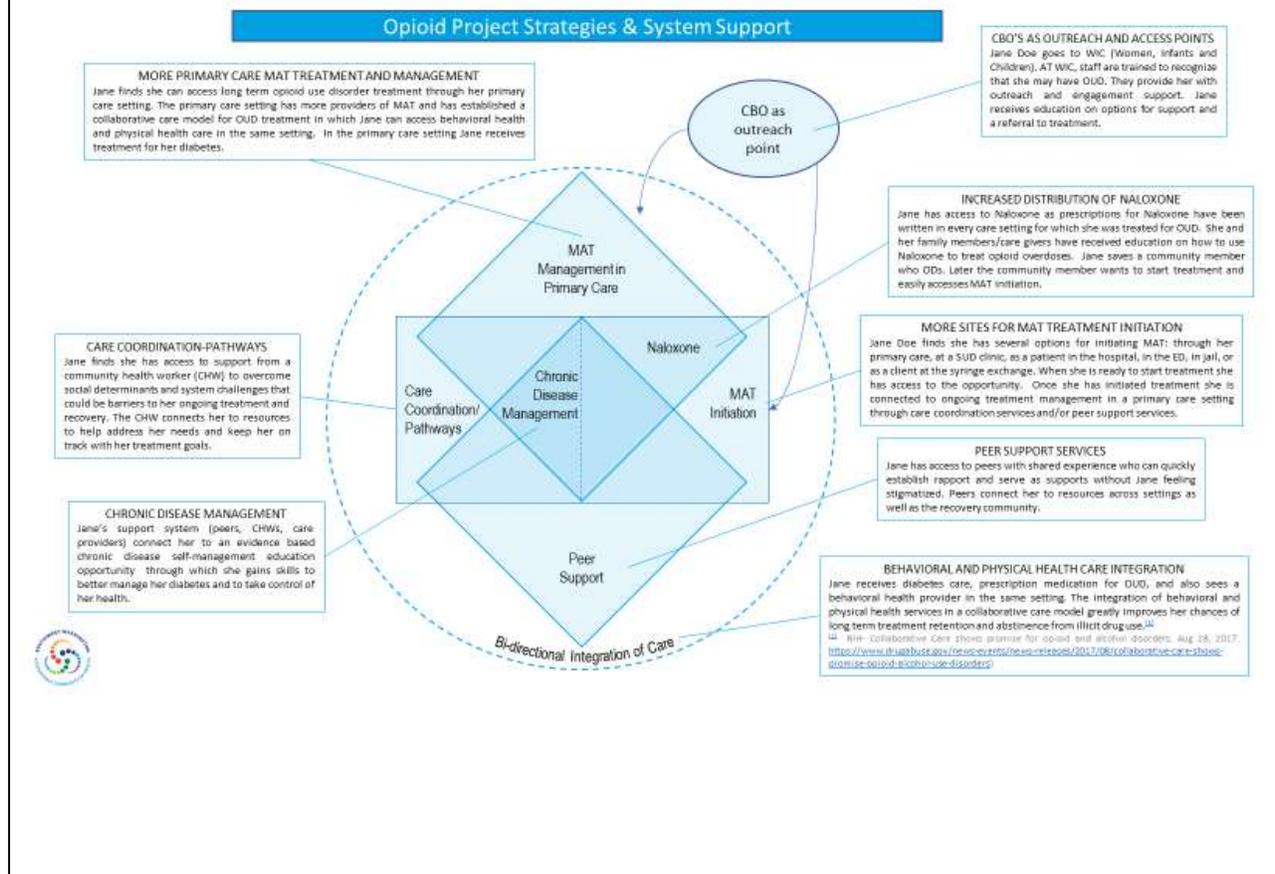
Anticipated project benefits beyond target population:

- Trainings and technical assistance to providers (opioid prescribing, PMP, pain management, SUD management, MAT waiver trainings, Naloxone trainings, integration and peer support trainings, addressing stigma, etc.) will not be applied solely to the target population. The benefits of training will extend to all patients seen by providers (Medicaid, Medicare, Private Insurance, Uninsured etc.).
- Drug Take back programs will reduce accessibility of opioids for nonmedical use for all community members.
- One-time upfront costs for establishing telehealth system infrastructure for the opioid project creates cost effective opportunities for clinics to expand telehealth options for the entire clinic population.
- Increased access to naloxone will benefit all populations of opioid users, as well as prevent grief and suffering for the friends, families, and community members of the person whose life is saved by naloxone.
 - By providing peer services in different clinical settings it increases the opportunity for Medicaid beneficiaries to access peer services, link with peer run providers and allows for opportunities for clinics to integrate peer services in their settings.
- Increased MAT will reduce the number of persons who engage in anti-social behaviors to support opioid use disorder. Social benefits include less crime, more employment, reduced burden on court systems, jail systems, ED's, EMS.
- Increased MAT will benefit children of OUD affected families as well as decreasing the number of children in the courts and foster systems.

ACH projects support system transformation toward a whole person approach to patient care based on integration and collaboration across previously siloed settings. Projects do not stand alone but will interdependently address physical, mental and social determinants of health. The selected strategies of the opioid project likewise interdependently support and reinforce one another, creating an impact greater than the sum of their parts. SWACH work will support a system shift toward alignment and integration across settings, a shift that will endure beyond the Medicaid Transformation Project and will have broad and lasting impacts.

The opioid project is part of a paradigm shift toward cross-continuum collaboration. To illustrate how the opioid project and its strategies will relate to and support the bigger picture of system transformation, we can follow a hypothetical "Jane Doe" - a person with OUD and uncontrolled diabetes

who is not receiving treatment. Through Jane Doe's example we see how strategies to address the opioid epidemic support and are reinforced by the focus on whole person care through cross setting collaboration.



Implementation Approach and Timing

Using the **Implementation Approach** tabs of the **ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:
 - Describe the ACHs general approach to accomplishing requirements.
 - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
 - Specify which evidence-based approach option(s) will be used for the project.
 - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be

preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented. Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.

ACH Response

- *Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.*

SWACH has a variety of committees and workgroups, one of which is the Opioid Workgroup. SWACH began an organizational effort to create the opioid workgroup in the spring of 2017 after meeting with potential providers and their leadership teams. SWACH sent out invitations to a broad swath of providers and community stakeholders serving the Medicaid population. Participants in the opioid project represented a care and community spectrum including primary care clinics, hospitals, behavioral health settings, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations.

Every member of the workgroup and the organizations they represent have been dedicated to serving the Medicaid population for many years. The workgroup is currently represented by 27 individuals who are all Medicaid providers in the community or represent an organization that provides services to Medicaid members. The following list are the organizations that are represented:

- Community Health Plan of WA
- United
- Consumer Voices are Born
- Peace Health Medical Group

- Klickitat Valley Health
- Lifeline Connections
- Columbia River Mental Health
- Clark County Corrections
- Clark County Public Health
- Molina
- ESD 112
- Clark County Department of Community Services
- Comprehensive Healthcare
- SeaMar Community Health Centers
- North Shore Medical Group
- Our Klickitat Prevention Coalition
- Healthy Living Collaborative
- ShareHouse
- Klickitat & Lyle Against Substance Abuse Coalition (KLASAC)
- SW Washington League of United Latin American Citizens
- Cowlitz Tribal Treatment

Additionally, SWACH has established a partnership relationship with more than 100 agencies in the region. SWACH will leverage these relationships as appropriate to support continued planning and implementation of the opioid project.

- *Describe process for ensuring partnering providers commit to serving the Medicaid population.*

SWACH is developing binding provider participation agreements that will require providers' commitment to Medicaid. Financial incentives for partnering providers will be tied, in part, to Medicaid lives served, offering further commitment to serving Medicaid.

- *Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.*

SWACH reached out and on-boarded potential partners and community stakeholders to the opioid project, involving them in workgroups and committees as appropriate. As noted above, the opioid workgroup represents a broad spectrum of care and social services.

The opioid workgroup developed a charter to help guide work and ensure partnering provider engagement. The charter stipulates workgroup participation to provide input and guide regional strategies to ensure that SWACH and its partners can learn, plan, and act collectively to reduce opioid-related morbidity and mortality throughout the regional service area. The charter further stipulates that opioid workgroup participants support steps critical to project success including: needs assessment, project selection, measure selection, program implementation, self-monitoring, reporting, and evaluation efforts.

As outlined in the charter, the opioid workgroup's guiding principles are:

- Encourage shared decision making among all SW ACH partners;
- Develop projects which address health inequities among SW ACH region residents;
- Promote collaborative, collective processes from multiple organizations and sectors;

- Value integrity and agree to uphold all SW ACH standards, privacy laws, and other human rights as applicable; and
- Support the goals of the triple aim of health care reform and the Healthier Washington initiative, including the Medicaid Transformation Demonstration Project.
- Use of recommended plans to guide implementation: 2016 Washington State Interagency Opioid Working Plan; Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan
- Application of an Equity and Social Justice (ESJ) lens to projects.

