



Healthier Washington Medicaid Transformation

Independent Assessment of Accountable Communities of Health Project Plans

January 2018

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Full Report

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the State's Healthier Washington Medicaid Transformation (Medicaid Transformation), Section 1115 Medicaid waiver. As part of this engagement, Myers and Stauffer conducted an assessment of Project Plans submitted by each of the nine Accountable Communities of Health (ACHs) as further described in Section I, Introduction.

The purpose of this report is to:

- Document the Independent Assessor's approach to assessment of ACH Project Plans.
- Provide the Independent Assessor's scoring of the Project Plans and resulting valuations.
- Summarize findings and opportunities.

Based on the independent assessment and its own considerations, HCA will use the Delivery System Reform Incentive Payment (DSRIP) Program governance and decision-making group for final determination of Project Plan approval for each ACH.

For the reader's convenience, please see a listing of acronyms and glossary of terms at the end of this report.

Section I — Introduction

1. Healthier Washington Medicaid Transformation Overview

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington's application to implement a five-year *Medicaid Transformation* (No. 1 1-W-00304/0) through December 31, 2021. The state has the following goals for the Medicaid Transformation:

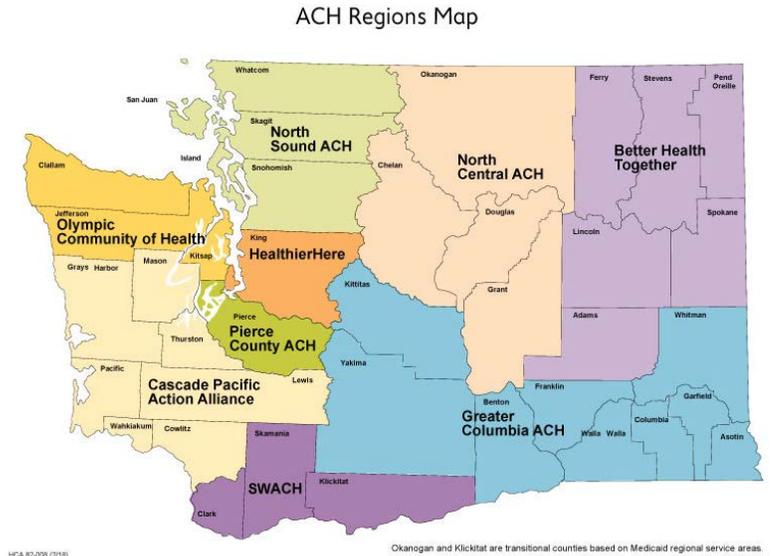
- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume.
- Support provider capacity to adopt new payment and care models.
- Implement population health strategies that improve health equity.
- Provide new targeted services that address the needs of the state's aging population and address key determinants of health.

HCA plans to accomplish these goals through the following three initiatives:

- Initiative 1: Transformation through Accountable Communities of Health (ACHs)

- Initiative 2: Long-term Services and Supports
- Initiative 3: Foundational Community Supports

The focus of the Independent Assessor's work and this report is on Initiative 1, Transformation through ACHs, for which an estimated \$1.1 billion of the \$1.5 billion federal waiver funds are allocated. The objectives as set forth in the STCs are as follows:



- *Health Systems and Community Capacity.* Creating appropriate health systems capacity to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.
- *Financial Sustainability through Participation in Value-based Payment.* Medicaid transformation efforts must contribute meaningfully to moving the state forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation. For this reason, ACHs will be required to design project plan activities that enable the success of Alternative Payment Models required by the state for Medicaid managed care plans.
- *Bi-directional Integration of Physical and Behavioral Health.* Requiring comprehensive integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Projects may include: co-location of providers; adoption of evidence-based standards of integrated care; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes for all populations with behavioral health needs. Along with directly promoting integration of care, the projects will promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. The state will provide increased incentives for regions that commit to and implement fully integrated managed care prior to January 2020.
- *Community-based Whole-person Care.* Use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and

manage their health. In addition, develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and to promote accountable tracking of those beneficiaries being served. Projects will be designed and implemented to promote evidence-based practices that meet the needs of a region's identified high-risk, high-needs target populations.

- *Improve Health Equity and Reduce Health Disparities.* Implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity. Projects will require the full engagement of traditional and non-traditional providers, and project areas may include: chronic disease prevention, maternal and child health, and access to oral health services, and the promotion of strategies to address the opioid epidemic.

The nine ACHs operate in nine separate regions and bring together health care and community leaders to focus on improving population health, achieving health equity, and addressing specific health-related issues affecting quality of life. They are self-governing multi-sector organizations with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. ACHs are not new service delivery system organizations nor a replacement of Medicaid managed care organizations (MCOs) or health care delivery roles and responsibilities. ACHs include managed care, health care delivery, and many other critical organizations as part of their multi-sector governance and as partners in implementation of delivery system reform initiatives.

With support from the state, ACHs are pursuing transformation projects focused on three domains:

- **Domain 1 — Health systems capacity building:** Workforce development; system infrastructure technology and tools; and system supports to assist providers in adopting value-based purchasing and payment.
- **Domain 2 — Care delivery redesign:** Integrated delivery of physical and behavioral health services; care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach, engagement, and recovery supports.
- **Domain 3 — Prevention and health promotion:** Prevention activities for targeted populations and regions.

