



Healthier Washington Medicaid Transformation
Accountable Communities of Health
SWACH Semi-annual report
Reporting Period: July 1, 2018 – December 31, 2018

Due Date: January 31, 2019

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Attachments:

- Semi-annual report workbook
- Organizational self-assessment of internal controls and risks

ACH contact information

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

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Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not applicable.

- In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
<i>Provider with low VBP knowledge</i>	1:1 meeting Clinical Integration Committee	7/2/18 7/26/18	<i>Defining a Strategy for VBC</i> <i>Value-Based Payment Practice Transformation Planning Guide</i>
<i>Small provider</i>	1:1 Meeting	8/13/18	<i>Defining a Strategy for VBC</i>

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
	Email Communication		<i>Value-Based Payment Practice Transformation Planning Guide</i> <i>Healthier Washington Practice Transformation Support HUB Resource Portal</i>
<i>Behavioral health provider</i>	1:1 meeting SW Integration Champions Meeting Email Communication	9/19/18 11/19/18	<i>Value-Based Payment Practice Transformation Planning Guide</i> <i>Children's Behavioral Health Integration & Value Transformation Toolkit</i>

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response: Not applicable

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
Elected officials, health system leadership, physical and behavioral health providers, community-serving agencies, peers, other community and clinical stakeholders	<ol style="list-style-type: none"> 1) Promote a culture shift to understand and treat opioid use disorder as a chronic disease of the brain 2) Support trauma-informed care and understanding of ACES 3) Recognize and support peers as central to the aim of recovery 	<ol style="list-style-type: none"> 1) Local and regional champions to present / appear on panels 2) SWACH staff for logistical coordination 3) SWACH funding for logistical coordination 4) SWACH staff, funding and coordination for video documenting to create training tools
Providers ready to prescribe MAT	<ol style="list-style-type: none"> 1) Greater access to MAT for patients through more waived prescribers of MAT from diverse settings 2) Greater provider understanding of opioid use disorder as chronic brain disease and implications of treatment 3) X-Waiver and associated training to prescribe MAT 	<ol style="list-style-type: none"> 1) Regional MAT trainer champion 2) SWACH staff for logistical coordination 3) SWACH funding for logistical coordination 4) SWACH funding for waiver completion incentives 5) Partner organization logistical support
Prescribing providers of MAT	Provider support and mentorship regarding practical applications of Suboxone in a clinical setting	<ol style="list-style-type: none"> 1) Regional MAT trainer champion 2) SWACH staff for logistical coordination 3) SWACH funding for logistical coordination 4) Partner organization logistical support 5) SWACH staff, funding and coordination for video documenting to create training tools

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH's efforts to support completion of the state's 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
Personalized email to partners	No	No
Monthly e-newsletter article	No	Yes
Tailored follow up email to targeted providers	No	Yes
Web post featured on the home page	No	Yes
Social media postings	No	Yes

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
<i>Provider with low VBP knowledge</i>	Research and education of VBC models Financial resources	1:1 Technical Assistance meetings Access to educational and toolkit materials	Creation of Clinical Transformation Plans Development of scope of work (action plans) to implement	Training plan strategy developed Clinical Transformation Plans completed

ACH provider support activities

Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
	<p>Partnerships and collaboration with payers</p> <p>Alignments with contracts incentives and/or contract requirements</p> <p>Regulations and/or policies</p> <p>Aligned quality measures and definitions</p>	<p>Regional meetings to develop relationships and address needs</p> <p>Creation of Clinical Transformation Plan template</p>	<p>transformation activities</p> <p>Creation of funding protocols for the allocation of resources to organizations</p> <p>Execution of binding contracts for TY 3-4</p> <p>Regional and organizational training plan development for TY 3</p>	<p>Strategy and framework for learning collaboratives drafted</p> <p>Cohorts of partners identified</p>
<i>Small provider</i>	<p>Training</p> <p>Interoperable data systems</p> <p>Workforce shortages</p> <p>Regulations and/or policies</p> <p>Aligned quality measures and definitions</p>	<p>1:1 Technical Assistance meetings</p> <p>Access to educational and toolkit materials</p> <p>Regional meetings to develop relationships and address needs</p> <p>Creation of Clinical Transformation Plans</p>	<p>Creation of Clinical Transformation Plans</p> <p>Development of scope of work (action plans) to implement transformation activities</p> <p>Creation of funding protocols for the allocation of resources to organizations</p> <p>Execution of binding contracts for TY 3-4</p> <p>Regional and organizational training plan development for TY 3</p>	<p>Training plan strategy developed</p> <p>Clinical Transformation Plans completed</p> <p>Strategy and framework for a learning collaborative drafted</p> <p>Cohorts of partners identified</p>
<i>Behavioral health provider</i>	<p>Clinical Protocols/guidelines trainings for VBC</p> <p>Analytic support training</p>	<p>1:1 Technical Assistance meetings</p> <p>Access to educational and toolkit materials</p>	<p>Creation of Clinical Transformation Plans</p> <p>Development of scope of work (action plans) to implement</p>	<p>Training plan strategy developed</p> <p>Clinical Transformation Plans completed</p>

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
	Access to comprehensive data Access to timely patient/population cost data Regulations and/or policies Aligned quality measures and definitions	Regional meetings to develop relationships and address needs Creation of Clinical Transformation Plans	transformation activities Creation of funding protocols for the allocation of resources to organizations Execution of binding contracts for TY 3-4 Regional and organizational training plan development for TY 3	Strategy and framework for learning collaboratives drafted Cohorts of partners identified

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.1, provide the rationale for having not

discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not applicable (*SWACH is not an IMC 2020 region*)

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not Applicable (*SWACH is not an IMC 2020 region*)

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?

- a. If yes, describe the region’s plan to establish an EWS Workgroup, including:
- i. Which organization will lead the workgroup?
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type workgroup participants

- b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response: Not Applicable

4. Describe the region’s efforts to establish a communications workgroup, including:

- i. Which organization will lead the workgroup
- ii. Estimated date for establishing the workgroup

- iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable

- 5. Describe the region's efforts to establish a provider readiness/technical assistance (TA) workgroup, including:

- i. Which organization will lead the workgroup
- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable

- 6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response: Not Applicable

- 7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response: Not Applicable

- 8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response: Not Applicable

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond "Not applicable."

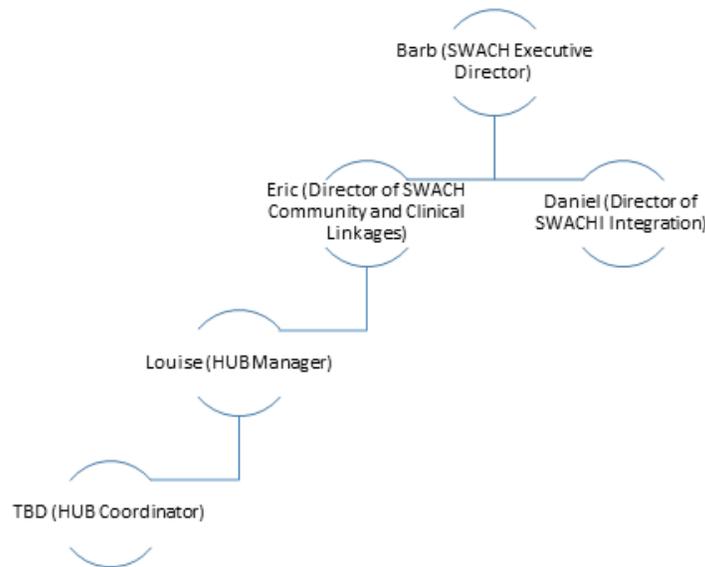
The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

- 1. Identify the Project 2B HUB lead entity and describe the entity's qualifications. Include a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response:

Regional partners and the SWACH Board of Trustees determined that SWACH meets all the prerequisite requirements to be the HUB lead entity. SWACH is both a legal and neutral entity. The HUB will be a program within SWACH, rather than a separate legal entity. Additionally, as SWACH is committed to Project 2B and meets the required prerequisites for pre-certification with the Rockville Institute, SWACH meets all the requirements to be designated as the HUB lead entity.

As the SWACH Pathways Community HUB (“HUB”) is a program within the SWACH structure (see diagram below for HUB structure), the shared staffing to support the development of the HUB infrastructure includes: SWACH Executive Director, Finance Director and Director of Community-Clinical Linkages. Two positions dedicated to HUB operations include the HUB Manager and HUB Coordinator.



2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response:

As required in the prerequisites and standards for Pathways Community HUB certification by the Rockville Institute, the SWACH HUB will apply for pre-certification approximately six months after HUB go live. Go live is projected for March 2019 and the HUB will apply for precertification in the fourth quarter of 2019.

3. Describe the Project 2B HUB lead entity’s role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff and referring or other entities.

ACH response:

As the HUB lead entity, SWACH is responsible for ensuring the HUB operations manual meets all requirements for certification, which includes HIPPA protection policies, as well as data governance and processes to manage HUB data. SWACH has contracted with Care Coordination Systems (CCS) to build the platform to exchange data and track care coordination. SWACH is also currently under a Business Associate Agreement with Pierce County ACH to share and adopt appropriate policies for data governance, including clinical and administrative data collection, storage and reporting; and SWACH has taken the Pierce County ACH recommendations for additional security in preparation for HUB implementation. Additionally, SWACH is negotiating a contract with Blue Orange Compliance, a healthcare information privacy and security specialty consultant, to provide an assessment and certification rating for SWACH policies, procedures and practices.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not applicable.”