Since the relatively recent genesis of the opioid workgroup in July 2017, we have seen accelerating interest and engagement in project participation. SWACH will continue outreach to all providers in the region serving at least 500 Medicaid beneficiaries.. Many who are not on the opioid workgroup are engaged with SWACH through other workgroups, the RHIP council or the board and have been provided updates on the first stage of opioid project planning. To facilitate the next stage of implementation planning, SWACH will convene advisory groups of setting specific champions with identified champions from each partnering provider. We intend to leverage these groups and champions in our continued outreach efforts to unengaged providers. By the end of Q1 2018 we intend to have invited all regional providers to participate in the opioid project and to join the opioid workgroup. By end of DY2, Q2 SWACH will secure written commitments from implementation partners.

- *Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.*

The Opioid Workgroup has representation from the MCO's serving the region: Molina, CHPW and United. SWACH has also developed a coordinated alignment meeting that meets each month to ensure that the health plans, our TA partners and SWACH are in alignment, can leverage expertise across domains and strategize collectively about opportunities.

Regional Assets, Anticipated Challenges and Proposed Solutions

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

Assets, Challenges and Mitigation of Identified Barriers

Prevention -Community Systems and Social Services

Assets: Community Systems and Social Services Substance abuse prevention and education efforts in schools and community groups are active in all three counties. Prevention coalitions engagement include One Prevention Alliance, Connect Evergreen, BattleGround, West Van for Youth, Unite! Washougal, Our Klickitat, CPAKC (Coalitions Preventing Abuse in Klickitat County), and Klickitat & Lyle

Against Substance Abuse Coalition (KLASAC). Prevention coalitions work with Educational Service District 112. ESD 112 has created a toolkit with videos for educating parents on opioid prevention.¹²⁵ ESD 112 also provides prevention services and employs or contracts for Prevention/Intervention Specialists (PI's) to be placed in schools across the region. The Prevent Coalition recently received a grant for prevention work in Clark, Skamania and Klickitat to support expansion of Drug Take Back events and create a social marketing campaign to raise awareness of the dangers of opioid and prescription drug misuse.

Challenges: Community Systems and Social Services: Disproportionate county populations and differences between urban and rural contexts present equity challenges and require contextually based approaches to project implementation. In 2016 Clark County had a Medicaid population of 123,608 persons and the majority of regional resources to address the opioid crisis. Klickitat and Skamania had 6,817 and 2,455 members respectively¹²⁶, are primarily rural counties, and have more limited social services and resources serving largely decentralized populations. Challenges in the rural areas include issues of poverty and isolation by distance, lack of basic utilities, transportation, no central news source, unreliable internet and cell service.

Strategy for Mitigation- Community Systems and Social Services: SWACH will leverage its role as a convener to support development of an Opioid Taskforce to address challenges and opportunities for ACH project implementation specific to the context of our rural/frontier communities. The work will be championed by two local physicians: Dr. Michael Garnett, family physician with Klickitat Valley Health is an active member of the opioid workgroup. He has engaged Dr. Witherrite to serve as a champion in White Salmon. Dr. Witherrite is a family physician with North Shore Medical Group and, until recently, the sole provider offering MAT in Klickitat or Skamania County.

Prevention - Prescribing Guidelines

Assets- Prescribing Guidelines 1) Anecdotal reports from primary care and hospital partners (including PeaceHealth, Skyline, KVH, SeaMar CHC) on opioid prescribing guidelines in the region suggest there is variance in established protocols and adherence. Recent regional and statewide efforts to support adherence to evidence based opioid prescribing guidelines have taken place. In 2015 The Healthy Columbia Willamette Collaborative (HCWC) developed prescribing guidelines that have been adopted by hospitals in Clark County including Peace Health and Legacy. More recently, the Health Care Authority implemented clinical policy around opioid prescribing for non-cancer pain that applies to all Medicaid members to begin in November 2017.

Challenges- Prescribing Guidelines 1) There is a lack of alignment around a single set of guidelines and there is variance in levels of adherence to guidelines across settings. Providers who have invested in a particular approach to opioid guidelines may be reluctant to change. Providers may be reluctant to absorb the time and costs necessary for instituting and managing prescribing practices, protocols and quality improvement initiatives. 2) Providers have expressed concern about inefficiencies in utilizing the PMP as it is currently available. In opioid workgroup meetings, the PMP has been called "clunky" and "time intensive" and "problematic" as it is not linked to EHRs. 3) There are few alternatives to opioids for treatment of legitimate chronic pain patients. Limited Medicaid reimbursement for providers of alternative therapies is a barrier to their proliferation and utilization.

¹²⁵ https://www.starttalkingnowtoolkit.org/wp-content/uploads/2017/04/Opioid-Prevention_Social-Media-Toolkit.pdf

¹²⁶ HCA/ Starter Set Data Files/Medicaid Enrollment by MCO Tab/ FY 2016.

Strategy for Mitigation- Prescribing Guidelines - 1) SWACH will adopt a flexible approach to working with partnering organizations to ensure adherence to evidence based prescribing guidelines without requiring a singular approach. SWACH will provide support in training, technical assistance and workforce development to mitigate barriers of cost and time for partners. 2) SWACH will partner with the Washington State Medical Association to support adoption of a physician-driven peer to peer QIP model to improve opioid prescribing.¹²⁷ 3) SWACH intends to work with the state to support Health Information Technology improvements that will integrate the PMP with electronic health records. In practices where this is not an option, SWACH will support development of workforce capacity, workflows, and protocols to bring greater efficiency to checking the PMP. 4) Alternative pain management programs (physical therapy, chiropractic, naturopathy, etc.) are scarce but do exist in the region. The ACH intends to work with MCO's to explore payment reimbursement models that support alternative therapies.

Treatment- Access to MAT

Assets- Access to MAT: Rural -Treatment assets are available in Clark County but less so in Skamania and Klickitat. We know of only two providers waived to offer MAT in our rural/frontier counties.

Assets- Access to MAT: Urban- In Clark County, MAT is available to Medicaid members at Lifeline Connections, Columbia River Mental Health and Kaiser Permanente Department of Addiction Medicine. Peace Health provides MAT for its primary care Medicaid members. SeaMar Community Health Centers is in process of developing MAT services. Cowlitz Tribal Treatment currently offers substance use disorder treatment without medication in Clark County, will serve MAT patients who are connected to a provider, and has developed MAT services at their site in Tukwila. Treatment access for the region has been enhanced by a State Target Response (STR) grant to Lifeline Connections to establish a "Hub and Spoke" model in Clark County. Hub and Spoke models support increased access to opioid treatment and MAT through contracted partnerships between a hub, that provides at least two MAT medications, and community agencies that provide treatment, outreach, education, referral and follow up services. Clark County jail is one spoke, has provided continuation of MAT for inmates, and intends to develop a MAT initiation program for inmates.

Challenges- Access to MAT: Regional

Few clinicians have gotten certified to prescribe MAT medications. SAMSHA's registry identifies only 13 MAT providers within a 50 mile radius of Vancouver in Clark County.¹²⁸ Only two providers are waived to offer MAT services in Skamania and Klickitat. There is a need for workforce development to support long term management of persons with OUD. Barriers to increasing numbers of MAT providers include: 1) Time and cost to get certified- an eight hour course is required for MD's and DO's, a three day course is required for ARNP's or PA's. Providers are not reimbursed for taking the course. 2) Limited support for physicians or inclination to work with patients with OUD due to stigma and prevalence of confounding conditions associated with opioid addiction.¹²⁹

¹²⁷ Jeb Shepard, Associate Director of Policy and Regulatory Affairs, WSMA. jeb@wsma.org 10.24.17

¹²⁸ https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?distance%5Bpostal_code%5D=&distance%5Bsearch_distance%5D=50&distance%5Bsearch_units%5D=mile&field_bup_physician_city_value=Vancouver&field_bup_physician_us_state_value=WA&Apply

¹²⁹ Walley et al: Office Based Management of Opioid Dependence with Buprenorphine: Clinical Practices and Barriers / ACH Project Plan Template (October 16, 2017)

Challenges - Access to MAT: Rural Klickitat and Skamania Medicaid members have limited access to MAT. Comprehensive Healthcare offers treatment services for substance abuse in Klickitat but does not offer MAT in Klickitat. Comprehensive does provide methadone treatment at their site in Yakima, approximately 90 miles from Klickitat.

Challenges- Access to MAT: Urban According to the CEO of Columbia River Mental Health, which provides MAT services, treatment penetration is a challenge. Utilization of existing MAT services in Clark County is not yet at full capacity. Outreach and consequent engagement in treatment to persons with OUD must improve to ensure MAT services are fully utilized. Peer support services, effective in engaging persons with OUD in treatment, are not reimbursed under current Medicaid payment structures.