Domain 1 strategies address the core health system capacities to be developed or enhanced to support the transition to Domains 2 and 3.

HCA defined a portfolio of eight Transformation projects as shown in *Table 1*. Two of the eight projects are required, and each ACH must implement a minimum of four projects to participate in the Medicaid Transformation. HCA granted ACHs flexibility to withdraw project(s) included in their November 16, 2017 Project Plan submissions. The final ACH project portfolio must meet the baseline requirement of four projects total (two required projects, and one additional project from Domains 2 and 3).

Table 1. Medicaid Transformation: Project Plan Portfolio

Domain 2: Care Delivery Redesign	Domain 3: Prevention and Health Promotion
Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation <i>(Required)</i>	Project 3A: Addressing the Opioid Use Public Health Crisis <i>(Required)</i>
Project 2B: Community-based Care Coordination	Project 3B: Reproductive and Maternal and Child Health
Project 2C: Transitional Care	Project 3C: Access to Oral Health Services
Project 2D: Diversions Interventions	Project 3D: Chronic Disease Prevention and Control

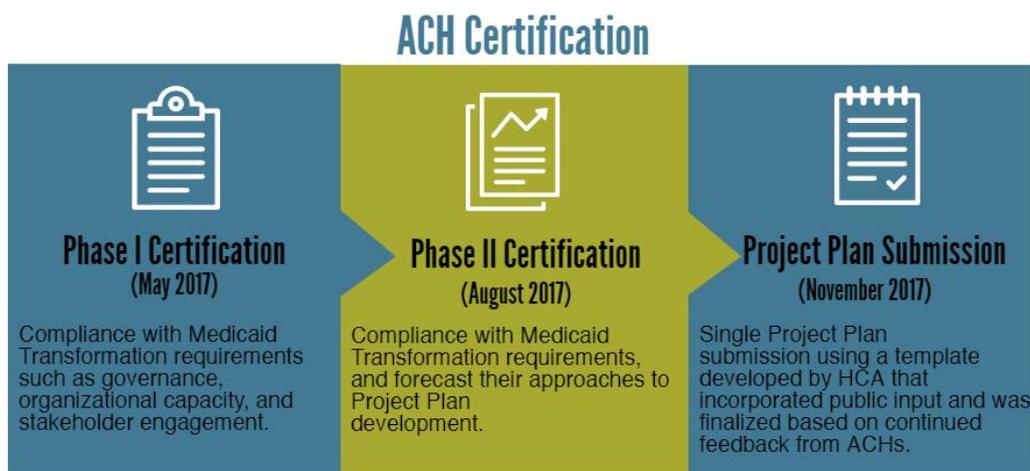
HCA established various milestones and project goals for which each ACH will be held accountable to receive Medicaid Transformation funds to support ongoing project planning and implementation. Payments are initially available for meeting process milestones and later will transition to payment based on improvements made in outcomes.

2. ACH Certification and Project Plan Phases¹

During the first year of the Medicaid Transformation, HCA established a detailed process requiring ACHs to submit documentation to HCA about their project planning processes and progress, and to demonstrate readiness to begin implementation. HCA provided through its contractor, Manatt, a significant amount of technical assistance to support ACHs in their planning.

As shown in *Figure 1*, HCA conducted a two-phase certification process followed by required ACH Project Plan submission.

Figure 1. ACH Certification



¹ Certification and Project Plan materials are available at: <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>. See Initiative 1: Transformation through ACHs tab.

Each ACH successfully completed both certification phases and received the allocated funding associated with the relevant phase. ACHs are eligible to earn project incentives based on their Project Plan assessment score and final HCA approval. HCA also established a Project Plan Bonus Pool, where unearned funds, if any, are available to ACHs that select six or more projects.²

ACHs developed Project Plans that built on Phase I and Phase II certification applications and in collaboration with community stakeholders. The Project Plans were required to respond to community-specific needs, and to support Medicaid Transformation objectives. The Project Plan template includes two sections:

- Section I: Focuses on updated ACH organizational and planning information originally submitted as part of Phase I and Phase II certifications.
- Section II: Focuses on project-level details for all required elements of each selected project.

Table 2 provides a side-by-side listing of major sections within each certification application and Project Plan template.

Table 2. Certification Application and Project Plan Sections

Phase I Certification	Phase II Certification	Project Plan Submission
Data and Analytic Capacity	Data and Analytic Capacity	Regional Health Needs Inventory
ACH Theory of Action and Alignment Strategy	ACH Theory of Action and Alignment Strategy	ACH Theory of Action and Alignment Strategy
Governance and Organizational Structure	Governance and Organizational Structure	Governance
Tribal Engagement and Collaboration	Tribal Engagement and Collaboration	Tribal Engagement and Collaboration
Community and Stakeholder Engagement	Community and Stakeholder Engagement	Community and Stakeholder Engagement and Input
Budget and Funds Flow	Budget and Funds Flow	Funds Allocation
Clinical Capacity and Engagement	Clinical Capacity	
		Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs
	Transformation Project Planning	Project Level Information