ACH response: Not applicable.

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

1. **Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes,” to all items respond “Not applicable.”

ACH response: Not Applicable

3. **Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of

attestation.

Place an “X” in the appropriate box.

Yes	No
X	

- a. If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked “Yes,” to item A.3 respond “Not applicable.”

ACH response: Not Applicable

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period	X	

If the ACH checked “Yes” in item A.4 above:

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

B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).¹

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the

¹ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response: Not Applicable

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

ACH response: Not Applicable

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response:

SWACH is both an early adopter and a mid-adopter region. During the reporting period, SWACH’s was primarily focused on developing Clinical Transformation Plans with all behavioral health providers. In addition, there is one behavioral health provider in the mid-adopter county (Klickitat County) and our focus in that region has been on readiness for IMC, along with clinical transformation. We have worked collaboratively with our neighboring ACH partner because the behavioral health provider in the region straddles both service areas. Moreover, most of their services are provided in the neighboring region.

SWACH developed a Clinical Transformation Plan template and process that supports the administrative and clinical transition to IMC. This approach has allowed providers to work directly with SWACH to determine their needs, evaluate their priorities and begin to develop the goals, strategies, tactics and work steps to meet their organizational goals and the goals of the SWACH region. Furthermore, this process then established the basis for negotiations with providers and will end with an agreed upon budget and binding contract.

SWACH has provided technical assistance to providers that requested it or were identified as needing technical assistance in one or more areas. Some examples of technical assistance include change management, organizational assessments, budgeting, continuous quality improvement frameworks, clinical best practices, shared learning with peers and subject matter experts related to information technology, and health information exchange.

SWACH also meets monthly with all behavioral health providers in the region. This meeting provides an opportunity for SWACH to provide and receive information, understand behavioral health issues and collaboratively problem solve.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and

will continue to participate in discussions on the prioritization of incentives.

ACH response:

The Southwest Washington Regional Health Care Advisory Group continues to review the progress of behavioral health integration in Clark, Skamania and Klickitat counties. This advisory group hosts a quarterly meeting and receives reports on the progress of integration by managed care organizations, the Health Care Authority, SWACH, providers and community members. The Advisory Group is composed of county commissioners, elected officials, public health directors from the three counties, and a member of the Behavioral Health Advisory Board (BHAB).

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

In the Clinical Transformation Plan Proposal process, behavioral health and physical health providers were asked to submit a Clinical Transformation Plan that included the transition to integrated managed care. Clinical Transformation Plans were reviewed against a set of criteria, which were developed by SWACH staff and consultants. One of the evaluation criteria was “Medicaid lives served by behavioral health”. Recommendations were then advanced to the SWACH executive director and a community review group. A set of guiding principles were utilized to ensure a balanced portfolio of plans were advanced to the SWACH Board of Trustees. Twenty-three Clinical Transformation Plans were approved by the SWACH Board of Trustees. In developing two-year binding agreements with partnering clinical providers, they must agree to continue to serve the Medicaid population as a condition of the agreement.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

During the reporting period, SWACH developed the process to enter into binding contracts with our partnering providers, including behavioral health providers. This process incorporated the co-creation of a scope of work that will drive transformation for at least the next two years. Within the scope of work providers are creating milestones, action steps and measurements that align with whole-person care, community-clinical linkages and the internal and operational system investments that are needed to carry out their scopes of work. SWACH has conducted assessments of behavioral health provider needs and met individually with each organization, creating a feedback loop to inform the scope of work for each organization. SWACH leadership also worked closely with an external stakeholder steering committee and Board of Trustees executive

committee to create a funds flow strategy. This plan, which aligned with partnering providers' forecasted needs and strategies, was approved by the Board of Trustees during this reporting period.

SWACH has utilized three standing coalition meetings (Klickitat CORE, Healthy Skamania, Clinical Integration Committee) to develop the framework for learning collaboratives. A key strategy for supporting providers during the implementation (e.g. post IMC transition) phase is to utilize a shared learning framework and the science of improvement methodology to foster a culture of learning, while applying test of change strategies within provider organizations. SWACH has also consulted with subject matter experts to help support the development of our collaborative frameworks. Alongside our consultants, SWACH created an ad hoc planning group with behavioral health and primary care leaders to inform the ongoing support structures that will be needed post-IMC transition.

In partnership with the MCOs in the region, SWACH created a training and technical assistance matrix to inform future training and technical assistance needs. SWACH gathered input from partnering providers, the Regional Health Improvement Plan (RHIP) Council, clinical assessments and stakeholder meetings to prioritize training topics and began the process of creating a two-year training and technical assistance calendar. Moreover, SWACH partnered with Qualis HUB during the reporting period to finalize and transfer practice transformation initiatives in the region that were led by Qualis HUB during the reporting period.

2. Complete the items outlined in tab 3.C of the semi-annual report workbook.

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH's Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH's activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.²

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

the changes.

1. Provide the ACH's current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

Strategy	Accomplishments
<ul style="list-style-type: none"> • Develop a policy agenda that is community-led and supported 	<ul style="list-style-type: none"> • Policy agenda approved by Board of Trustees
<ul style="list-style-type: none"> • Developed equity shared learning cohort and curriculum 	<ul style="list-style-type: none"> • Manager of equity initiatives hired • Learning cohorts identified by partners • Learning curriculum being developed within the stakeholder group
<ul style="list-style-type: none"> • Developed a regional approach for implementation of Pathways, a care coordination model 	<ul style="list-style-type: none"> • CCS contract reviewed and approved • Identified rural Care Coordination Agencies (CCAs) in Klickitat and Skamania Counties • Two-day strategic training and an introduction to Pathways, presented to MCOs, potential referral agencies and CCAs from the larger geographical area
<ul style="list-style-type: none"> • Lead a series of opioid learning sessions: “The Uses of Suboxone in a Practical Clinical Setting” • Engaged three counties to address opioid issues 	<ul style="list-style-type: none"> • Two Successful events for providers in Clark and Skamania Counties; 39 participants completed MAT prescriber training. • Hep C Cures peer integration project and related CDC/DOH funding awarded to SWACH for project implementation • Three county opioid coalition project and related CDC/DOH funding secured to set up county-specific opioid coalitions • Opioid Treatment Network collaboration and related HCA funding secured to increase MAT initiation sites and link clinical and community partners
Risks	Mitigation Strategies

Workforce capacity	<ul style="list-style-type: none"> • Developed funds flow to provide financial resources for providers to offset costs (TY3 Q2) • Co-created milestones to guide scope of work action plan (TY3 Q1) • Procure outside subject matter expertise (TY3 Q2)
Provider fatigue	<ul style="list-style-type: none"> • Partnering with regional ACHs to minimize duplication and maximize efficiencies (ongoing) • Minimize reporting burdens by establishing online reporting tools and strategic alignment with state measures and partnerships with Managed Care Organizations. (TY3 Q2)
Market consolidation	<ul style="list-style-type: none"> • Co-create scopes of work that align with emerging partnerships (TY3 Q1) • Tools and process for clinical and community partner negotiations finalized (TY2 Q4) • Consultation with market experts and consultants (ongoing) • Meetings with consultants and providers (ongoing)

3. **Did the ACH** make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
	X

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response: Not Applicable

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>Coordinate with Greater Columbia ACH for IMC</i>	<p>Align IMC provider readiness assessments</p> <p>Align IMC strategies (early warning system, communications, MCO collaboration, HCA collaboration, crisis system changes)</p> <p>Avoid reporting and meeting duplication for shared BH provider</p> <p>Align provider investments</p>	<p>IMC implementation strategies and coordination avoided duplication and maximized efficiencies for provider</p> <p>Joint communication strategies implemented</p> <p>Shared provider assessments, TA strategies and ACH processes to avoid duplications, when possible.</p>
<p>Participation in cross-ACH meetings, including but not limited to:</p> <p>HCA Learning Symposium</p> <p>ACH Executive Director Meetings</p> <p>Ad Hoc-ACH Executive peer meetings</p>	<p>Share information and best practices across ACHs</p> <p>Identify opportunities for collaboration and joint contracting</p> <p>Surface common challenges to HCA and MCOs</p>	<p>ACHs met to discuss common challenges and mitigation strategies, including:</p> <p>Data</p> <p>Coordination with MCOs</p> <p>Training for community health workers (CHWs) to support the MTP</p> <p>Collaboration on Partner trainings</p>
Participation in statewide Pathways ACH Meetings	Implement consistent training for Community Health Workers. Agree on common evaluation methodology	<p>Training modules approved</p> <p>Agreement reached for core evaluation measures</p>

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response:

SWACH developed several strategies to engage community partners, a few of which are described below. SWACH identified early on that a key component to achieving the region’s goals relied on developing a strategy that connected community-serving

organizations and traditional clinical partners. To close this gap, our strategy was to develop a process for community-serving organizations, who often lack capacity, to participate in transformation activities and identify needs/gaps. The primary vehicle to support this process was through an open Request for Information (RFI) proposal. This approach also provided SWACH with information on how to close the gaps and address the needs of the region. SWACH developed a RFI review process and funding strategy to support the work in YY 3 and future years. Approximately 30 new providers responded to the RFI and nine new providers will likely enter into contract negotiations with SWACH.