Strategy for Mitigation- Access to MAT

To address identified barriers SWACH initiatives will include the following:

- 1) Increase outreach and engagement through partnership and capacity building of CBO's to recognize, educate and refer persons with OUD to treatment.
- 2) Increase outreach and engagement through increased utilization of peers across settings. Peers can bridge the barriers of stigma and distrust that prevent many persons with OUD from seeking services. We will partner with peer support services to increase workforce capacity and to develop partnerships and protocols with care settings so that more peers are available as resources in primary care, hospitals and ED's. We intend to work with MCO's to consider payment reimbursement plans for peer SUD services, potentially modelling after current peer reimbursement models for mental health services.
- 3) Partner with MCO's and care settings to increase the number of MAT providers in primary care settings and to ensure they are supported. We will work with partners to support providers through evidence based models for successfully treating substance abuse in primary care. Partners might work within a "Hub and Spoke" model or they may implement the "Massachusetts Model" in which a nurse case manager works with a MAT prescribing provider to manage their panel. The Massachusetts Model has proven to be cost effective and, as of 2013, had a 67 percent success rate in keeping persons with OUD in treatment for at least a year.¹³⁰ We intend to work with partners and MCO's to consider funding flows that align with VBP, support the increase in utilization and number of MAT providers, and support management of larger panels of persons with OUD.
- 4) Partner with care settings and community partner to increase the number of MAT initiation sites in the region. Hospitals, ED's, the syringe exchange, and jails are all prime locations for MAT initiation.
- 5) Increase support, capacity and confidence around opioid management in care settings and among providers through trainings and technical assistance on prescribing practices and opioid management.

OD Prevention- Increase Distribution of Naloxone

J. Gen Intern Med 23 (9): 1393-1398 (2008)

¹³⁰ Ct.LaBelle et al / Journal of Substance Abuse Treatment 60 (2016) 6-13
ACH Project Plan Template (October 16, 2017)

Assets-OD Prevention Clark County Public Health needle exchange offers naloxone. Clark County's Department of Community Services has programs to provide naloxone to Clark County and Battleground police.

Challenges- OD Prevention 1) Attitudes toward persons with OUD that equate naloxone distribution as condoning of illegal drug use. 2) Development of sustainable funding models for purchasing and distributing naloxone beyond the MTP. 3) Concerns as to matters of liability for naloxone distribution in various care settings including behavioral health, primary care, hospitals and ED's.

Strategy for Mitigation- OD Prevention 1) SWACH intends to work with ESD-112 and prevention coalitions to support community education efforts that align with current guidance from the American Society of Addiction Medicine) to treat OUD as a chronic disease as opposed to a choice.¹³¹ 2) In the transition to Value Based Payment, SWACH intends to work with community partners and MCO's toward development of sustainable funding models for Naloxone distribution as well as increased sites distributing the medication. Increased naloxone distribution supports VBP metric goals such as decreasing ED utilization. 3) SWACH will facilitate trainings and technical assistance to address concerns about liability and support protocols for increased distribution of naloxone across care settings.

Recovery – Support for Peer Services

Assets - Recovery: Clark County has a strong recovery community which SWACH will leverage to enhance and expand peer support services. Consumer Voices are Born (CVAB) is located in Clark County and is the only peer run organization from board down in the state doing direct services under contract with MCOs or BHOs. Many behavioral health agencies in Clark County have peers working for them. Other assets actively supporting recovery include twelve step programs, recovery programs at the Veterans Administration, youth focused recovery services (Transitional Youth), recovery focused housing (Fairhaven, Oxford House), faith based organizations (New Heights, Grace Ministries, Living Hope, Open House Ministries) and a recovery focused café (Kleen Street). In Klickitat, there are peer counselors available through Father's House Fellowship and a narcotics anonymous program.

Challenges- Recovery: There will be challenges to ensure appropriate administrative capacity to expand existing programming and peer support services. Challenges exist in rural areas as there are fewer established peer services in Klickitat and Skamania. Behavioral health agencies in Skamania and Klickitat do not have peers working for them.

Strategy for Mitigation- Recovery: We intend to partner with existing peer support services to explore avenues of sustainable growth with the objective of expanding capacity of peer services in the region. Leveraging the organizational knowledge and advising capacity of established peer support organizations, we intend to develop, scale and sustain peer support services in rural/frontier areas.

¹³¹ <https://www.asam.org/docs/default-source/advocacy/cmm-fact-sheet---11-07-14.pdf?sfvrsn=0>
ACH Project Plan Template (October 16, 2017)

Monitoring and Continuous Improvement

Describe the ACH’s process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

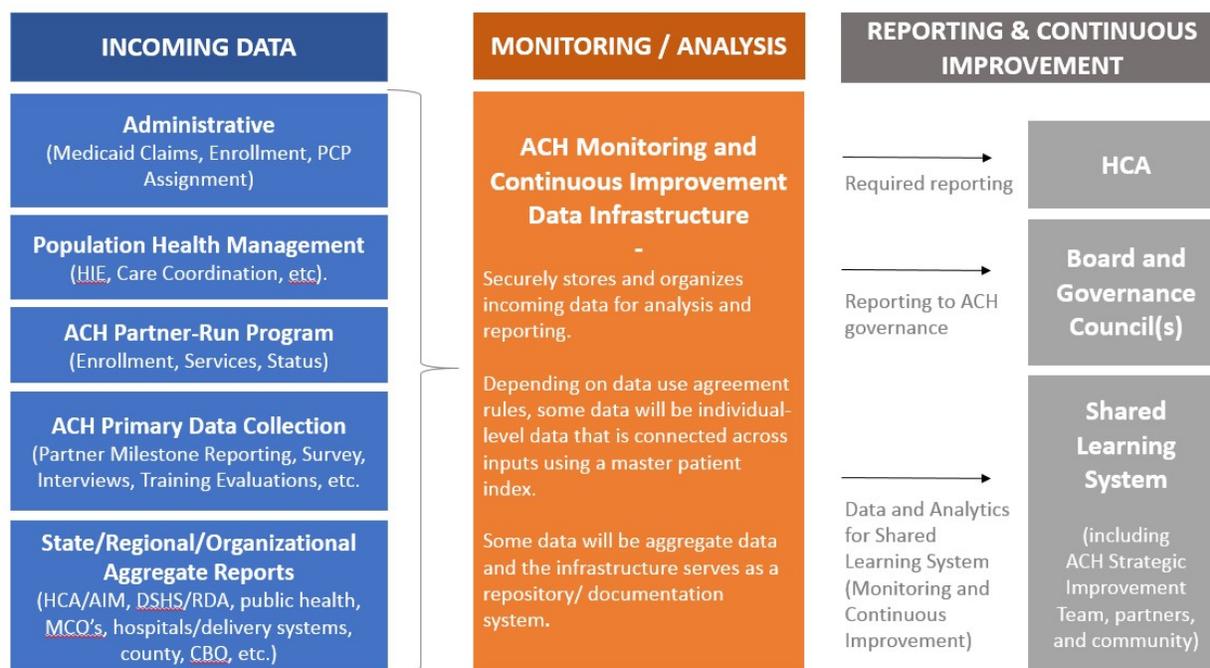
- Describe the ACH’s plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH’s plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?
- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

ACH Response

Monitoring and Continuous Improvement

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, a Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below (see Figure 1).

Figure 1. Process for Monitoring and Continuous Improvement



The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care”

population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the Opioid Workgroup and the SWACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

Metrics to track progress and outcomes identified for the opioid project vary by approach and may include but are not limited to:

Prevention:

- Number of hospitals/clinics who have policies and procedures regarding opioid prescribing guidelines.
- Number of health care providers, by type, trained on the AMDG's/CDC opioid prescribing guidelines.
- Number of hospitals/clinics who have policies and procedures in place to receive opioid variance reports.
- Number of variance reports received.
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedative prescriptions
- Number of hospitals/clinics who have policies and procedures regarding telehealth.
- Number of providers trained in the use of telehealth for opioids.
- Number of hospitals and clinics that check PMP before prescribing opioids
- Number of hospitals and clinics registered for facility level access to state PMP
- Number of queries to the PMP before implementation
- Number of queries to the PMP during and after implementation
- Number of facilities with EHR's that link to the PMP
- Number of drop boxes for medication disposal

Treatment:

- Number of hospitals/EDs/clinics/CBOs with policies and procedures for initiating MAT for individuals with OUD
- Contracts between MAT initiating agencies and community MAT providers in place
- Number of patients by setting who are initiated on MAT and received supporting education
- Numbers of patients who are initiated on MAT who receive follow-up care from a community partner
- Number of patients receiving MAT
- Number and location of providers with a DEA number that provide patient care waived to provide MAT services (before, during and after project)
- Number and location of waived providers providing MAT services (before, during and after project)
- Number of referrals to MAT treatment (before, during and after project)
- Number of CBO's trained to engage and educate persons with OUD
- Number of CBO's that refer to treatment

OD Prevention:

- Number of hospitals/clinics/CBO's that have performed a gap analysis and assessment of resources for prescribing / distributing naloxone.
- Number of hospitals/clinics/CBO's that have policies and procedures for prescribing/distributing naloxone in place.
- Number of hospitals/clinics/CBO's prescribing / distributing naloxone.
- Number of patients on high-dose opioid therapy who were also prescribed naloxone.
- Number of patients who present to the ED with an opioid use disorder (OUD) or overdose event who were prescribed naloxone.
- Number of patients who present in hospital with an opioid use disorder (OUD) or overdose event who were prescribed naloxone.