² For detailed information about project incentives and the available bonus pool, see “Delivery System Reform Incentive Payment (DSRIP) Funds Flow Update, November 2017.” Available at: <https://static1.squarespace.com/static/5730f4e68a65e244fd4ff897/t/5a2585d29140b74b9deeb68c/1512408532422/WA+DSRIP+November+Funds+Flow+Update+2017+12+01+%28002%29.pdf>

Section II — Independent Assessment for Initiative 1: Transformation through ACHs

1. CMS Requirements for an Independent Assessment

As part of its approval of Washington Medicaid Transformation, CMS issued Special Terms and Conditions (STCs) that include a requirement for HCA to contract with an Independent Assessor to review ACH Project Plans.³ CMS requires the following of the Independent Assessor:

- Has no affiliation with ACHs or their partnering providers.
- Conduct review of ACH project proposals using the state's review tool and consider anticipated project performance.
- Make recommendations to HCA for approvals, denials, or recommended changes to Project Plans to make them approvable.
- Make recommendations to the state for payment distribution.

HCA must affirm the Independent Assessor's recommendations and submit them to the Financial Executor to distribute incentive payments to ACHs.

2. Independent Assessor Role and Project Plan Assessment Process and Timeline

HCA engaged Myers and Stauffer to serve as the Independent Assessor for the Medicaid Transformation. As the Independent Assessor, Myers and Stauffer conducted the following key tasks for the ACH Project Plan Assessment:

- Worked with HCA to establish Project Plan criteria ranking and scoring methodology.
- Provided a draft review tool for public input and finalized the tool based on recommended changes of HCA and the public.
- Conducted a webinar to inform the public and ACHs of the Project Plan assessment process.
- Developed the Washington CPAS (Collaboration, Performance, and Analytics System), a web-based portal used for document submission and information exchange between Myers and Stauffer and ACHs (e.g., ACH Project Plans, semi-annual and mid-point reports).
- Assessed all Project Plan submissions and provided feedback to ACHs about areas of potential improvement.

³ Standard Terms and Conditions are available at: <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>. See CMS Documents tab.

- Submitted final Project Plan report to HCA for use in making a final determination of Project Plan approval and project incentive award decisions.

Below is more information about these key tasks.

Project Plan Review Tool Development

The Medicaid Transformation STCs require that the state obtain public input on the independent assessment review tool that defines the relevant factors of the Project Plan that the Independent Assessor will assess, assigns weights to each factor, and includes scoring for each factor. As such, one of Myers and Stauffer's initial activities in planning for the assessment involved working with HCA to develop criteria categories and definitions and related weights for each. The criteria categories align with Phase II certification evaluations in that specific emphasis is placed on completeness, clarity, specificity, and logic in ACHs' Project Plans. Additionally, HCA determined that scoring would be at the Project Plan subsection level versus the individual question level. Myers and Stauffer made point allocation recommendations and incorporated HCA's requested revisions.

The draft review tool information was posted publicly from September 28 through October 13, 2017. Myers and Stauffer also held meetings with ACHs to discuss questions. Myers and Stauffer worked with HCA to make refinements based on public comment, as well as to address comments and questions received during a public webinar held on October 26, 2017. During this webinar, Myers and Stauffer also provided additional details about the process for conducting the Project Plan assessments and related timelines.

Table 3 provides the final criteria categories and related definitions. *Table 4* provides the final point allocations by subsection of the Project Plan.

Table 3. Project Plan Criteria Categories and Related Definitions

Criteria Category	Percentage of Points Received	Definition
Meets or Exceeds Criteria	100%	<p>Minor deficiencies may exist in the response, but are outweighed by the strengths. Deficiencies can be readily corrected.</p> <ul style="list-style-type: none"> • <i>Completeness</i>: Responds to all parts of the subsection, and required attachments provide all information requested. • <i>Clarity</i>: Articulates clear answers to the subsection. • <i>Specificity and Detail</i>: Conveys a depth in information through thoughtful and meaningful efforts and evolving capacity (e.g., articulates key steps, considerations, timing, and accountability; cites concrete examples of progress/achievements). • <i>Logic</i>: Provides rationale between the strategy, process, and/or mechanism and the intended impact.
Needs Moderate Improvement	80%	<p>Deficiencies exist in the response that are balanced by the strengths. Deficiencies can be readily corrected.</p> <ul style="list-style-type: none"> • <i>Completeness</i>: Responds to the subsection and provides required attachments. • <i>Clarity</i>: Answers to subsection may not be clearly articulated. • <i>Specificity and Detail</i>: Narrative lacks depth in information; supporting details or concrete examples may be missing. • <i>Logic</i>: Response may not include the rationale between the strategy/process/mechanism and the intended impact.
Needs Substantial Improvement	60%	<p>Contains significant deficiencies that are not offset by strengths. Response marginally meets the response requirements and requires extensive corrections.</p> <ul style="list-style-type: none"> • <i>Completeness</i>: Responds to the subsection and provides required attachments. • <i>Clarity</i>: Answers to subsection are not clearly articulated. • <i>Specificity and Detail</i>: Narrative lacks depth in information; supporting details or concrete examples are missing. • <i>Logic</i>: Response does not include the rationale between the strategy/process/mechanism and the intended impact.
Incomplete	30%	<ul style="list-style-type: none"> • Response does not address the topic of the subsection, and/or all required components have not been addressed.
No Submission	0%	<ul style="list-style-type: none"> • Response has not been submitted or a required attachment has not been provided.
Completed: Yes/No	N/A	<ul style="list-style-type: none"> • Attachment, Attestations, and Supplemental Workbook tabs have been submitted and are complete. • The item does not have a separate allocated score but is considered in the overall subsection rating and score. • Two exceptions are the Project Metrics and Reporting Requirements and Relationship with Other Initiatives subsections. They do not have assigned scores given they only require attestations. • Subsection will be marked incomplete if any documentation is missing.