As part of a communications strategy to build stronger linkages between SWACH and current and potential partners, SWACH implemented a content strategy for its digital and social media that promotes and highlights the work of potential partners and subject matter experts around the region. The goal is to create a stronger sense of community and connectedness around focus areas such as the opioid crisis response, care coordination, and value-based payment. Articles, interviews and live videos provide education, highlight partners' expertise and promote regional engagement with Medicaid Transformation.

SWACH also organized events, including the Opioid Action Summit in Clark County and a Washington State University Community Health Forum, to convene stakeholders, community members and other experts around key issues; nurture opportunities for collaboration and partnership; and enhance interest and awareness of regional Medicaid Transformation efforts. The Opioid Action Summit, for example, convened more than 130 participants, including 15 stakeholder organizations who shared their work with attendees and other partners. Results included recruitment of new members for SWACH advisory groups, news media coverage and engagement with elected and tribal officials.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

During the reporting period, SWACH partnered with each MCO to create a strategic and collaborative approach towards MCO participation at many levels within the organization. SWACH senior staff meets with each MCO on a regular cadence to align strategies around value-based contracting, common measurement development, technical assistance resources, provider needs and common training objectives.

During the reporting period, SWACH conducted key informant interviews with each MCO and focused on the topic of shifting toward value-based payment. SWACH developed a joint communication with the MCOs, which included an article featuring interviews with the MCOs on the transition to VPB, published through our monthly newsletter, website and social media.

Our MCO partners are represented at two levels of governance within SWACH: RHIP Council and the Board of Trustees. This representation allows for Board of Trustees and MCO partners to collaborate and send a unified message of partnership and strategic vision to SWACH’s network of providers. All regional MCOs are also active participants in SWACH’s standing committees and the RHIP Council. Through these forums, the MCO partners, SWACH and providers create an opportunity to gather input and work together to provide direct operational support and input into strategies and tactics to achieve the goals in the SWACH region.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”

ACH response: Not Applicable

3. Provide three examples of the ACH’s community engagement³ and health equity⁴ activities that occurred during the reporting period that reflect the ACH’s priorities for health equity and community engagement.

ACH response:

Example 1. Structural work to embed community engagement and health equity into the ACH’s culture and practices.

During the reporting period, SWACH worked to strengthen and embed community engagement and health equity practices into its culture and everyday routines. In August 2018, SWACH hired a full-time Community Engagement Manager to oversee the community engagement strategy. The Community Engagement Manager led all SWACH

³ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH’s projects.

⁴ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

staff through a community engagement assessment, using a tool from Nexus Community Partners to measure how SWACH engages with community residents. The community engagement manager collated data from the assessment and made recommendations for policy and practice improvement. Recommendations have led to:

- Work with the SWACH Board of Trustees to obtain support for a community resident with experience with the Medicaid system to serve on the Board of Trustees
- Assessment and development of policies and practices around how SWACH hosts meetings and events, with the purpose of making meetings and events more inclusive and welcoming for community residents
- Support of all SWACH staff to develop a community engagement goal within their body of work and development of a monthly meeting practice with each staff member and the community engagement manager
- Development of a Community Leadership Collaborative concept and meetings with community members to seek their feedback and recruit participants for a design team;
- Review of hiring practices and training for staff on common biases when hiring
- Completion of a hiring process to welcome a Manager of Equity Initiatives
- Continued hosting of equity trainings throughout the SWACH region
- Implementation of a community engagement work session with the RHIP Council and formation of an ad-hoc Community Engagement Team to support RHIP in engaging community residents
- Development of a partnership with WSU-Vancouver's Initiative for Public Deliberation and work with students to host a forum on community health on WSU-Vancouver's campus
- Support provided to the Southwest Washington Community Health Advocates and Peer Support Network (SW CHAPS) to host a Community Health Worker (CHW) Conversation about CHW workforce development and recommendations for the work of the statewide CHW taskforce
- Commitment from all staff to participate in a staff retreat to strengthen team communication and work toward our organizational values of community engagement and equity

Example 2. Collaboration with community organizations and community residents to host an event to improve collective work to reduce the opioid crisis.

In December 2018, SWACH and community partners hosted an Opioid Action Summit in Clark County. This event hosted 130+ community residents, local and national organizations, and state legislators seeking to collaborate with one another to reduce the opioid crisis in Clark County. SWACH implemented its strengthened community engagement strategy when planning and hosting this event. SWACH built an event team

consisting of SWACH staff, the interim director of WSU-Vancouver's Initiative for Public Deliberation and a student leader from WSU-Vancouver. The team developed an event program that offered opportunities for community residents and organizational partners to engage in the event:

- Welcome and honoring of the land, Steve Kutz, Cowlitz Tribe
- Peer voices on the opioid crisis (community residents with lived experience with the opioid crisis and the Medicaid system, who are now working as Peers to provide mental health and recovery support to community residents)
- Highlight of work by 15 community organizations and opportunities to collaborate
- Small group discussions about community members' policy priorities, facilitated by students from WSU-Vancouver's Initiative for Public Deliberation
- Communication of policy priorities and response by state legislators (Senator Cleveland, Rep. Harris, and Rep. Stonier)

Example 3. Development of a 2019 state policy agenda through a community process that uses a health equity lens.

Healthy Living Collaborative (HLC), a program of SWACH, continued its commitment to health equity and policy advocacy as it built its 2019 state policy agenda. The HLC Policy Committee created an ad-hoc team to review and strengthen the equity lens it had used in the past to evaluate possible policy priorities. With this strengthened tool, HLC staff met with various community partners and residents to hear their state policy priorities, including:

- HLC Policy Committee
- SWACH Regional Health Improvement Plan (RHIP) Council
- Behavioral Health Advisory Board (BHAB)
- Rose Village Community Health Worker (CHW) Team
- Skamania County Human Services Advisory Board
- Over 70 additional community partners at the HLC Quarterly Meeting
- SWACH Board of Trustees

The HLC Policy Committee is preparing for upcoming legislative luncheons in January and February 2019. During these luncheons, HLC Policy Committee members, community residents and organizational partners will meet with legislators to share personal stories and data to encourage policy development around key issues.

9. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. Earned Project Incentives

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

In the Clinical Transformation Plans submitted by health systems, clinical and behavioral health partners, SWACH will recognize progress on transformation goals to include population health management capability and value-based contracting. Progress will be recognized with quarterly incentives. To track progress on these goals, partners will submit quarterly reports against forecasted milestones which may include:

- Adoption of population health management tools
- Common electronic health records or electronic behavioral health records
- Potential implementation of value-based payment arrangements with MCOs

In addition, community-serving organizations were asked to describe plans to partner and integrate social services with clinical organizations. Recognition of this integration will be incentivized based on quarterly reports. These reports will document a description of any significant efforts or accomplishments toward pre-identified milestones in organization's workplans, an explanation of any changes in the workplan during that period, and any challenges encountered or anticipated. In addition, measures related to the partner's transformation activities, as defined in the scope of work, will be reported. These will include HCA required measures and may also include process, quality or outcome measures related to the partner's transformation activities.

One or more learning collaboratives will be established to ensure that clinical partners are successful in implementing their change plans and maximizing their incentive payments. These learning collaboratives will utilize QI methodology to implement improvements.

In addition to the above investments, SWACH continues to sit with other ACH partners and the Association of Washington Public Hospital Districts to align and plan Health Systems and

Capacity Building investments from Domain 1 activities to achieve short-term goals and broader transformation goals.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

SWACH has established a Community Resiliency Fund (CRF) to focus on primary prevention and/or social determinants of health. Initially, this fund will focus on one or two strategies that could remove barriers to health and have a significant impact on one or more health sector partners. The CRF will be braided with several community partners to initiate an upfront investment. If the partnership achieves certain metrics (which financially benefit healthcare partners), those partners would allocate some of the savings into the CRF for continued reinvestment. This approach is complicated but addresses social determinants and ultimately improvement to overall health of the community.

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁵

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.