-Number of persons at CBO's with OUD who were provided naloxone.

-Opioid overdose deaths.

Recovery:

-Number of peers engaged in SUD support

-Number of peers who have received recovery training

-Number of agencies across settings who have established access to peer support services

SWACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

SWACH's self-monitoring system will allow providers to input data and give SWACH and our partners an early view of progress. This data will allow SWACH to see if providers are falling behind or not meeting requirements early, providing ample time to share the data with them, help them understand the import of the data, and to design rapid-cycle feedback and quality improvement strategies before veering too far off track. This will be more effective with pay for reporting requirements, however, we are working with CORE to develop a system that will allow us to track data elements that will be predictive of overall pay for performance metrics as well.

Our Improvement Advisors will work with provider organizations to assist them in developing the capacity to review their own data and begin to design their own quality improvement projects.

In addition, SWACH will continue in sharing information with other ACHs and participates in a weekly opioid project meeting to facilitate peer learning. This forum includes opportunities for discussion around models and strategies for effective systems of monitoring and continuous improvement. For example, a recent presentation by the Washington State Medical Association (WSMA) focused on a peer to peer Quality Improvement Plan (QIP) around improved opioid prescribing as well as opportunities for collaboration on this QIP model and information sharing between ACH's and the WSMA. The forum has also jointly explored the "6 Building Blocks" for opioid management in primary care which includes models for monitoring and continuous improvement (see chart below).¹³² Challenges, solutions and best practices in monitoring and improvement will be an ongoing subject for shared learning in collaboration across ACH's.

¹³² Oregon Prescription Drug Overdose Project: Pain Management and Safe Opioid Therapy in Primary Care. Six Building Blocks and Self-Assessment Questionnaire. July 2017. © 2015 MacColl Center for Health Care Innovation

Building Block 6: Measuring Success

The goals and clinical measures defined in building block #1 are monitored and reported on monthly or quarterly by the individual responsible in regularly scheduled (monthly/quarterly) meetings with the leadership and other providers. The leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Leadership decides if any changes or adjustments to the process improvement project is needed. Changes are implemented as a high priority for the clinic/organization.

28. Monitoring Progress, Reporting, Improvements	1	2	3	4
Goals, policies and clinical measures defined in building blocks #1 and #2 are monitored and reported on by the individual responsible in monthly or quarterly meetings with the leadership and other providers. The leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Leadership decides what changes or adjustments are needed. These changes are implemented as a high priority.	No measurement is being done. Clinical metrics have not been implemented.	Methods to measure progress on goals and associated policies have been defined, but only partially implemented. Clinical metrics have been agreed and are partially implemented.	Progress on goals and associated policies are being measured regularly. Reports are occasionally reviewed by leadership, but not consistently. Compliance is not fully monitored and enforced with all providers. Clinical metrics have been implemented, but are not reviewed regularly with the providers.	Goals, policies and clinical measures are monitored and reported on by the responsible individual in monthly or quarterly meetings with the leadership and other providers. The leadership shares and discusses results with the clinical team and encourages suggestions for improvement. Leadership decides what changes or adjustments are needed. These changes are implemented as a high priority.

Plan for monitoring project implementation progress, including addressing delays in implementation

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers. These learning collaboratives will allow regional providers to see trends and work together to determine the underlying cause of these trends.

SWACH Improvement Advisors, in concert with Qualis Health and MCOs will work with each partnering provider to determine the level of support desired and needed. For larger, more sophisticated organizations, SWACH will work with quality improvement teams already working within these organizations. Using data and reports, SWACH will ensure quality improvement personnel know the issues and have the tools to address those issues. If more assistance is requested, SWACH will provide more in-depth support. This support may be in the form of training, technical assistance, or coaching.

For smaller organizations, SWACH envisions being the quality improvement engine for these providers. Based upon provider reported data, and broader data sources, SWACH will provide technical assistance, training, and coaching. SWACH will work with provider organizations to improve their performance with respect to projects, as well as train these organizations to begin to establish their own quality improvement teams and processes.

SWACH envisions needing to be flexible in creating this quality improvement process to meet the varied needs of providers in different sectors, geographies, and stages of maturity. Our own work will require assessment and improvement to continuously meet the needs of our partnering providers.

Plan for addressing strategies that are not working or not achieving outcomes

The comprehensive shared learning system, PDSA continuous improvement process, and on-going opioid related peer learning across ACH's will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

Our workgroups, committees, and governance bodies will continue to meet to discuss the data and progress of our partnering providers throughout the MTP. SWACH will work with the Quality and Continuous Improvement Committee to ensure all assets are brought to bear when monitoring suggests a project is off course. However, we are aware that there is the possibility that despite best efforts, a strategy may not result in desired outcomes. SWACH is considering charging the Quality and Continuous Improvement Committee with defining when a project may be deemed to require a change in approach versus a quality improvement strategy. SWACH is also open to other ideas from the Quality and Continuous Improvement Committee, our workgroups and committees, the community, and other ACHs to determine whether the data indicates a change in approach is warranted.

If the SI Team, Quality and Continuous Improvement Committee, and Care Coordination Advisory Committee determine course correction is not possible, they will refer their findings to the RHIP Council for review. The RHIP Council will take a broader look to ensure a possible solution has not been overlooked. The RHIP Council will then recommend to the Board whether changes to the approaches or project should be considered, and SWACH would pursue the appropriate path with HCA.

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

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

YES	NO
X	

Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

ACH Response

Sustainability through advances in Population Management:

Advances in health information technology will sustain opioid project impacts beyond the MTP period. SWACH will focus on enhanced utilization of the PMP for opioid management and together with partnering providers, managed care organizations, the state and other ACH stakeholders will work towards:

- 1) Making the PMP more user-friendly by integrating it into electronic health records.
- 2) Enhancing the PMP to ensure real time information sharing on opioid overdoses
- 3) Ensuring that dental is included in efforts to enhance PMP utilization
- 4) Developing capacity to mine and analyze data in the PMP to better measure impact and achievement towards VBP targets.

Sustainability through building Workforce Capacity:

SWACH will ensure sustainability of clinical opioid management efforts by championing evidence based models and requiring partners to make and monitor lasting system changes that support integration and collaboration across settings. SWACH will work with partners to identify workforce needs and provide necessary training and technical support. We intend to mitigate costs associated with development of new policies, protocols, infrastructure and workforce capacity expansion. We will work closely with MCOs and other partners to consider how new payment models can sustain these new structures. SWACH intends to support workforce capacity development as related to:

- 1) Improving provider capacity to adhere to evidence based opioid prescribing practices- particularly in primary care, dental, and hospital settings.

- 2) Increasing access to treatment through capacity development of peer support services to contract and collaborate with care settings.
- 3) Increasing access to treatment through capacity development of CBO's to create infrastructure supporting identification, education and referral of persons with OUD.
- 4) Increasing access to and management of treatment by increasing prescribers in our region who offer MAT in acute and primary care settings.
- 5) Providing support for implementing new positions/staff responsibilities that improve outcomes related to opioid management models: for example, supporting a position in primary clinics responsible for checking PMPs and communicating with provider; or supporting the nurse care manager position fundamental to the "Massachusetts Model" of providing MAT in primary care settings.
- 6) Increased collaboration across settings and across concurrent SWACH projects to achieve greater outcomes. For example, development of workforce capacity through training and technical assistance to effectively integrate care coordination and bidirectional care in the approach to opioid management.

Sustainability through achieving Payment for Performance targets

- SWACH will work with partnering agencies to enhance outreach efforts and lower barriers for persons with OUD to enroll in insurance and engage in primary care services. Anecdotal reports from providers, including at the syringe exchange, indicate that significant numbers of persons with opioid use disorder remain uninsured and/or unengaged with primary care. They therefore wait to seek treatment and utilize costly emergency services for their health care needs. SWACH intends to support a shift towards greater health outcomes and increased sustainability through a focus on enrollment and engagement of persons with OUD who are not receiving MAT.
- SWACH intends to support sustainability through demonstration of opioid project cost effectiveness and success in achieving P4P targets. At 1,786 people, the target population of Medicaid members diagnosed with OUD who are not receiving MAT is relatively small.¹³³ However we know that, nationally, approximately five percent of the utilizers of health care services population account for almost half (49 percent) of total health care expenses.¹³⁴ We also know that people with unmet OUD treatment needs are high utilizers of health services and at least three times more likely to have multiple ED visits (3 or more) a year.¹³⁵ In 2015 the costs to insurance companies were more than five times higher for patients with diagnoses of opioid abuse or dependence than for those with any other diagnoses.¹³⁶ We

¹³³ HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse. FY 2016.

¹³⁴ <https://archive.ahrq.gov/research/findings/factsheets/costs/expriach/index.html>

¹³⁵ HCA / RDA Measure Decomposition file, provided August 2017. Data for CY 2016, adult Medicaid users with 3 or more ED visits in the past year.