Table 4. Project Plan Assessment: Point Allocations by Subsection

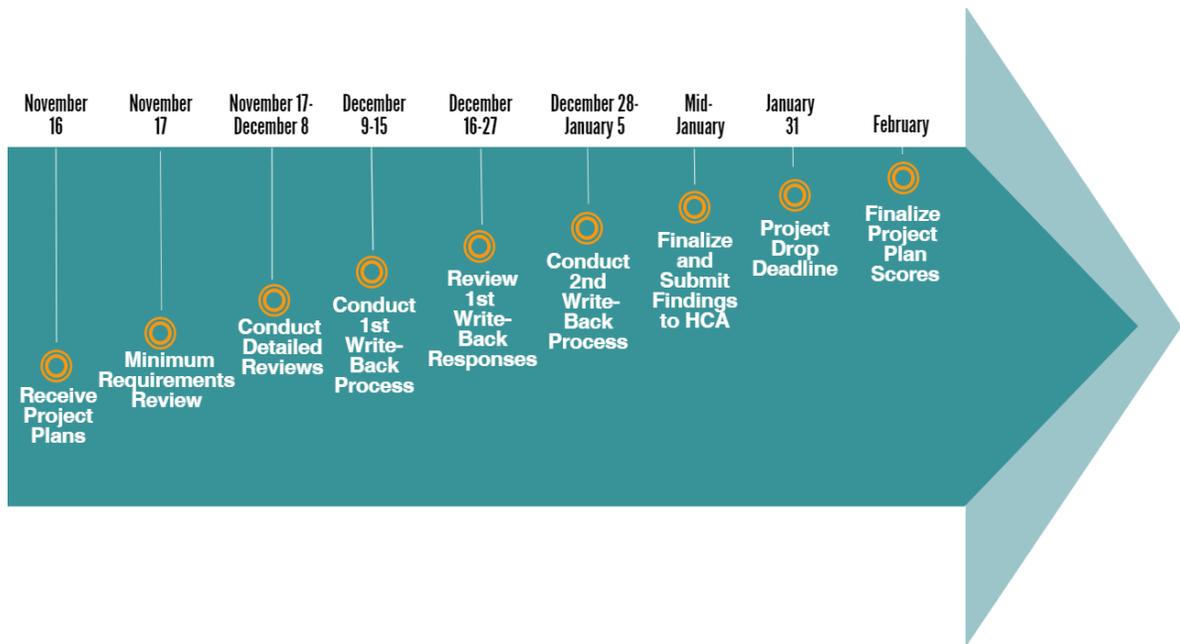
Section I: ACH Level	Total Points Available	Section II: Project Level	Total Points Available
Regional Health Needs Inventory	40	Project Selection and Expected Outcomes	25
ACH Theory of Action and Alignment Strategy	35	Implementation Approach and Timing	20
Governance	30	Partnering Organizations	20
Community Engagement and Stakeholder Input	33	Regional Assets, Anticipated Challenges, Proposed Solutions	15
Tribal Engagement and Input	33	Monitoring and Continuous Improvement	10
Funds Allocation	35	Project Metrics and Reporting Requirements	Yes/No
Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs	34	Relationship with Other Initiatives	Yes/No
		Project Sustainability	5
Section I Total Points Available	240	Section II Total Points per Project	95
Section I Percentage of Total Score	30%	Section II Percentage of Total Score	70%
Section I Available Points	72	Section II Available Points per Project	66.5

Myers and Stauffer assessed ACH responses to each Project Plan subsection based on the above criteria and related definitions. Each Project Plan subsection received a criteria rating, and based on that rating, total points were calculated.

Project Plan Assessment Timeline and Process

Figure 2 is the high-level timeline to conduct each step of the Independent Assessment followed by detailed information of the process.

Figure 2. High-level Project Plan Assessment Timeline: November 2017 to February 2018



All ACHs submitted Project Plans to Myers and Stauffer via the web portal, Washington CPAS. Upon receipt, Myers and Stauffer conducted the following review activities:

- **Minimum Submission Requirements assessment** to confirm that all required information was provided, so that Myers and Stauffer could provide immediate notification to an ACH regarding missing information.
- **Detailed assessments** conducted by Myers and Stauffer primary and secondary reviewers. Primary reviewers conducted comprehensive Project Plan assessments for completeness, clarity, specificity, and logic (as outlined in the criteria categories in *Table 3*). Reviewers identified areas of strength in the Project Plans as well as clarifications to request from the ACHs through the write-back process. They also served as the lead for communications with their assigned ACHs.