⁵ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

- b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
- c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

- 2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response:

SWACH has begun to develop an understanding of partnering provider participation at the clinic and site-level. This understanding is occurring in conversations with each partner that has been invited forward to develop clinical transformation binding agreements. Each partnering provider will identify organization-wide and clinic specific scope of work. SWACH will track information internally and use it to inform partner reporting requirements. SWACH is already working to design partner reporting that will accommodate both organization and site level reporting but has not yet identified any barriers to tracking.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

- 1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

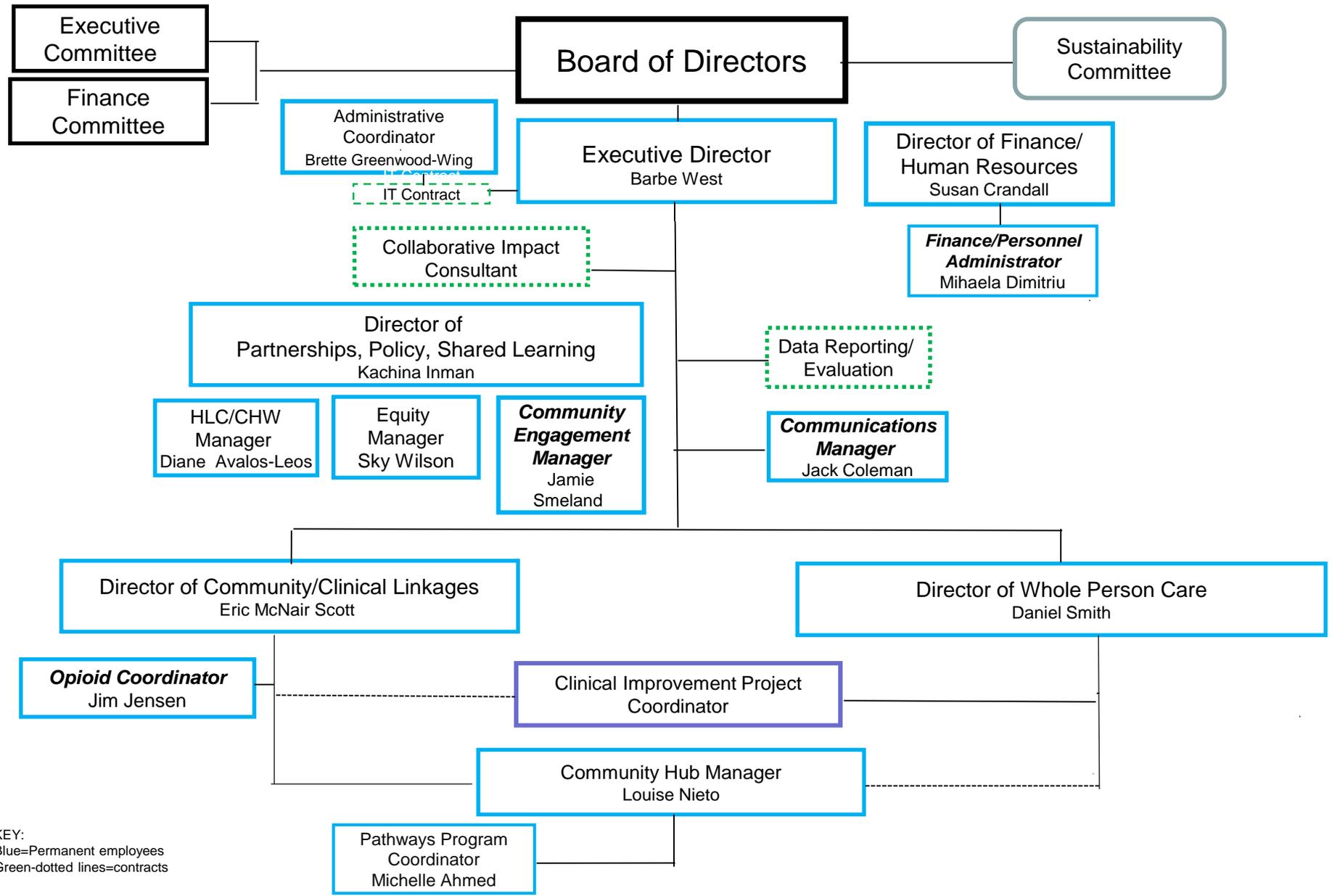
- 2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not Applicable

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Organizational Chart

January 2019



KEY:
 Blue=Permanent employees
 Green-dotted lines=contracts

Southwest Washington Accountable Community of Health

ACH Earned Incentives and Expenditures

July 1, 2018 - December 31, 2018

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period²	
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$3,737,983
2B: Community-Based Care Coordination	\$2,569,863
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing the Opioid Use Public Health Crisis	\$467,248
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	\$934,496
Behavioral Health Integration Incentives	
Value-Based Payment (VBP) Incentives	
IHCP-Specific Projects	
High Performance Pool	
Total Funds Earned	\$7,709,590

Funds Distributed by ACH During Reporting Period, by Use Category³	
Administration	\$120,800
Community Health Fund	
Health Systems and Community Capacity Building	\$118,000
Integration Incentives	
Project Management	
Provider Engagement, Participation and Implementation	\$1,090,000
Provider Performance and Quality Incentives	
Reserve / Contingency Fund	
Shared Domain 1 Incentives	\$1,944,469
Total	\$3,273,269

Funds Distributed by ACH During Reporting Period, by Use Category³	
ACH	\$238,800
Non-Traditional Provider	\$32,500
Traditional Medicaid Provider	\$1,057,500
Tribal Provider (Tribe)	
Tribal Provider (UIHP)	
Shared Domain 1 Provider	\$1,944,469
Total Funds Distributed During Reporting Period	\$3,273,269

Total Funds Earned During Reporting Period	\$7,709,590
Total Funds Distributed During Reporting Period	\$3,273,269
Total Funds Left Available for Distribution During Reporting Period	\$4,436,321

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 4, 2019 to accompany the second Semi-Annual Report submission for the reporting period July 1 to December 31, 2018.

² For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.
- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

³ Definitions for [Use Categories and Provider Types](#)

Organizational Self-Assessment of Internal Controls and Risks

ACH Name: **SOUTHWEST WASHINGTON ACCOUNTABLE COMMUNITY OF HEALTH**

Date Prepared: **1/21/2019**

Answer "Yes" if the activity in question is performed internally or externally (unless specified). Each "No" answer indicates a potential weakness of internal fiscal controls. All "No" answers require an explanation of mitigating controls or a note of planned changes. If the activity does not apply to your organization, answer N/A.

I. CONTROL ENVIRONMENT

A. Management's Philosophy and Operating Style

Yes N/A No

1. Are periodic (monthly, quarterly) reports on the status of actual to budgeted expenditures prepared and reviewed by top management?

Monthly status reports are reviewed but no budget for this period.

2. Are unusual variances between budgeted revenues and expenditures and actual revenues and expenditures examined?

3. Is the internal control structure supervised and reviewed by management to determine if it is operating as intended?

B. Organizational Structure

4. Is there a current organizational chart defining the lines of responsibility?

5. Have all staff been sufficiently trained to perform their assigned duties?

In Progress (many staff are new)

C. Assignment of Authority and Responsibility

6. Are sufficient training opportunities to improve competency and update employees on Program, Fiscal and Personnel policies and procedures available?

Both a Personnel and Financial policies manual are in final stages of development.

7. Have managers been provided with clear goals and direction from the governing body or top management? Goals are established by the BOD for the Executive Director. The goals for directors will be established Q1 2019.

8. Is program information issued by the Health Care Authority distributed to appropriate staff?

II. HUMAN RESOURCES

A. Control Activities/Information and Communication

Yes **N/A** **No**

1. Are personnel policies in writing?

Contracted HR consulting firm policies in place, new policies in development.

2. Are personnel files maintained for all employees?

Files maintained by HR consulting firm, new files established Q1 2019 onsite including electronic HRMS system.

II. HUMAN RESOURCES (continued)

A. Control Activities/Information and Communication

Yes N/A No

 3. Are payroll costs accurately charged to grants using time spent in each program?

 4. Are accurate, up-to-date position descriptions available?

 5. Do all supervisors and managers have at least a working knowledge of personnel policies and procedures?

In progress due to new policies and new roles

 6. Does each supervisor and manager have a copy or access to a copy of personnel policies and procedures? *In progress*

 7. Does management ensure compliance with the organization's personnel policies and procedures manual concerning hiring, training, promoting, and compensating employees? *In progress*

8. Are the following duties generally performed by different people?

 a. Processing personnel action forms and processing payroll?

 b. Supervising and timekeeping, payroll processing, disbursing, and making general ledger entries?

 c. Personnel and approving time reports?

 d. Personnel and payroll preparation?

 e. Recording the payroll in the general ledger and the payroll processing function?

 9. Is access to payroll/personnel files limited to authorized individuals?

 10. Are procedures in place to ensure that all keys, equipment, credit cards, cell phones, laptops, etc. are returned by the terminating employee?

 11. Is information on employment applications verified and are references contacted?

III. ACCOUNTS PAYABLE

A. Control Activities/Information and Communication

Yes N/A No

 1. Has the organization established procedures to ensure that all voided checks are properly accounted for and effectively cancelled?

III.ACCOUNTS PAYABLE (continued)

A. Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
			2. Do invoice-processing procedures provide for:
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	a. Obtaining copies of requisitions, purchase orders and receiving reports?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	b. Comparison of invoice quantities, prices, and terms with those indicated on the purchase order?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	c. Comparison of invoice quantities with those indicated on the receiving reports?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. As appropriate, checking accuracy of calculations?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Alteration/destruction of extra copies of invoices to prevent duplicate payments?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. All file copies of invoices are stamped/marked paid to prevent duplicate payments?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Are payments made only on the basis of original invoices and to suppliers identified on supporting documentation?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Are the accounting and purchasing departments promptly notified of returned purchases and are such purchases correlated with vendor credit memos?
			5. Are monthly reconciliations performed on the following:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. All petty cash accounts?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. All bank accounts?
			6. Are the following duties generally performed by different people?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Requisitioning, purchasing, and receiving functions and the invoice processing, accounts payable, and general ledger functions?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	b. Purchasing, requisitioning, and receiving?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Invoice processing and making entries to the general ledger?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Preparation of cash disbursements, approval of them, and making entries to the general ledger?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is check signing limited to only authorized personnel?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Are disbursements approved for payment only by properly designated officials?