¹³⁶ <https://www.statnews.com/2016/09/26/opioid-epidemic-private-insurance-payments/>
ACH Project Plan Template (October 16, 2017)

therefore anticipate the impact of opioid projects to be significant on outcome metrics as treatment penetration increases. We intend to work with MCO's and other stakeholders to develop payment models that sustain the impacts of our projects beyond the MTP.

Transformation Project Description

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

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
 - Describe the project's anticipated target population. How many individuals does the ACH anticipate reaching through the project?
 - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
 - How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups, etc.)
 - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency

and quality of care for the ACH region's Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

Project Description and Justification

SWACH has identified Chronic Disease Prevention and Control as a priority for the region and will focus on sustained implementation of the evidence-based Chronic Care Model across diverse care settings. The Chronic Care Model will serve as a key driver to ensure integration of health system and community-based approaches to improve health outcomes for Southwest ACH Medicaid beneficiaries, with a focus on those individuals experiencing the greatest level of disease burden.

Justification for selecting project and how it addresses regional priorities

SWACH Medicaid beneficiaries face a heavy burden of chronic disease and health disparities. As identified through the Regional Health Needs Inventory, 33,250 Medicaid members in SWACH have been diagnosed with mental illness and 13,300 Medicaid members have at least one indicator of substance use disorder (SUD). Among adults in SWACH, 29% have hypertension, 11.1% have a diagnosis of cardiovascular disease, 7% have a diagnosis of Type 2 Diabetes, and 1.1% have cancer. As of June 2016, 4.7% of the SWACH Medicaid population had a behavioral health diagnosis *and* substance abuse *and* at least one chronic disease. Almost a third of SWACH members have a BMI of 30 or higher. Columbia Gorge CHNA, which covers Klickitat County, found that two out of three residents were obese. Obesity is a known risk factor for diabetes, cardiovascular conditions, and cancer.

Among adult Medicaid members in SWACH, 11.1% (12,187 members) have a diagnosis of cardiovascular disease, 7% have a diagnosis of Diabetes (3,947 members), and 1.1% (1,178 members) have a diagnosis of cancer.¹³⁷ Obesity is a known risk factor for diabetes, cardiovascular conditions, and cancer, and prevalent across the region. The Columbia Gorge Community Health Needs Assessment, which covers Klickitat and Skamania Counties, found that 38.5% of Medicaid members in the Columbia Gorge region were obese (had a BMI of 30 or higher).¹³⁸ 2014 data for the general population of Clark County found that 26.9% of adults were obese. We can apply these rates to SWACH's Medicaid population to estimate that at least 25% of the 71,106 adult Medicaid members are obese (approximately 17,776 members).¹³⁹

Social determinants of health drive premature mortality in chronic disease sufferers. Hispanic and Black individuals with chronic disease in SWACH have more complications due to lack of access to

¹³⁷ Ibid.

¹³⁸ Columbia Gorge Community Health Assessment, June 2017. <http://cghealthcouncil.org/documents/>. The Columbia Gorge region includes Hood River, Wasco, Sherman, Gilliam, and Wheeler counties in Oregon, and Skamania and Klickitat Counties in Washington.

¹³⁹ Adult Medicaid population from December 2016, Healthier Washington Data Dashboard.
ACH Project Plan Template (October 16, 2017)

preventative health care.¹⁴⁰ 16% of emergency room visits are preventable¹⁴¹, which further suggests access issues. Clark County's provider to individual ratio is 1510:1, and Skamania and Klickitat (frontier and urban, respectively) struggle with access issues as well. 50% of SWACH residents spend 30% of income or more on housing, and over 20% report food insecurity in Clark and Klickitat counties, with 53% reporting food insecurity in Skamania.¹⁴²

This project choice was vetted through extensive community conversations, including monthly meetings of SWACH's RHIP council beginning last spring. We have involved hospital systems, physical care providers, behavioral health providers, substance abuse disorder providers, emergency services organizations, community-based organizations, representatives from county government, Managed Care Organizations (MCOs) and the criminal justice system in these discussions. SWACH intends to create and analyze a setting-specific provider survey that will further inform our planning and implementation. The Chronic Care Model has been noted to dovetail perfectly with work already underway in the region, and presents an opportunity to deepen impact for Medicaid enrollees living with or at risk for chronic disease in SWACH.

- **To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region's Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies**

Through prioritization of the Chronic Care Model, SWACH will support sustainable health system transformation for the target populations in the following ways:

- Expand the necessary infrastructure to assess approaches that have been effective, as well as identify additional needed capacity/resources across the Pierce County community
- Align chronic disease and prevention efforts across health system and community partners that allows for greater efficiency and deepened impact
- Extend intentional focus on specific subpopulations experiencing the greatest health disparities
- Build experience with the use of data, HIT resources and QI tools across regional providers and organizations
- Deepen experience with VBP contracting among providers and community based organizations related to chronic disease prevention
- Transform systems of care to produce meaningful health improvements
- Build capacity and communication through attention to recruitment, retention, and development of providers in alignment with the Quadruple Aim
- Support upstream initiatives to positively affect social determinants of health

How SWACH will ensure project coordinates with and doesn't duplicate existing efforts

¹⁴⁰ PeaceHealth Southwest CHNA, 2016

¹⁴¹ Utilization data from the Healthier Washington Data Dashboard, Oct 2015-Sept. 2016
<https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>

¹⁴² Please see RHNI for additional data sources

ACH Project Plan Template (October 16, 2017)

Throughout planning for the Chronic Disease Prevention and Control project, SWACH has worked to ensure coordination and avoid duplication by its broad engagement with a multitude of partners and community members. To gain a deeper understanding of work underway and the needs in the community, we began an environmental scan of our partners about their work in chronic disease and prevention to learn about the successes they've had, the obstacles they've faced and to discuss solutions for moving forward. We will design and analyze setting-specific provider surveys to determine readiness and capacity. We are also gathering information to ensure we aren't adding unnecessary layers to the work of providers and CBOs, but are filling gaps. During the planning period, we will continue to convene groups of providing partners on a regular basis to ensure we are not duplicating existing efforts and that SWACH's work complements and enhances existing initiatives to address chronic disease and prevention.

Anticipated Project Scope

We envision SWACH's Chronic Disease Prevention and Control Project will be focused on implementation of Wagner's evidence-based, Chronic Care Model across care settings for a set of targeted populations. This project will be centered on the following drivers of change:

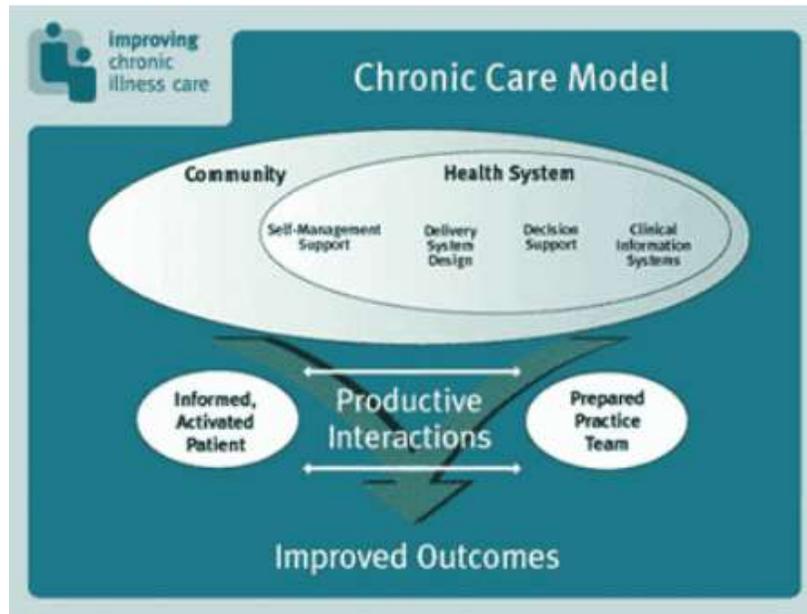
- Adoption of SWACH's Transformation Rules of Engagement ensuring consistent guidelines across regional partners
- Implementation of CDSM interventions (or elements specific to setting)
- Provision of support for effective complex care and disease management for targets
- Utilization of RHIP Council & Clinical Integration Taskforce to support interventions

As participants in the Chronic Disease Prevention and Control project, prospective Transformation Partners must decide on 1) the target population(s) they will focus upon, as well as 2) the change strategy they will implement from a list of the Chronic Care Model elements, including:

1. 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, develop agreements that facilitate coordination of care across organizations
2. 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; seek to break down barriers to utilization of community health workers as part of a treatment team; actively promote evidence-based self-management education for patients as part of whole person care
3. 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, provide clinical case management services for complex patients with coordination
4. Decision support: embed evidence-based guidelines into daily clinical practice, integrate specialty expertise in primary care, share evidence-based guidelines and information with patients
5. 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, monitor performance of practice team

6. 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.