Secondary reviewers assessed subsections and projects across all ACH Project Plans. They reviewed the primary reviewers’ comments and questions to cross verify the content of the Project Plan areas to which they were assigned. They also served as a “second set of eyes,” for example, looking for specific information the primary reviewer could not locate. Secondary reviewers also reviewed consistency of comments and questions included in the write-back requests to the ACHs. They raised any inconsistencies during daily meetings with all primary and secondary reviewers and team leadership.

- **Subject matter experts** (SMEs) assessed specified subsections of ACH Project Plans. For example, Myers and Stauffer's financial SME has many years of experience in state government focusing on health care financing, budgeting, accounting, data analysis, and project evaluation, and has performed this same review for another state's independent assessment. A pharmacist served as a secondary reviewer of Project 3A: Addressing the Opioid Use Public Health Crisis.
- **Quality checks** were conducted after primary and secondary assessments, in an effort to assure reviewers captured all information and intent detailed in the Project Plans, and to increase consistency and objectivity.
- **Write-back process** to address Project Plan deficiencies. CMS indicates in the STCs that one purpose of the independent assessment is to offer recommended changes to make Project Plans approvable. Therefore, Myers and Stauffer established an assessment process to allow for scoring independently, while maintaining an overarching goal of supporting ACHs in attaining successful Project Plans in accordance with the STCs. To do so, Myers and Stauffer implemented an iterative process through which ACHs could receive up to three rounds of feedback about their Project Plan Submissions: an initial review and notification as to whether any minimum information requirements were missing from an ACH submission (as described above) followed by two rounds of "write-back" requests for additional information. This process allows opportunity for ongoing communication to identify opportunities to improve upon submitted Project Plans.

Through these communications, Myers and Stauffer provided feedback, questions, and comments to assist ACHs in identifying deficiencies in their Project Plans that may need improvement, and to submit complete and thorough information. Several ACHs requested conference calls to further discuss the needed clarifications. ACHs made significant efforts to address the identified deficiencies.

3. Project Plan Scoring

After completion of the assessment and write-back process, all ACHs were found to meet or exceed criteria in all subsections of the Project Plans, which maps to each ACH receiving 100 percent of total possible points. This scoring is based on the following as agreed upon by HCA and Myers and Stauffer:

- As shown in Table 3 above, receiving 100 percent of possible points means the project plan "Meets or Exceeds" criteria for receiving full points. It does not mean responses have no deficiencies, but that the ACH has provided sufficient documentation to address the Project Plan questions.
- Criteria rankings and scoring are based on assessment by subsections and not individual questions.
- It was recognized that, at the time of Project Plan submission and assessments, ACHs would be in the early stages of project planning. Therefore, project descriptions and information about upcoming DY2 milestones would be preliminary.

- Project Plan assessment includes the previously described write-back process which allowed Myers and Stauffer to identify recommended changes and work with ACHs to address deficiencies to make Project Plans approvable.

A number of factors contributed to the high scores, including:

- ACHs existed prior to inception of the Medicaid Transformation.
- ACHs received extensive technical assistance from HCA and Manatt in 2017, including webinars and materials that aligned with Project Plan subsections.⁴ ACHs also maintained ongoing communications with HCA and HCA’s consultants and received ongoing guidance.
- All nine ACHs successfully met expectations and passed two phases of certification.
- Each ACH provided thoughtful and detailed responses to write-back requests.

Table 5 is a summary of initial scoring prior to the write-back process and final scoring for each ACH.

Table 5. Progression of Project Plan Scores by ACH through the Write-back Process

Project Plan Scores						
ACH	Section 1		Section 2		Total Score	
	Initial	Final	Initial	Final	Initial	Final
Better Health Together (BHT)	82.92%	100%	93.16%	100%	90.09%	100%
Cascade Pacific Action Alliance (CPAA)	94.17%	100%	91.40%	100%	92.23%	100%
Greater Columbia (GCACH)	94.58%	100%	72.76%	100%	79.31%	100%
HealthierHere⁵	96.67%	100%	95.53%	100%	95.87%	100%
North Central (NCACH)	88.33%	100%	87.54%	100%	87.78%	100%
North Sound (NS ACH)	82.92%	100%	77.50%	100%	79.13%	100%
Olympic (OCH)	76.67%	100%	77.19%	100%	77.04%	100%
Pierce County (PCACH)	73.75%	100%	87.63%	100%	83.47%	100%
SWACH⁶	88.33%	100%	88.68%	100%	88.58%	100%
Average	86.48%	100%	85.71%	100%	85.94%	100%

⁴ Materials are available on the ACH Toolkit website at: <http://www.achta.org/>.

⁵ Formerly known as (FKA) King County ACH.

⁶ Formerly known as Southwest Washington ACH.

Section III — Findings Across ACHs

ACHs proposed to implement a range of four to eight projects from the Medicaid Transformation project portfolio as shown in *Table 6*.