III.ACCOUNTS PAYABLE (continued)

A. Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Is the individual responsible for approval or check signing furnished with invoices and supporting data to be reviewed prior to approval or check-signing?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Are unused checks adequately controlled and safeguarded?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is it prohibited to sign blank checks in advance?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is it prohibited to make checks out to the order of "cash"?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. If facsimile or e-signatures are used, are the signature plates adequately controlled and separated physically from blank checks?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Are purchase orders pre-numbered and issued in sequence?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are changes to contracts or purchase orders subject to the same controls and approvals as the original agreement?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are all records, checks and supporting documents retained according to the applicable record retention policy?

IV. COMPLIANCE SUPPLEMENT ELEMENTS

A. Cash Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Are requests for advance payment (A-19's) based on actual program needs?
			2. Are the following duties generally performed by different people?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Preparing the request for payment from HCA (A-19)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	b. Reviewing and approving the request for advance payment from HCA (A-19)?

B. Equipment and Real Property Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Are all disposals of property approved by a designated person with proper authority?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Has organization management chosen and documented the threshold level for capitalization in an internal policy/procedure book?

§5k threshold established in new financial policies

IV.COMPLIANCE SUPPLEMENT ELEMENTS (continued)

B. Equipment and Real Property Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Is someone assigned custodial responsibility by location for all assets?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is access to the perpetual fixed asset records limited to authorized individuals?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Is there adequate physical security surrounding the fixed asset items?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Is there adequate insurance coverage of the fixed asset items?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is insurance coverage independently reviewed periodically?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is a fixed asset inventory taken annually?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Are missing items investigated and reasons for them documented?

C. Procurement and Suspension and Debarment

Non-Federal entities are prohibited from contracting with or making sub awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of \$100,000 and all non-procurement transactions. [Http://www.sam.gov/](http://www.sam.gov/) This website is provided by the General Services Administration (GSA) for the purpose of disseminating information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits.

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Is there established segregation of duties between employees responsible for contracting; accounts payable and cash disbursing.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Is the contractor's performance included in the terms, conditions, and specifications of the contract monitored and documented?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do supervisors review procurement and contracting decisions for compliance with Federal procurement policies? In development
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Are procedures established to verify that vendors providing goods and services under the award have not been suspended or debarred by the Federal government?

**C. Procurement and Suspension and Debarment
Control Activities/Information and Communication**

Yes **N/A** **No**

5. Are there written policies for the procurement and contracts establishing:
- a. Contract files
 - b. Methods of procurement
 - c. Contractor rejection or selection
 - d. Basis of contract price
 - e. Verification of full and open competition
 - f. Requirements for cost or price analysis
 - g. Obtaining and reacting to suspension and debarment certifications
 - h. Other applicable requirements for Federal procurement
 - i. Conflict of interest
6. Is there written policy addressing suspension and debarments of contractors?
7. Are there proper channels for communicating suspected procurement and contracting improprieties?
8. Does management perform periodic review of procurement and contracting activities to determine whether policies and procedures are being followed?

**D. Reporting
Control Activities/Information and Communication**

Yes **N/A** **No**

- 1. Are personnel responsible for submitting required reporting information adequately trained?
- 2. Does management review required reports before submitting?

**E. Single Audit
Control Activities/Information and Communication**

Yes **N/A** **No**

- 1. Was the organization audited by an objective accounting firm this past fiscal year? [Audit in progress... 990 extension filed and approved](#)
- 2. Did appropriate organization staff review the findings of the previous years' audit as preparation for the current year audit?

E. Single Audit (continued)

Control Activities/Information and Communication

Yes N/A No

3. Have all audit findings and questioned costs from previous years been appropriately resolved?

V. CERTIFICATION

I hereby certify that the information presented in this self-assessment of internal controls and risk is true, accurate, and complete, to the best of my knowledge.

Organization Name *SOUTHWEST WASHINGTON ACCOUNTABLE COMMUNITY OF HEALTH*

Barbara A. West

Authorized Official Signature

1/22/19

Date



Healthier Washington Medicaid Transformation

Accountable Communities of Health

SWACH Semi-annual report

Reporting Period: July 1, 2018 – December 31, 2018

Due Date: January 31, 2019

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Attachments:

- Semi-annual report workbook
- Organizational self-assessment of internal controls and risks

ACH contact information

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

ACH name:	SW Washington Accountable Community of Health (SWACH)
Primary contact name	Barbe West
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Secondary contact name	Daniel Smith
Phone number	503-459-6495
E-mail address	Daniel.Smith@southwestach.org

Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- 1. Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- 2.** If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not applicable.

- 3.** In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
<i>Provider with low VBP knowledge</i> Children’s Center	1:1 meeting Clinical Integration Committee	7/2/18 7/26/18	<i>Defining a Strategy for VBC: a workbook that was designed to assist BHAs in becoming familiar with elements of VBP and provide tools to help with these transformation efforts.</i>

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
			The workbook is located at: https://waportal.org/resources/defining-strategy-value-based-contracting <i>Value-Based Payment Practice Transformation Planning Guide</i>
<i>Small provider</i> Family Solutions	1:1 Meeting Email Communication	8/13/18	<i>Defining a Strategy for VBC</i> <i>Value-Based Payment Practice Transformation Planning Guide</i> <i>Healthier Washington Practice Transformation Support HUB Resource Portal</i>
<i>Behavioral health provider</i> Columbia River Mental Health	1:1 meeting SW Integration Champions Meeting Email Communication	9/19/18 11/19/18	<i>Value-Based Payment Practice Transformation Planning Guide</i> <i>Children's Behavioral Health Integration & Value Transformation Toolkit</i>

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response: Not applicable

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
Elected officials, health system leadership, physical and behavioral health providers, community-serving agencies, peers, other community and clinical stakeholders	<ol style="list-style-type: none"> 1) Promote a culture shift to understand and treat Opioid Use Disorder (OUD) as a chronic brain disease 2) Support trauma-informed care and understanding of ACES <p>Recognize and support peers as central to the aim of recovery</p>	<ol style="list-style-type: none"> 1) SWACH environmental scans, and development of a regional opioid response workgroup, identified local and regional champions to participate in a four-part training summit. 2) Convened training summit focused on understanding and treatment of OUD as a chronic brain disease. 3) SWACH cultivated partnerships and participation with regional champions including a) Dr. John Hart (Physiatrist - PeaceHealth) - pathophysiology of opioid addiction and implications for medication assisted treatment b) Lydia Bartholow (Associate Medical Director for Outpatient Substance Use Disorder Services - Central City Concern) - trauma and opioid addiction c) Cyndie Meyers (Public Health) - adverse childhood experiences and trauma informed care d) Brad Berry (ED - Community Voices are Born) - Peer providers and peer supports as central to the opioid response e) Peer providers from Project Impact (Peers in

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
		<p>hospital responding to opioids) and Community Voices are Born.</p> <p>4) SWACH provided all outreach, coordination and logistical groundwork and funding for registering participants, hosting and delivering the trainings.</p> <p>5) SWACH developed a communications strategy to extend the training opportunity to community stakeholders who could not participate in-person, through video documentation.</p> <p>6) SWACH communications team utilized resources including funding and staff time to edit and create publicly accessible training videos with supplemental materials.</p> <p>SWACH developed plans to promote and communicate SWACH produced training video opportunities with clinical partners across region.</p>
Providers ready to prescribe MAT	<p>1) Greater access to MAT for patients through more waived prescribers of MAT from diverse settings.</p> <p>2) More MAT waived providers. In 2016 there were 39 DEA waived prescribers, many of whom were not prescribing, in the SWACH region. In the totality of Klickitat and Skamania counties there was only 1 provider who offered MAT.</p> <p>3) SWACH region needed a coordinating body to organize promote and champion MAT waiver trainings. SWACH convened and coordinated multiple trainings of the</p>	<p>1) Through environmental scans, opioid workgroups and partner outreach, SWACH sought and identified a local provider who is trained and certified to deliver MAT waiver trainings.</p> <p>2) SWACH partnered with Dr. Melinda Landchild to deliver two trainings in 2018 and to continue delivering MAT trainings as SWACH continues work to accelerate the opioid response in the SWACH region.</p> <p>3) 26 providers completed the trainings in 2018.</p>

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
	<p>4-hour face-to-face component of the AAAP waiver trainings. 26 providers participated in two trainings in 2018.</p> <p>4) Greater provider understanding of opioid use disorder as chronic brain disease and implications of treatment.</p>	<p>4) SWACH provided all outreach, coordination and logistical groundwork for registering participants, hosting and delivering the trainings.</p> <p>5) SWACH planned/coordinated with Dr. Landchild to identify opportunities for MAT waiver trainings in 2019, especially in support of the Opioid Treatment Network expansion.</p> <p>6) SWACH conducted outreach to partner agencies, health system leadership and providers, and SWACH opioid network stakeholders to promote MAT training, register participants, provide communications support, and support post-training follow up with providers.</p> <p>SWACH communicated and provided, as incentive, \$300 reimbursements for providers to complete the full training (online portion of 4-20 hours required following the face-to-face component to receive DEA waiver)</p>
Prescribing providers of MAT	<p>Many DEA waived MAT prescribers do not go on to prescribe due to unfamiliarity/discomfort, systems barriers, stigma, etc. Identified needs for newly waived prescribers to feel ready and willing to prescribe MAT, including connection to a MAT provider champion, mentorship and shared learning opportunities.</p>	<p>1) SWACH conceived and developed, with Dr. Hart (Physiatrist- PeaceHealth- MAT provider champion) a dinner presentation for regional MAT providers.</p> <p>2) Training titled “Practical applications of Suboxone in a clinical setting.” Hosted 26 attendees from across the SWACH region.</p> <p>3) SWACH outreach to</p>