In addition to these Chronic Care Model elements, each Transformation Partner can choose optional activities such as implementation of the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, CDC National Diabetes Prevention Program, and/or partner with Community Paramedicine. Finally, all Transformation Partners will need to identify an HIE/EHR strategy to better coordinate community linkages and will also be required to participate in the SWACH Pathways Community Hub.

Many of our community collaborators have instituted chronic disease management systems and protocols. The Vancouver Clinic, PeaceHealth, Legacy, and Kaiser have “swim lanes,” planned encounters, chronic disease nurse managers and social workers, and preventative care reminder systems in place. The Vancouver Clinic has a dedicated Transition Program which serves complex chronic disease populations to prevent hospital readmission. We will strive to align with these programs.

One of the leading approaches that SWACH will undertake to advance the communities’ work in chronic disease prevention and control is through the implementation of the ACH’s Strategic Improvement (SI) Team. The Southwest Accountable Community of Health is adhering to the principles of science of improvement, shared learning and the building of improvement capabilities through our development of a SI Team that will ensure our regional work is driven by improvement science. The SI Team will coordinate with SWACH’s Chief Information & Technology Officer to ensure population health strategies including HIT/HIE will support our providers that span the spectrum of care beyond the primary care setting.

Anticipated Target Population

The Southwest ACH has used a multi-phase process to identify target populations for the Chronic Disease Prevention and Control project. With the help of Providence’s Core team and the SWACH Data and Learning Team (DLT), workgroup and council members were asked to identify populations according to need and potential for impact. Subsequently, the following three criteria were applied to the identified populations to isolate the best-suited target population(s) for the initial Hub pilot:

- **Need:** Does the priority population disproportionately experience poor health outcomes? Are there subgroups within the population that experience disparities? Is there a gap in existing services that could effectively address these outcomes?
- **Impact:** Is there strong potential for the project/intervention to improve outcomes for the population in 2-3 years? Is the priority population large enough for improvements to drive community-wide outcomes?
- **Data feasibility:** What data currently exist to explore the priority population, track outcomes, and evaluate impact?

Because of these assessments and a deep look at regional data, a set of priority populations with multiple chronic care conditions were identified as the target populations for this project, including:

- Adults with diabetes (particularly Type 2)
- Children and adults with obesity
- Adults with hypertension and cardiovascular disease

According to data provided by HCA, approximately 3,947 adult members have evidence of a diabetes diagnosis (the Healthier Washington Data Dashboard indicates that 6% of SWACH Medicaid adults have a diagnosis of diabetes), and 12,187 adult members have evidence of a cardiovascular disease diagnosis.¹⁴³

Washington Department of Health’s Chronic Disease Profiles indicate that 30% of adults in Clark County and Klickitat County have ever been told they have high blood pressure, as do 37% of adults in Skamania County.¹⁴⁴ If we apply these general population disease estimates to the SWACH Medicaid population, we can estimate that approximately 21,330 adult members have high blood pressure.

As estimated above, at least 17,000 adult Medicaid beneficiaries have obesity. Determining the number or percent of Medicaid children with obesity is more challenging, although estimates can be made from the general population using data from the 2016 Healthy Youth Survey:

	8 th Graders	10 th Graders	12 th Graders
Clark	10%	11%	12%
Klickitat	13%	17%	13%

¹⁴³ Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA September 29, 2017. Disease groupings are based on the CDPS model, so this diabetes estimate includes adults with type 1 diabetes with and without complications, and type 2 diabetes with and without complications.

¹⁴⁴ Washington Department of Health Chronic Disease Profiles by County. High blood pressure estimates from the Washington Behavioral Risk Factor Surveillance System 2013-2015 combined.

<https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/ChronicDiseaseProfiles>

Skamania	3%	26%	*
----------	----	-----	---

*Data suppressed due to small numbers

If we assume at least 10% of Medicaid children in the SWACH region have obesity, and there are approximately 20,500 12 – 19 year olds, we would add 2,050 individuals to our target population for an estimated total of 19,050 Medicaid members ages 12 and older with obesity.

Involvement of Partnering Providers

Partnering providers have been engaged in the development of SWACH’s Chronic Disease Prevention and Control project through extensive community meetings, participation in discussions and decision-making through ACH workgroups and councils, and through direct outreach from ACH leadership to get a deeper understanding of priorities, capacity, and needed resources. The RHIP Council includes both MCO’s in the region (Community Health Plan of Washington and Molina), the FQHC (Sea Mar), representatives from Vancouver Clinic, PeaceHealth, Kaiser, and Legacy, the Clark and Skamania County Departments of Health, diabetes educators, Council for the Homeless of Clark County, the Vancouver Free Clinic, the Area Agency on Aging and Disabilities, Community Voices are Born, and other CBO’s, Clark College, Washington State University, and others. In addition to these broad engagement efforts, a partner inventory survey will be disseminated to further assess interest and capacity among partnering providers.

Level of Impact

Through extensive regional partners and organizations serving the cultural, linguistic and geographic diversity across the Southwest ACH, SWACH expects to have significant improvement on performance metrics identified for the Chronic Disease Prevention and Control project area, including a reduction in health disparities. These metrics include:

- Emergency Department Visits per 1,000-member months
- Child and Adolescents’ Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: HbA1c
- Comprehensive Diabetes Care Medical Attention to Nephropathy
- Inpatient Hospital Utilization
- Statin therapy for patients with cardiovascular disease

Through this project, we anticipate reaching 6000 Medicaid lives.

Social determinants of health drive chronic disease. 20% of the population in Clark County, 52% in Skamania County, and 23% in Klickitat County report food insecurity. According to the 2015 United Ways of the Pacific Northwest ALICE report, (ALICE stands for Asset Limited, Income Constrained, Employed) report, 33% of all households are either in poverty or are ALICE¹⁴⁵. These are families that

145

are employed but cannot afford basic household expenses such as housing, child care, and health care. By far, the most pressing issue in our region is access to care. SWACH has the highest population-to-provider ration in the state. SWACH's acquisition of the Healthy Living Collaborative with its mission of policy initiatives and community health workers, its capacity as a convener, its ability to increase HIT/HIE infrastructure in the region, and commitment to upstream health initiatives-all contribute to addressing regional health priorities.

How SWACH will ensure that health equity is addressed in the project design

Health equity has been a foundational element in Southwest ACH's chronic disease and prevention project design and planning. To ensure that individuals facing the greatest health disparities inform the assessment of priorities and needed resources in the community, SWACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of Clark, Skamania, and Klickitat County Medicaid members. These representatives have directly informed discussions and decisions regarding the Chronic Care Model selection, identification of target populations, and ACH rules of engagement for the chronic disease prevention and control project.

Rates of cardiovascular disorders are higher in Klickitat and Skamania, while diabetes rates are higher in Clark County. American Indian/Alaska native and Vietnamese-speaking members have higher rates of diabetes. Women across the region have higher rates of depression. Almost a third of SWACH members across the region have a BMI of 30% or above. Access to care in rural and frontier areas (Klickitat and Skamania) presents a health disparity that will require innovation and dedication—and possibly telemedicine and Community Paramedicine.

SWACH's Community Pathways Hub is expected to be a critically important asset for the successful pursuit of improved health outcomes for individuals at risk for or experiencing chronic disease. Our approach to community-based care coordination through the Pathways Hub Model represents another opportunity for addressing health equity for individuals with chronic disease. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries' access to culturally and linguistically responsive care.

In addition to SWACH's development of the Chronic Disease and Prevention project, we are also working to deepen our impact on health equity through additional cross-cutting strategies. SWACH has brought in additional grant dollars from United Way, Northwest Health Foundation and leveraged partner organization funds. We have sponsored, and will again, an 8- hour health equity training for all our partners. In addition, SWACH will ensure that:

- Community trainings are available in multiple languages and across diverse cultural and geographical community sites
- A trauma-informed lens is applied to all the project designs (as informed through partnership with the Clark County Health Department which brings deep expertise in this area)
- The Board of Trustees receives intensive training on diversity, equity and inclusion

- An equity lens is applied to ACH policies/procedures/systems (e.g., hiring processes established that enhance diversity and inclusion in the ACH workplace)
- Cultural humility and trauma informed care are incorporated as essential components of the Strategic Improvement Team’s work
- Diverse community partners define the needed resources to strengthen community resilience and that these needs are addressed through SWACH’s Community Resilience Fund.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

Because of SWACH and partnering provider’s focus chronic disease and prevention through the MTP, the following lasting impacts are expected which will benefit the region’s overall Medicaid population:

- Deepened capacity and expanded skills related to continuous quality improvement
- Expanded infrastructure and resources (workforce, HIT/HIE, VBP contracts) to support system transformation that addresses chronic care prevention and treatment
- Deepened partnerships across health systems and the community, with aligned focus for target populations and improvement efforts
- Community resources that are focused on addressing the health needs of individuals and populations facing the greatest health disparities
- Expansion of capacity through convening universities, medical schools, health care providers and systems, to uncover barriers to recruitment, retention, and the Quadruple Aim
- Provision of workforce development aimed at breaking down professional silos and encouraging use of non-physician members to the limit of their professional scope

Implementation Approach and Timing

Using the **Implementation Approach** tabs of the **ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH’s selected projects.
- In the implementation approach descriptions:
 - Describe the ACHs general approach to accomplishing requirements.
 - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
 - Specify which evidence-based approach option(s) will be used for the project.
 - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

Partnering providers may include clinical providers, community-based organizations, county governments,

and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented. Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.