Table 6. Proposed Projects by ACH

Project	BHT	CPAA	GCACH	HealthierHere	NCACH	NS ACH	OCH	PCACH	SWACH
2A: Bi-directional Integration of Care	●	●	●	●	●	●	●	●	●
2B: Community-based Care Coordination	●	●			●	●		●	●
2C: Transitional Care		●	●	●	●	●			
2D: Diversions Interventions					●	●	●		
3A: Addressing Opioid Use	●	●	●	●	●	●	●	●	●
3B: Reproductive and Maternal and Child Health		●				●	●		
3C: Access to Oral Health Services						●	●		
3D: Chronic Disease Prevention and Control	●	●	●	●	●	●	●	●	●

1. Summary Findings Across ACHs

Below Myers and Stauffer highlights findings, summary-level information, and opportunities identified during the Project Plan assessments that apply to all or multiple ACHs. Where appropriate, this section provides recommendations for monitoring the Project Plans as the Medicaid Transformation planning and implementation phases progress.

- Significant Planning Conducted by All ACHs:** Although Project Plans represent early thinking, it is clear that significant planning occurred to set the stage for ongoing planning in demonstration year (DY) 2. For example, ACHs have started to engage or plan to engage a variety of potential partners identified as critical participants for each project. Additionally, ACHs completed detailed analyses to understand the regions’ needs and have identified opportunities and initiatives for building projects within their regions.

- **Addressing Duplication of Regional and/or Statewide Initiatives:** ACHs identified existing initiatives or programs in their regions for which project duplication could occur. At a high-level, ACHs described collaboration that is occurring and processes that will be used to avoid duplication. A number of proposed projects are building on existing pilot programs or initiatives that may already receive federal or other state funding. **Recommendation:** HCA will want to consider opportunities for ongoing dialogue or reporting by ACHs about approaches to avoid duplication as well as ongoing confirmation from ACHs that their selected approach is not duplicative of existing pilot programs or initiatives that may already receive federal or other state funding.
- **Addressing Administrative Burden:** Providers in some instances are being asked to participate in multiple projects and each project may include multiple efforts or initiatives. Additionally, they are most likely participating in other initiatives (e.g., State Innovation Model (SIM), Medicare, other insurers). **Recommendation:** Myers and Stauffer recommends ACHs continually consider opportunities for efficiencies and coordination so as to decrease provider administrative burden and fatigue and to increase likelihood of participation.
- **Opportunities for Coordination Among an ACH's Medicaid Transformation Projects:** ACHs acknowledged that some proposed Medicaid Transformation initiatives across selected projects are complementary and will be coordinated to support transformation in the region. **Recommendation:** Each ACH should consider that target populations and partnering providers will likely overlap in many instances across the ACH's selected projects. The ACH's coordination across its selected projects will be particularly important for avoiding increased burden on partnering providers and to avoid confusion for target populations. For example, if a Medicaid beneficiary is in the targeted populations for multiple projects (e.g., Bi-directional Integration, Care Coordination, and Chronic Disease), are projects coordinated in a manner to best serve the beneficiary (e.g., to avoid multiple care plans)?
- **Target Populations and Evidence-based Approaches:** All ACHs indicated preliminary thoughts on target populations and proposed evidence-based approaches and promising practices. As HCA is aware, ACHs must provide definitions for both in DY 2. **Recommendation:** Myers and Stauffer will work with HCA to identify the information that ACHs must submit in the July 2018 Semi-annual Report to document definitions for targeted populations and evidence-based approaches and promising practices. For example, if an ACH modifies the preliminary target populations or approaches identified in its Project Plan, Myers and Stauffer will confirm they comply with requirements and support outcomes outlined in the Medicaid Transformation Toolkit. Additionally, Myers and Stauffer, with HCA, will need to determine what information, if any, to require from ACHs about potential impacts to the proposed projects.
- **Size of Targeted Populations:** Some ACHs indicated they intend to target a small number of individuals for select projects. **Recommendation:** As project planning continues, Myers and Stauffer recommends the ACHs give additional consideration to the number of individuals

targeted for a project. Myers and Stauffer recommends consideration of questions, such as the following:

- Will the number of targeted individuals support the project process and outcome measures?
 - Is the target population inclusive of all populations required to meet the project goals and objectives?
 - Will a small target population impact provider willingness to incorporate the necessary changes into their practices?
 - What monitoring procedures will be in place to assess the selected target population over time to identify and make adjustments as warranted by the project progress?
- **Workforce Challenges:** ACHs documented several regional and/or statewide strategies addressing workforce challenges including, but not limited to: tuition reimbursement, retention, recruitment, cross-training, telemedicine (including telepsychiatry), and sharing of best practices.
Recommendations: As the Medicaid Transformation progresses, it will be important for HCA and ACHs to ensure transparency in outcomes of these workforce efforts to support furthering individual project goals, as well as the broader objectives of the Medicaid Transformation. Additionally, HCA will want to understand findings of additional workforce assessments by ACHs that might impact proposed Project Plans (e.g., if a project initiative would need to change).
 - **Continued Collaboration:** ACHs are committed to continue collaboration with other ACHs, tribal partners, participating providers and internal stakeholders (i.e., members of committees, boards and Workgroups). These collaborations have resulted in shared learnings, aligned strategies, and identification of priorities. **Recommendation:** Myers and Stauffer encourages ongoing dialogue about opportunities for collaboration to support efficiency and consistency in approaches. A few example areas are as follows:
 - ACHs have noted provider engagement will continue in DY 2, acknowledging the importance of working with providers. Engagement can assist with addressing social determinants of health that influence health care delivery. This included the need to address issues such as housing and transportation. Best practices that emerge from these efforts should be shared with HCA and ACHs.
 - ACHs discuss some level of provider training for the required projects (Project 2A and Project 3A). Opportunities to share learnings and materials, should be considered by HCA and ACHs, particularly when the same evidence-based approaches or promising practices are used.
 - North Sound ACH noted that they are implementing multiple annual learning opportunities specific to health equity that will be available to participating partners,

board, and committee members. The ACH indicated it is exploring opportunities to partner with other ACH regions that have expressed interest in the trainings.