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
		<p>participants of previous SWACH MAT waiver trainings, partner agencies, health system leadership and providers, and SWACH opioid network stakeholders to promote training.</p> <p>4) SWACH registered participants, provided communications support and supported post-training follow up with providers.</p> <p>5) SWACH provided coordination, logistical support and funding for participant dinners.</p> <p>6) SWACH developed a communications strategy to extend the training opportunity to community stakeholders who could not participate in person to include video documentation.</p> <p>7) SWACH communications team utilized resources including funding and staff time to edit and create publicly accessible training videos with supplemental materials.</p> <p>8) SWACH developed plans to promote and communicate SWACH produced training video opportunities with clinical partners across region.</p>

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH's efforts to support completion of the state's 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
Personalized email to partners	No	No
Monthly e-newsletter article	No	Yes
Tailored follow up email to targeted providers	No	Yes
Web post featured on the home page	No	Yes
Social media postings	No	Yes

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
<i>Provider with low VBP knowledge</i>	Research and education of VBC models Financial resources Partnerships and collaboration with payers	1:1 Technical Assistance meetings Access to educational and toolkit materials Regional meetings to develop	Creation of Clinical Transformation Plans Development of scope of work (action plans) to implement transformation activities Creation of funding protocols for the	Training plan strategy developed Clinical Transformation Plans completed Strategy and framework for

ACH provider support activities

Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
	Alignments with contracts incentives and/or contract requirements Regulations and/or policies Aligned quality measures and definitions	relationships and address needs Creation of Clinical Transformation Plan template	allocation of resources to organizations Execution of binding contracts for TY 3-4 Regional and organizational training plan development for TY 3	learning collaboratives drafted Cohorts of partners identified
<i>Small provider</i>	Training Interoperable data systems Workforce shortages Regulations and/or policies Aligned quality measures and definitions	1:1 Technical Assistance meetings Access to educational and toolkit materials Regional meetings to develop relationships and address needs Creation of Clinical Transformation Plans	Creation of Clinical Transformation Plans Development of scope of work (action plans) to implement transformation activities Creation of funding protocols for the allocation of resources to organizations Execution of binding contracts for TY 3-4 Regional and organizational training plan development for TY 3	Training plan strategy developed Clinical Transformation Plans completed Strategy and framework for a learning collaborative drafted Cohorts of partners identified
<i>Behavioral health provider</i>	Clinical Protocols/guidelines trainings for VBC Analytic support training Access to comprehensive data	1:1 Technical Assistance meetings Access to educational and toolkit materials Regional meetings to develop relationships and address needs	Creation of Clinical Transformation Plans Development of scope of work (action plans) to implement transformation activities Creation of funding protocols for the allocation of	Training plan strategy developed Clinical Transformation Plans completed Strategy and framework for learning collaboratives drafted

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
	Access to timely patient/population cost data Regulations and/or policies Aligned quality measures and definitions	Creation of Clinical Transformation Plans	resources to organizations Execution of binding contracts for TY 3-4 Regional and organizational training plan development for TY 3	Cohorts of partners identified

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not applicable (*SWACH is not an IMC 2020 region*)

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
	X

- a. If the ACH checked “No” in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not Applicable (*SWACH is not an IMC 2020 region*)

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?

- a. If yes, describe the region’s plan to establish an EWS Workgroup, including:

- i. Which organization will lead the workgroup?
- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type workgroup participants

- b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response: Not Applicable

4. Describe the region’s efforts to establish a communications workgroup, including:

- i. Which organization will lead the workgroup
- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable

5. Describe the region’s efforts to establish a provider readiness/technical assistance (TA)

workgroup, including:

- i. Which organization will lead the workgroup
- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response: Not Applicable

7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response: Not Applicable

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response: Not Applicable

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond “Not applicable.”

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

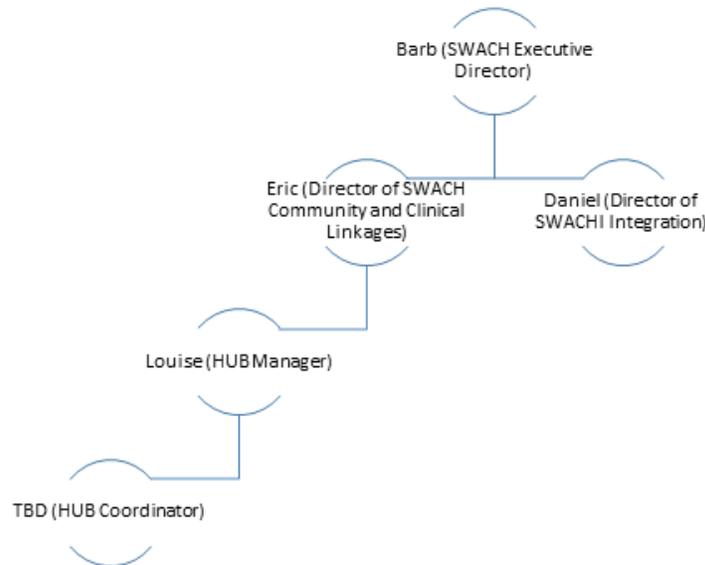
1. Identify the Project 2B HUB lead entity and describe the entity’s qualifications. Include a description of the HUB lead entity’s organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response:

Regional partners and the SWACH Board of Trustees determined that SWACH meets all the prerequisite requirements to be the HUB lead entity. SWACH is both a legal and neutral entity. The HUB will be a program within SWACH, rather than a separate legal entity. Additionally, as SWACH is committed to Project 2B and meets the required

prerequisites for pre-certification with the Rockville Institute, SWACH meets all the requirements to be designated as the HUB lead entity.

As the SWACH Pathways Community HUB (“HUB”) is a program within the SWACH structure (see diagram below for HUB structure), the shared staffing to support the development of the HUB infrastructure includes: SWACH Executive Director, Finance Director and Director of Community-Clinical Linkages. Two positions dedicated to HUB operations include the HUB Manager and HUB Coordinator.



2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response:

As required in the prerequisites and standards for Pathways Community HUB certification by the Rockville Institute, the SWACH HUB will apply for pre-certification approximately six months after HUB go live. Go live is projected for March 2019 and the HUB will apply for precertification in the fourth quarter of 2019.

3. Describe the Project 2B HUB lead entity’s role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff and referring or other entities.

ACH response:

As the HUB lead entity, SWACH is responsible for ensuring the HUB operations manual meets all requirements for certification, which includes HIPPA protection policies, as

well as data governance and processes to manage HUB data. SWACH has contracted with Care Coordination Systems (CCS) to build the platform to exchange data and track care coordination. SWACH is also currently under a Business Associate Agreement with Pierce County ACH to share and adopt appropriate policies for data governance, including clinical and administrative data collection, storage and reporting; and SWACH has taken the Pierce County ACH recommendations for additional security in preparation for HUB implementation. Additionally, SWACH is negotiating a contract with Blue Orange Compliance, a healthcare information privacy and security specialty consultant, to provide an assessment and certification rating for SWACH policies, procedures and practices.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not applicable.”

ACH response: Not applicable.

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

1. **Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes,” to all items respond “Not applicable.”

ACH response: Not Applicable

3. **Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

- a. If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked “Yes,” to item A.3 respond “Not applicable.”

ACH response: Not Applicable

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period	X	

If the ACH checked “Yes” in item A.4 above:

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

B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).¹

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response: Not Applicable

¹ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

ACH response: Not Applicable

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response:

SWACH is both an early adopter and a mid-adopter region. During the reporting period, SWACH's was primarily focused on developing Clinical Transformation Plans with all behavioral health providers. In addition, there is one behavioral health provider in the mid-adopter county (Klickitat County) and our focus in that region has been on readiness for IMC, along with clinical transformation. We have worked collaboratively with our neighboring ACH partner because the behavioral health provider in the region straddles both service areas. Moreover, most of their services are provided in the neighboring region.

SWACH developed a Clinical Transformation Plan template and process that supports the administrative and clinical transition to IMC. This approach has allowed providers to work directly with SWACH to determine their needs, evaluate their priorities and begin to develop the goals, strategies, tactics and work steps to meet their organizational goals and the goals of the SWACH region. Furthermore, this process then established the basis for negotiations with providers and will end with an agreed upon budget and binding contract.

SWACH has provided technical assistance to providers that requested it or were identified as needing technical assistance in one or more areas. Some examples of technical assistance include change management, organizational assessments, budgeting, continuous quality improvement frameworks, clinical best practices, shared learning with peers and subject matter experts related to information technology, and health information exchange.