ACH Response

How SWACH has included partnering providers that collectively serve a significant portion of the Medicaid population

Based on analysis of provider claims data provided by HCA, SWACH is working with partnering providers representing the highest Medicaid billers in each major setting (primary care, mental health/substance abuse, inpatient and ED). Three of the main health systems who care for most Medicaid beneficiaries in the region, Rose, PeaceHealth, and SeaMar, are at some stage of implementing chronic disease management into their practices. All are interested in participating in the CDM project.

Process for ensuring partnering providers commit to serving the Medicaid population.

In DY2, Q2 2018, SWACH will secure Memoranda of Understanding or Agreement from partnering providers that will include a commitment to SWACH's Transformation Rules of Engagement and to serving the target Medicaid populations. SWACH's plan for ongoing Monitoring and Continuous improvement will also provide ongoing oversight of providers to ensure that they are serving

Medicaid populations and implementing strategies that are working to reach the desired outcomes for the target Medicaid populations.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

SWACH has established the Clinical Integration Committee to engage a broad spectrum of partnering providers in the identification of regional needs and development of the proposed project to date. It is anticipated that a subgroup of this committee will be formed to examine chronic disease prevention and treatment strategies and setting-specific integration. Our deep partnerships with providers, health systems, community-based organizations and other stakeholders will remain a focus throughout the planning period. Our RHIP Council has broad representation from stakeholders across the region.

SWACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with state and local officials is attained.

How SWACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

SWACH has been working with MCOs in multiple ways to leverage their expertise, identify areas of alignment, and ensure there is no duplication. MCOs have been active participants across all SWACH councils and workgroups. Through these roles, MCOs have directly informed discussions and decisions pertaining to the Chronic Care Model adoption, identification of target populations, and development of the ACH rules of engagement for chronic disease prevention and control Transformation Partners.

In addition to this intentional and broad engagement, SWACH has met with Molina, and intends to coordinate with Community Health Plan of Washington, and have identified the following opportunities for deepened and coordinated work: 1) assessment and support to expand provider readiness for VBP contracts, 2) optimization of data sharing to inform monitoring and continuous quality improvement, 3) provider support regarding utilization of data to inform quality improvement efforts, 4) provider support regarding adoption of effective strategies to improve patient engagement, and 5) coordination between the Pathways Community Hub and Health Home models to ensure that members needs are being met, duplication is avoided, and value-based payment methodologies are advanced.

Regional Assets, Anticipated Challenges and Proposed Solutions

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

Assets SWACH and regional partnering providers will bring to the project

Southwest ACH will bring substantial assets and supports for regional advancement of the Chronic Care Model through our upcoming Strategic Improvement Team. The SI Team will support “practice transformation” by utilizing Improvement Advisors to leverage current technical assistance resources, facilitation and capabilities.

The SWACH team brings extensive knowledge about the Pathways Community Hub Model which will be an important foundation and thread for the region’s work to advance chronic disease prevention and control. The ACH has already invested substantial time and financial resources to ensure the successful implementation of the Pathways Hub Model, including early development of the Pathways IT platform, preparation for certification, and approaches to budget forecasting and sustainability.

Clark and Skamania Counties became early adopters of the FIMC project in April of 2016. Our region is positioned to enhance the adoption of chronic care models because we have cleared the important hurdle of integrating financial models of health care purchasing. The region prioritized the clinical integration of services in 2014 and the current work of the ACH will enhance adoption of chronic care disease prevention and treatment by capitalizing on this enhanced provision of services.

The Healthy Living Collaborative, with its policy focus on social determinants of health and its mission of training and supporting the work of community health workers, was acquired by SWACH in October of 2017. The Collaborative has deep relationships with virtually all partners engaged in chronic care in the region. The ACH will be able to leverage this community access, coupled with the DOH and its prevention-focused upstream initiatives related to worksite wellness, community gardens, Veggie RX, housing, and access to affordable health care.

SWACH also has an eager network of behavioral health/substance use disorder providers, community based organizations and emergency medical service providers ready to partner in new ways to support the management of people with chronic disease. Examples of the assets by provider type include:

Physical Care/Primary Care Providers:

PeaceHealth, Legacy, SeaMar, and the Vancouver Clinic are interested in participating in this project and will dedicate leadership and staff to ensure success. They all identify critical partnerships with community based organizations, diabetes educators, community and hospital based education services, pharmacies, housing services, and environmental partners. Although Planned Parenthood does not currently provide chronic disease management services, they recognize the key role they could play in delivering preventive care and early identification of chronic conditions to their patients. This is an opportunity for SWACH to broker relationships between partnering providers to better serve PP’s patient base and improve access and equity. There is opportunity to expand these services to other conditions.

Behavioral Health/Substance Use Disorder Providers:

Community Services Northwest, Lifeline, Columbia River Mental Health Services, Sea Mar: Interest exists but there is a lack of understanding about the critical link behavioral health and substance use disorder providers play in managing chronic disease. According to the 2001-2003 National Comorbidity Study Replication (NCS-R), more than 68% of adults with a mental illness diagnosed by a structured interview reported a concomitant medical condition.¹⁴⁶ Opportunity exists for SWACH to encourage/incentivize BH/SUD partnership with primary care providers and increase involvement in the chronic disease management project through its Clinical Integration Project, the Opioid Project, and coordination with the Pathways Hub.

Community-based and Emergency Service Organizations:

Community Voices Are Born, Planned Parenthood, Area Agency on Aging and Disabilities, Coalition for the Homeless: All are interested in participating but need help building partnerships with clinical partners. Opportunity exists for SWACH to target people with co-occurring behavioral health and chronic disease at syringe exchange, through the Harm Reduction Center of the Clark County Department of Health, and Emergency Medical Services agencies in SWACH. Battleground Fire #3 has indicated interest in piloting a Community Paramedicine model to extend service provision. This project overlaps with SWACH's care coordination project – the Pathways Hub model. The region will pilot the use of EDIE/PreManage with the three largest BHA's, beginning in Q4 of 2017. The integration of EDIE/PreManage into the healthcare delivery ecosystem will provide an opportunity across care settings and advance EHR capabilities through real-time interfaces. SWACH's acquisition of the Healthy Living Collaborative, with its workforce of community health workers, provides an opportunity for delivering self-management strategies and navigation for chronic disease management and prevention.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers

After listening to our Provider Community, one of the biggest barriers to achieving this goal is the uneasiness of payment reform and fatigue from competing improvement concepts and programs. This stems from the lack of a common framework, roadmap, cohesive technical support, and coherent payment models for practice transformation. Additional barriers that have been identified include:

- Stigma: the experience of chronic disease, especially for marginalized populations, presents a challenge for improving their care and requires a coordinated, culturally responsive and trauma-informed approach
- Data sharing and communication: these elements are critical for all aspects of the Chronic Care Model and current infrastructure does not meet the full needs of partnering providers
- Existing workforce skills and capacity are unable to keep up with demand and type of care that is called for. SWACH has the highest ratio of individuals to providers in the state—1510-1.
- The social determinants of health- and coordination of needs outside of the health care delivery system remain foundational elements of achieving improved health of targeted

¹⁴⁶ https://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf

populations and are not reimbursable within traditional financing models. Our community is rent-burdened—50% spend more than 30% of their incomes on housing.

- Lack of integrated services or well- coordinated care
- Poor alignment between incentives and quality measures make sustained attention or deep impact difficult to achieve
- Startup costs for building the technical infrastructure to support integration

SWACH strategy for mitigating the identified risks and overcoming barriers

The design of the Strategic Improvement Team has been carefully crafted to provide the technical assistance, infrastructure, and community expertise needed to address the barriers identified in the community. Specifically, through development of the Strategic Improvement Team, SWACH will launch a learning lab that can begin to identify and address shared barriers and approaches to addressing them. In addition, this team will allow SWACH to leverage (link or develop) the following tools and technical assistance that will be vital for advancing Chronic Disease Prevention and Control:

- Facilitation, Coaching, Training, Consultation
- Accountability
- Performance Technology
- Change Management
- Population Health Management (HIE/HIT)
- Workforce Development strategies
- Contracting / Billing / VBP
- Communication strategies
- Policies and Procedures
- Rules of Engagement deployment
- Self-monitoring and reporting partner
- Convening groups and “matchmaking”
- Emphasis on the Quadruple Aim