- Of the optional projects, all nine ACHs selected Project 3D: Chronic Disease Prevention and Control. *Table 7* provides a summary of preliminary chronic disease conditions indicated by ACHs for Project 3D. ACHs should consider potential cross-ACH coordination and collaboration in planning efforts, approaches, messaging to providers, learning collaboratives, and trainings.

Table 7. Project 3D, Chronic Disease Prevention and Control, Preliminary Chronic Conditions of Focus by ACH⁷

ACH Name	Respiratory Disease <i>(e.g., Asthma, Chronic Obstructive Pulmonary Disease)</i>	Diabetes	Obesity	Cardiovascular Disease	Hypertension
BHT	●	●			
CPAA	●	●		●	
GCACH		●	●		
HealthierHere	●	●		●	
NCACH		●		●	
NS ACH	●	●			●
OCH	●	●		●	●
PCACH	●	●	●	●	●
SWACH		●		●	●

- **Tribal Partnership:** ACHs documented their continuing efforts in tribal partner engagement, including how tribal and Indian Health Care Provider (IHCP) priorities are being identified, either through the ACH or through tribal/IHCP partners, and how those priorities informed project selection and planning. ACHs discussed building on existing tribal initiatives and successful practices within their projects. ACHs also provided examples of efforts being implemented to support ongoing collaboration with tribal partners, such as tribal liaisons or consultants working to strengthen relationships with tribes within respective regions. **Recommendation:** HCA’s monitoring of progress of these efforts and continued outreach for ongoing and meaningful participation will be essential.
- **Community and Stakeholder Engagement:** ACHs have conducted community and stakeholder engagement through various means, including, but not limited to: one-on-one meetings, focus groups, and development by ACHs of consumer councils within their governance structures to

⁷ As cited in ACH Plans.

inform Medicaid beneficiary experience. **Recommendation:** HCA’s continued monitoring of progress of these efforts and continued outreach for ongoing and meaningful participation will be essential.

- **Health Information Technology (HIT)/Health Information Exchange (HIE) Strategy.** ACHs described concerns that meeting the Medicaid Transformation timeframe for implementation of a successful HIE is uncertain, given complexities, costs, and timing.
- **Allocation of Project Funds:** ACHs were asked to provide the projected percent funding of the Project Incentive funds by use category over the course of the Medicaid Transformation (DY 1 through DY 5 combined). *Table 8* provides a summary of project incentive funds by use category by ACH. **Recommendation:** Myers and Stauffer found significant variability in allocations across some categories (e.g., 2 to 22 percent for Project Management and Administration). Myers and Stauffer recommends that as project planning continues, HCA request additional information about expenses being grouped into each use category and rationale.

Table 8. High-level Distribution of Project Incentive Funds by Use Category by ACH

Funding Category	BHT	CPAA	GCACH	Healthier Here	NCACH	NSACH ⁸	OCH	PCACH	SWACH
Project Management and Administration	5%	4%	5%	15%	2%	10%	22%	8%	10%
Provider Engagement, Participation, and Implementation	32%	8%	32%	33%	60%	50%	2%	12%	0% ⁹
Provider Performance and Quality Incentive Payments	23%	43%	28%	30%	23%	20%	50%	34%	26%
Health Systems and Community Capacity Building	30%	28%	17%	13%	15%	10%	19%	36%	48%
Other									
Health Systems and Community Capacity Building						10%			
Reserve/ Contingency		2%	5%	3%			3%		
Community Resiliency Fund	10%							10%	16%
Innovation Fund (CPAA); Integration Fund (GCACH)		15%	13%						

⁸ North Sound ACH has two Health Systems and Community Capacity Building use categories: one is applicable to contractors and partnering providers and the other to the ACH.

⁹ SWACH included provider engagement, participation, and implementation in the Health Systems and Community Capacity Building use category.

Funding Category	BHT	CPAA	GCACH	Healthier Here	NCACH	NSACH ⁸	OCH	PCACH	SWACH
Social Equity and Wellness Fund (HealthierHere); Community/Social Determinants of Health Projects and Consumer Empowerment; Policy and Advocacy (OCH)				6%			4% (2% each)		

Section IV — Key Findings by ACH

In this section, Myers and Stauffer provides a high-level overview of information from each ACH's Project Plan and key findings from our independent assessment.

High-level Overview

Please note that overview information is directly derived from each ACH's Project Plans. Myers and Stauffer revised wording slightly in some cases for flow; but to avoid changing content or meaning, did not make significant changes.

Project Plan Section I — ACH Level is focused on subsections that were not part of Phase I or II certifications:

- Regional Health Needs Inventory
- Funds Allocation
- Required Health Systems and Community Capacity (Domain 1) Focus Areas

For Section I, Myers and Stauffer also documented significant changes or responses to areas of improvement identified by HCA during reviews of Phase II certifications, if applicable.