SWACH also meets monthly with all behavioral health providers in the region. This meeting provides an opportunity for SWACH to provide and receive information, understand behavioral health issues and collaboratively problem solve.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response:

The Southwest Washington Regional Health Care Advisory Group continues to review the progress of behavioral health integration in Clark, Skamania and Klickitat counties. This advisory group hosts a quarterly meeting and receives reports on the progress of integration by managed care organizations, the Health Care Authority, SWACH, providers and community members. The Advisory Group is composed of county commissioners, elected officials, public health directors from the three counties, and a member of the Behavioral Health Advisory Board (BHAB).

One specific example of how we have prioritized behavioral health providers transition to integrated managed care is with our mid-adopter partners. Through the reporting period (and during the prior reporting period), SWACH engaged the behavioral health provider in the region to review assessed needs for the transition. This included a review of needs related to administrative functions, infrastructure needed to manage billing and revenue cycles, technical assistance needed for new processes and workforce needs related to the transition. Through this collaborative process, we agreed to prioritize and allocate all the integration incentive dollars earned during the reporting period to the behavioral health provider. The provider developed a formal proposal for use of incentive funds, which outlined the gap analysis that was conducted, described needs and associated activities to address unmet needs through the transition process. SWACH and the provider began negotiations based on this document, shared the outcome of this process with the region's stakeholders and elected officials, and will continue to prioritize future integration incentive dollars for the mid-adopter region in the same way.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

In the Clinical Transformation Plan Proposal process, behavioral health and physical health providers were asked to submit a Clinical Transformation Plan that included the transition to integrated managed care. Clinical Transformation Plans were reviewed against a set of criteria, which were developed by SWACH staff and consultants. One of the evaluation criteria was "Medicaid lives served by behavioral health".

Recommendations were then advanced to the SWACH executive director and a community review group. A set of guiding principles were utilized to ensure a balanced portfolio of plans were advanced to the SWACH Board of Trustees. Twenty-three Clinical Transformation Plans were approved by the SWACH Board of Trustees. In developing two-year binding agreements with partnering clinical providers, they must agree to continue to serve the Medicaid population as a condition of the agreement.

During the reporting period, SWACH worked on developing an online reporting tool that partners will be required to use. The reporting tool will serve many functions related to ongoing monitoring and evaluation of progress. One component of the reports will include an attestation from the organization that affirms their organization's

commitment to serve individuals receiving Medicaid. SWACH will distribute funds to providers after they complete their quarterly reports and will not continue to provide funds if the reports do not reflect an affirmative response to supporting the Medicaid population.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

During the reporting period, SWACH developed the process to enter into binding contracts with our partnering providers, including behavioral health providers. This process incorporated the co-creation of a scope of work that will drive transformation for at least the next two years. Within the scope of work providers are creating milestones, action steps and measurements that align with whole-person care, community-clinical linkages and the internal and operational system investments that are needed to carry out their scopes of work. SWACH has conducted assessments of behavioral health provider needs and met individually with each organization, creating a feedback loop to inform the scope of work for each organization. SWACH leadership also worked closely with an external stakeholder steering committee and Board of Trustees executive committee to create a funds flow strategy. This plan, which aligned with partnering providers' forecasted needs and strategies, was approved by the Board of Trustees during this reporting period.

SWACH has utilized three standing coalition meetings (Klickitat CORE, Healthy Skamania, Clinical Integration Committee) to develop the framework for learning collaboratives. A key strategy for supporting providers during the implementation (e.g. post IMC transition) phase is to utilize a shared learning framework and the science of improvement methodology to foster a culture of learning, while applying test of change strategies within provider organizations. SWACH has also consulted with subject matter experts to help support the development of our collaborative frameworks. Alongside our consultants, SWACH created an ad hoc planning group with behavioral health and primary care leaders to inform the ongoing support structures that will be needed post-IMC transition.

In partnership with the MCOs in the region, SWACH created a training and technical assistance matrix to inform future training and technical assistance needs. SWACH gathered input from partnering providers, the Regional Health Improvement Plan (RHIP) Council, clinical assessments and stakeholder meetings to prioritize training topics and began the process of creating a two-year training and technical assistance calendar. Moreover, SWACH partnered with Qualis HUB during the reporting period to finalize and transfer practice transformation initiatives in the region that were led by Qualis HUB during the reporting period.

2. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.²

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
 - If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.
1. Provide the ACH’s current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

Strategy	Accomplishments
<ul style="list-style-type: none"> • Develop a policy agenda that is community-led and supported 	<ul style="list-style-type: none"> • Policy agenda approved by Board of Trustees
<ul style="list-style-type: none"> • Developed equity shared learning cohort and curriculum 	<ul style="list-style-type: none"> • Manager of equity initiatives hired • Learning cohorts identified by partners • Learning curriculum being developed within the stakeholder group

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

<ul style="list-style-type: none"> Developed a regional approach for implementation of Pathways, a care coordination model 	<ul style="list-style-type: none"> CCS contract reviewed and approved Identified rural Care Coordination Agencies (CCAs) in Klickitat and Skamania Counties Two-day strategic training and an introduction to Pathways, presented to MCOs, potential referral agencies and CCAs from the larger geographical area
<ul style="list-style-type: none"> Lead a series of opioid learning sessions: “The Uses of Suboxone in a Practical Clinical Setting” Engaged three counties to address opioid issues 	<ul style="list-style-type: none"> Two Successful events for providers in Clark and Skamania Counties; 39 participants completed MAT prescriber training. Hep C Cures peer integration project and related CDC/DOH funding awarded to SWACH for project implementation Three county opioid coalition project and related CDC/DOH funding secured to set up county-specific opioid coalitions Opioid Treatment Network collaboration and related HCA funding secured to increase MAT initiation sites and link clinical and community partners

Risks	Mitigation Strategies
Workforce capacity	<ul style="list-style-type: none"> Developed funds flow to provide financial resources for providers to offset costs (TY3 Q2) Co-created milestones to guide scope of work action plan (TY3 Q1) Procure outside subject matter expertise (TY3 Q2)
Provider fatigue	<ul style="list-style-type: none"> Partnering with regional ACHs to minimize duplication and maximize efficiencies (ongoing) Minimize reporting burdens by establishing online reporting tools and strategic alignment with state measures and partnerships with Managed Care Organizations. (TY3 Q2)
Market consolidation	<ul style="list-style-type: none"> Co-create scopes of work that align with emerging partnerships (TY3 Q1) Tools and process for clinical and community partner negotiations finalized (TY2 Q4) Consultation with market experts and consultants (ongoing) Meetings with consultants and providers (ongoing)

3. **Did the** ACH make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
	X

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target

populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response: Not Applicable

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>Coordinate with Greater Columbia ACH for IMC</i>	<p>Align IMC provider readiness assessments</p> <p>Align IMC strategies (early warning system, communications, MCO collaboration, HCA collaboration, crisis system changes)</p> <p>Avoid reporting and meeting duplication for shared BH provider</p> <p>Align provider investments</p>	<p>IMC implementation strategies and coordination avoided duplication and maximized efficiencies for provider</p> <p>Joint communication strategies implemented</p> <p>Shared provider assessments, TA strategies and ACH processes to avoid duplications, when possible.</p>
<p>Participation in cross-ACH meetings, including but not limited to:</p> <p>HCA Learning Symposium</p> <p>ACH Executive Director Meetings</p> <p>Ad Hoc-ACH Executive peer meetings</p>	<p>Share information and best practices across ACHs</p> <p>Identify opportunities for collaboration and joint contracting</p> <p>Surface common challenges to HCA and MCOs</p>	<p>ACHs met to discuss common challenges and mitigation strategies, including:</p> <p>Data</p> <p>Coordination with MCOs</p> <p>Training for community health workers (CHWs) to support the MTP</p> <p>Collaboration on Partner trainings</p>

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
Participation in statewide Pathways ACH Meetings	Implement consistent training for Community Health Workers. Agree on common evaluation methodology	Training modules approved Agreement reached for core evaluation measures

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response:

SWACH developed several strategies to engage community partners, a few of which are described below. SWACH identified early on that a key component to achieving the region’s goals relied on developing a strategy that connected community-serving organizations and traditional clinical partners. To close this gap, our strategy was to develop a process for community-serving organizations, who often lack capacity, to participate in transformation activities and identify needs/gaps. The primary vehicle to support this process was through an open Request for Information (RFI) proposal. This approach also provided SWACH with information on how to close the gaps and address the needs of the region. SWACH developed a RFI review process and funding strategy to support the work in YY 3 and future years. Approximately 30 new providers responded to the RFI and nine new providers will likely enter into contract negotiations with SWACH.

As part of a communications strategy to build stronger linkages between SWACH and current and potential partners, SWACH implemented a content strategy for its digital and social media that promotes and highlights the work of potential partners and subject matter experts around the region. The goal is to create a stronger sense of community and connectedness around focus areas such as the opioid crisis response, care coordination, and value-based payment. Articles, interviews and live videos provide education, highlight partners’ expertise and promote regional engagement with Medicaid Transformation.