Monitoring and Continuous Improvement

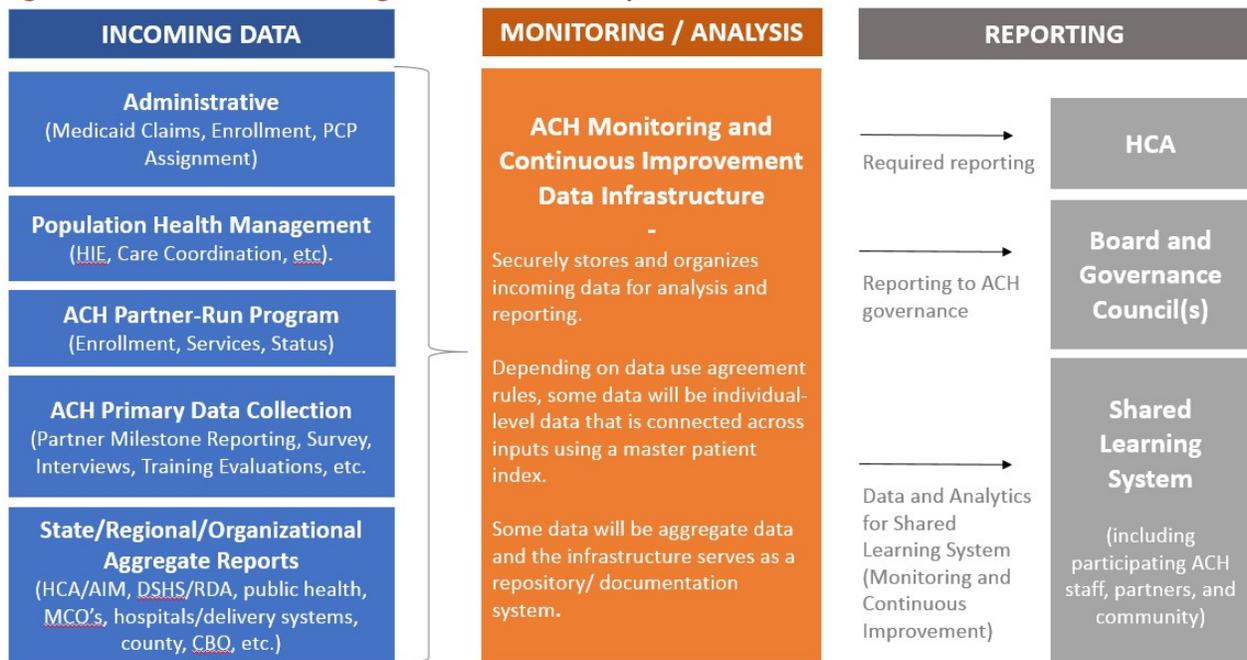
Describe the ACH’s process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH’s plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH’s plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?
- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

ACH Response

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, a Strategic Improvement Team and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below. (See Figure 1.)

Figure 1. Process for Monitoring and Continuous Improvement



The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread. SWACH has contracted with the Center for Outcomes Research & Education (CORE) at Providence Health & Services to design and run the monitoring system.

SWACH’s self-monitoring system will allow providers to input data and give SWACH and our partners an early view of progress. This data will allow SWACH to see if providers are falling behind or not meeting requirements early, providing ample time to share the data with them, help them understand the import of the data, and to design rapid-cycle feedback and quality improvement strategies before veering too far off track. This will be more effective with pay for reporting requirements, however, we are working with CORE to develop a system that will allow us to track data elements that will be predictive of overall pay for performance metrics as well.

Our Improvement Advisors will work with provider organizations to assist them in developing the capacity to review their own data and begin to design their own quality improvement projects.

Plan for monitoring project implementation progress, including addressing delays in implementation

The SWACH monitoring and continuous improvement system will incorporate key process measures and milestones for Chronic Disease Prevention and Control project implementation, as shown in Figure 1. Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by the ACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met the ACH will communicate a plan back to the state regarding reasons why timelines weren't met, a plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process.

In addition, the Pathways HUB model and data collection tool using the CCS platform will be explicitly developed to allow for real-time assessment of Pathways outcomes and provide SWACH the opportunity for addressing challenges as they arise. The system will be informed by key planning inputs that better position SWACH to invest in and provide supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and ACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the MTP for each project area.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers. These learning collaboratives will allow regional providers to see trends and work together to determine the underlying cause of these trends.

SWACH envisions supporting quality improvement in a variety of ways, ranging from 'matchmaking' partnering providers to existing resources to creating new opportunities for partnering providers.

SWACH wants its partners to be as successful as possible in project implementation and will design quality improvement efforts that offer a flexible approach. SWACH Improvement Advisors, in concert

with Qualis Health and MCOs will work with each partnering provider to determine the level of support desired and needed. For larger, more sophisticated organizations, SWACH will work with quality improvement teams already working within these organizations. Using data and reports, SWACH will ensure quality improvement personnel know the issues and have the tools to address those issues. If more assistance is requested, SWACH will provide more in-depth support. This support may be in the form of training, technical assistance, or coaching.

For smaller organizations, SWACH envisions being the quality improvement engine for these providers. Based upon provider reported data, and broader data sources, SWACH will provide technical assistance, training, and coaching. SWACH will work with provider organizations to improve their performance with respect to projects, as well as train these organizations to begin to establish their own quality improvement teams and processes.

SWACH envisions needing to be flexible in creating this quality improvement process to meet the varied needs of providers in different sectors, geographies, and stages of maturity. Our own work will require assessment and improvement to continuously meet the needs of our partnering providers.

Plan for addressing strategies that are not working or not achieving outcomes

The comprehensive shared learning system and PDSA continuous improvement process will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

Our workgroups, committees, and governance bodies will continue to meet to discuss the data and progress of our partnering providers throughout the MTP. SWACH will work with the Quality and Continuous Improvement Committee to ensure all assets are brought to bear when monitoring suggests a project is off course. However, we are aware that there is the possibility that despite best efforts, a strategy may not result in desired outcomes. SWACH is considering charging the Quality and Continuous Improvement Committee with defining when a project may be deemed to require a change in approach versus a quality improvement strategy. SWACH is also open to other ideas from the Quality and Continuous Improvement Committee, our workgroups and committees, the community, and other ACHs to determine whether the data indicates a change in approach is warranted.

Should the SI Team, Quality and Continuous Improvement Committee, and Care Coordination Advisory Committee determine course correction is not possible, they will refer their findings to the RHIP Council for review. The RHIP Council will take a broader look to ensure a possible solution has not been overlooked. The RHIP Council will then recommend to the Board whether changes to the approaches or project should be considered, and SWACH would pursue the appropriate path with HCA.

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

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

YES	NO
X	

Project Sustainability

Describe the ACH's strategy for long-term project sustainability, and its impact on Washington's health system transformation beyond the Demonstration period.

ACH Response

Southwest ACH strategy for long-term project sustainability

SWACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation about chronic disease prevention and control. SWACH is facilitating new linkages between providers and CBOs and expects that these partnerships will become part of the infrastructure and an accepted way of doing business within the Chronic Care Model. In addition, SWACH is working with providers to move from volume to value to transform practices. To do this, SWACH and its Strategic Improvement (SI) Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers to help them meet established success measures and outcomes.

The ACH will foster the development of the needed pathways and support the needed tools for providers to operate effectively in a value based payment environment. This effort will be critical to our sustainability efforts. We have been partnering with statewide workgroups regarding state Medicaid codes for Collaborative Care to help finance and sustain integrated care. We are working alongside our managed care partners to leverage the billing and coding work that has developed out

of SB 5779 along with developments for new billing codes in rural health clinics and FQHCs. Through an aligned strategy with the health plans and scaling successful integration models, by the end of the demonstration our region will be well positioned to provide effective clinically integrated care, and provide the scaffolding for chronic disease prevention and treatment.

SWACH's Community Resilience Fund is a key sustainability strategy. During the MTP, SWACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resilience through social determinant investments and key policies and system changes for overall population health. The Community Resilience Fund will deepen and strengthen existing investments as well as provide a model for future investments, one that builds off SWACH's infrastructure and vision and is adaptive to the changing landscape.

Chronic conditions account for 75% of the nation's aggregate health care spending.¹⁴⁷ Poor coordination of care often involves multiple providers and organizations with no single entity coordinating care. "Patients with highly fragmented care experienced more than twice as many PCP visits as those with better care coordination. They visited specialists six times as often and were also more likely to visit more primary care providers than their peers."¹⁴⁸ Coordination through community health workers and the Pathways hub could provide cost savings over the long term which could sustain the chronic disease prevention and treatment initiative. HIT/HIE infrastructure and memoranda of understanding among providers could provide real-time monitoring that could lead to reduced cost and improved outcomes. Community commitment through the Healthy Living Collaborative to upstream health initiatives like community gardens, workplace wellness, and walkable, safe streets could lead to chronic disease prevention and amelioration of its effects.

Project's impact on Washington's health system transformation beyond the Demonstration period

Through our work, SWACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and to the commercial market. We expect that our deep collaboration with providers, CBOs and other stakeholders will lead to transformation and set a standard for the health landscape in our region and our state.

¹⁴⁷ www.cdc.gov/chronicdisease/overview/index/htm

¹⁴⁸ <https://healthitanalytics.com/news/poor-care-coordination-raises-chronic-disease-costs-by-4500>

SUPPLEMENTARY MATERIALS CHECKLIST

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