SWACH also organized events, including the Opioid Action Summit in Clark County and a Washington State University Community Health Forum, to convene stakeholders, community members and other experts around key issues; nurture opportunities for collaboration and partnership; and enhance interest and awareness of regional Medicaid Transformation efforts. The Opioid Action Summit, for example, convened more than 130 participants, including 15 stakeholder organizations who shared their work with attendees and other partners. Results included recruitment of new members for SWACH

advisory groups, news media coverage and engagement with elected and tribal officials.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

During the reporting period, SWACH partnered with each MCO to create a strategic and collaborative approach towards MCO participation at many levels within the organization. SWACH senior staff meets with each MCO on a regular cadence to align strategies around value-based contracting, common measurement development, technical assistance resources, provider needs and common training objectives.

During the reporting period, SWACH conducted key informant interviews with each MCO and focused on the topic of shifting toward value-based payment. SWACH developed a joint communication with the MCOs, which included an article featuring interviews with the MCOs on the transition to VPB, published through our monthly newsletter, website and social media.

Our MCO partners are represented at two levels of governance within SWACH: RHIP Council and the Board of Trustees. This representation allows for Board of Trustees and MCO partners to collaborate and send a unified message of partnership and strategic vision to SWACH’s network of providers. All regional MCOs are also active participants in SWACH’s standing committees and the RHIP Council. Through these forums, the MCO partners, SWACH and providers create an opportunity to gather input and work together to provide direct operational support and input into strategies and tactics to achieve the goals in the SWACH region.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”

ACH response: Not Applicable

3. Provide three examples of the ACH's community engagement³ and health equity⁴ activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

ACH response:

Example 1. Structural work to embed community engagement and health equity into the ACH's culture and practices.

During the reporting period, SWACH worked to strengthen and embed community engagement and health equity practices into its culture and everyday routines. In August 2018, SWACH hired a full-time Community Engagement Manager to oversee the community engagement strategy. The Community Engagement Manager led all SWACH staff through a community engagement assessment, using a tool from Nexus Community Partners to measure how SWACH engages with community residents. The community engagement manager collated data from the assessment and made recommendations for policy and practice improvement. Recommendations have led to:

- Work with the SWACH Board of Trustees to obtain support for a community resident with experience with the Medicaid system to serve on the Board of Trustees
- Assessment and development of policies and practices around how SWACH hosts meetings and events, with the purpose of making meetings and events more inclusive and welcoming for community residents
- Support of all SWACH staff to develop a community engagement goal within their body of work and development of a monthly meeting practice with each staff member and the community engagement manager
- Development of a Community Leadership Collaborative concept and meetings with community members to seek their feedback and recruit participants for a design team;
- Review of hiring practices and training for staff on common biases when hiring
- Completion of a hiring process to welcome a Manager of Equity Initiatives
- Continued hosting of equity trainings throughout the SWACH region
- Implementation of a community engagement work session with the RHIP Council and formation of an ad-hoc Community Engagement Team to support

³ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

⁴ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

RHIP in engaging community residents

- Development of a partnership with WSU-Vancouver's Initiative for Public Deliberation and work with students to host a forum on community health on WSU-Vancouver's campus
- Support provided to the Southwest Washington Community Health Advocates and Peer Support Network (SW CHAPS) to host a Community Health Worker (CHW) Conversation about CHW workforce development and recommendations for the work of the statewide CHW taskforce
- Commitment from all staff to participate in a staff retreat to strengthen team communication and work toward our organizational values of community engagement and equity

Example 2. Collaboration with community organizations and community residents to host an event to improve collective work to reduce the opioid crisis.

In December 2018, SWACH and community partners hosted an Opioid Action Summit in Clark County. This event hosted 130+ community residents, local and national organizations, and state legislators seeking to collaborate with one another to reduce the opioid crisis in Clark County. SWACH implemented its strengthened community engagement strategy when planning and hosting this event. SWACH built an event team consisting of SWACH staff, the interim director of WSU-Vancouver's Initiative for Public Deliberation and a student leader from WSU-Vancouver. The team developed an event program that offered opportunities for community residents and organizational partners to engage in the event:

- Welcome and honoring of the land, Steve Kutz, Cowlitz Tribe
- Peer voices on the opioid crisis (community residents with lived experience with the opioid crisis and the Medicaid system, who are now working as Peers to provide mental health and recovery support to community residents)
- Highlight of work by 15 community organizations and opportunities to collaborate
- Small group discussions about community members' policy priorities, facilitated by students from WSU-Vancouver's Initiative for Public Deliberation
- Communication of policy priorities and response by state legislators (Senator Cleveland, Rep. Harris, and Rep. Stonier)

Example 3. Development of a 2019 state policy agenda through a community process that uses a health equity lens.

Healthy Living Collaborative (HLC), a program of SWACH, continued its commitment to health equity and policy advocacy as it built its 2019 state policy agenda. The HLC Policy Committee created an ad-hoc team to review and strengthen the equity lens it had used in the past to evaluate possible policy priorities. With this strengthened tool, HLC staff

met with various community partners and residents to hear their state policy priorities, including:

- HLC Policy Committee
- SWACH Regional Health Improvement Plan (RHIP) Council
- Behavioral Health Advisory Board (BHAB)
- Rose Village Community Health Worker (CHW) Team
- Skamania County Human Services Advisory Board
- Over 70 additional community partners at the HLC Quarterly Meeting
- SWACH Board of Trustees

The HLC Policy Committee is preparing for upcoming legislative luncheons in January and February 2019. During these luncheons, HLC Policy Committee members, community residents and organizational partners will meet with legislators to share personal stories and data to encourage policy development around key issues.

9. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. Earned Project Incentives

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

In the Clinical Transformation Plans submitted by health systems, clinical and behavioral health partners, SWACH will recognize progress on transformation goals to include population health management capability and value-based contracting. Progress will be recognized with quarterly incentives. To track progress on these goals, partners will submit quarterly reports against forecasted milestones which may include:

- Adoption of population health management tools
- Common electronic health records or electronic behavioral health records
- Potential implementation of value-based payment arrangements with MCOs

During the reporting period, SWACH made strategic health system and community capacity investments. Below are three examples of our strategic investments.

SWACH selected Pathways Community-based Care Coordination as one of the projects. Several key investments are required to develop this new program. During the reporting period, SWACH invested in the Information Technology infrastructure needed to support the SWACH Regional HUB. This was a significant investment that also provided the region with training support, development of the needed process and procedures, supported our partners with workforce development and training on the platform, and began to customize the platform to meet the program's needs.

SWACH also contracted with the Foundation for Healthy Generations to support the region with pre-launch and implementation preparedness for the Pathways program. This contract supported many aspects related to preparing the workforce and developing the necessary system changes to successfully launch a new care coordination program. The investment also supported numerous educational sessions with community partners, technical assistance for contract development, development of engagement strategies, establishment of peer to peer learning opportunities, and coaching for key managers in operations, evaluation, strategy, performance and personal growth.

Furthermore, SWACH invested community capacity resources to support our Regional Health Improvement Plan Council (RHIP). RHIP is a multi-stakeholder governing council for the region. SWACH established a contract with a subject matter expert, Uncommon Solutions, to develop capacity within the council that enables the council to perform at the highest level and have the largest impact on the region that is possible. This included monthly consultation with the RHIP steering committee, monthly consultation with SWACH leadership, presentation to SWACH Board of Trustees, and training and technical assistance to the RHIP membership. The trainings and technical assistance included collective impact models, decision-making, priority setting, continuous quality improvement and strategic mapping. This investment has provided a solid foundation for RHIP membership and provided the tools necessary to succeed in their role as a governing body.

In addition, community-serving organizations were asked to describe plans to partner and integrate social services with clinical organizations. Recognition of this integration will be incentivized based on quarterly reports. These reports will document a description of any significant efforts or accomplishments toward pre-identified milestones in organization's workplans, an explanation of any changes in the workplan during that period, and any challenges encountered or anticipated. In addition, measures related to the partner's transformation activities, as defined in the scope of work, will be reported. These will include HCA required measures and may also include process, quality or outcome measures related to the partner's transformation activities.

One or more learning collaboratives will be established to ensure that clinical partners are successful in implementing their change plans and maximizing their incentive payments. These learning collaboratives will utilize QI methodology to implement improvements.

In addition to the above investments, SWACH continues to sit with other ACH partners and the Association of Washington Public Hospital Districts to align and plan Health Systems and Capacity Building investments from Domain 1 activities to achieve short-term goals and broader transformation goals.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

SWACH has established a Community Resiliency Fund (CRF) to focus on primary prevention and/or social determinants of health. Initially, this fund will focus on one or two strategies that could remove barriers to health and have a significant impact on one or more health sector partners. The CRF will be braided with several community partners to initiate an upfront investment. If the partnership achieves certain metrics (which financially benefit healthcare partners), those partners would allocate some of the savings into the CRF for continued reinvestment. This approach is complicated but addresses social determinants and ultimately improvement to overall health of the community.

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁵

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

⁵ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.
 - b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
 - c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response:

SWACH has begun to develop an understanding of partnering provider participation at the clinic and site-level. This understanding is occurring in conversations with each partner that has been invited forward to develop clinical transformation binding agreements. Each partnering provider will identify organization-wide and clinic specific scope of work. SWACH will track information internally and use it to inform partner reporting requirements. SWACH is already working to design partner reporting that will accommodate both organization and site level reporting but has not yet identified any barriers to tracking.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not Applicable

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