Project Plan Section II – Project Level is focused on the ACH's general approach, preliminary target populations, and providers for each proposed project.

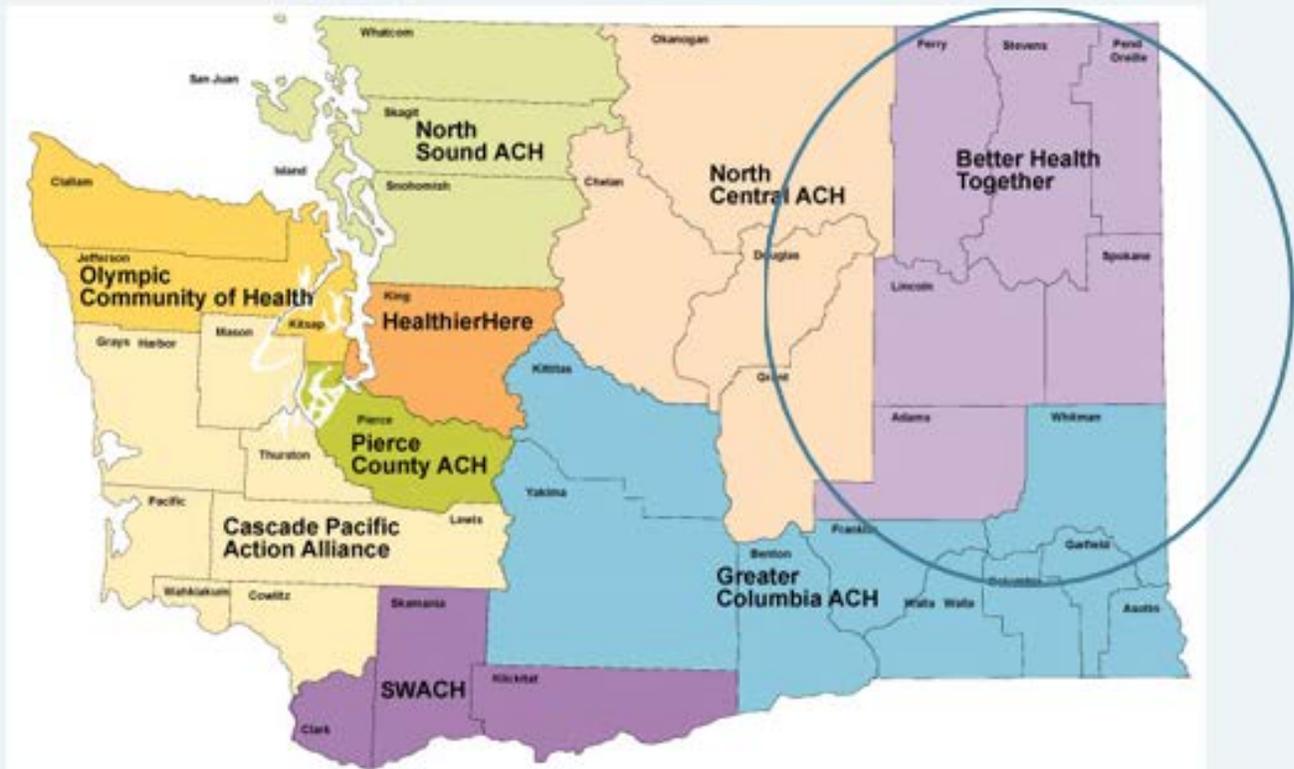
ACH Project Plans are available on HCA's website at: <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>.

Findings

Findings presented in this report focus on the following:

- **Examples of Project Plan Strengths.** Myers and Stauffer highlights examples of strengths for each ACH noted during our assessment of the Project Plan.
- **Opportunities.** Myers and Stauffer highlights opportunities for consideration as ACHs move into further planning and implementation. These include recommendations for continued monitoring or additional requests for information at later points in time and areas of consideration for the ACHs as they proceed.

Better Health Together Accountable Community of Health



Summary Findings for Better Health Together

Better Health Together	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Adams ○ Ferry ○ Lincoln 	<ul style="list-style-type: none"> ○ Pend Oreille ○ Spokane ○ Stevens
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: Spokane tribal lands and part of the Colville tribal lands are located in Stevens and Ferry counties, respectively. Kalispel Indian Reservation is located in Pend Oreille County. 	
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 175,052 	
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects Selected: <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2B: Community-based Care Coordination ○ 3A: Addressing the Opioid Use Crisis ○ 3D: Chronic Disease Prevention and Control 	

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. Better Health Together’s (BHT) regional health needs inventory was thorough and provided detailed information on the data sources used to inform project selection and planning: Health System and Care Coordination Inventories, public data resources, workforce studies, and other community datasets and reports (e.g., Spokane Urban Indian Health Profiles). BHT also described its process for providing detailed and tailored data to the Community Health Transformation Collaboratives and Councils for use in planning, monitoring, and continuous improvement.

Funds Allocation. BHT provided a detailed description of the governance structure in place to ensure effective stewardship and transparency of fund management and distribution. The BHT Board is the final decision-making body for Medicaid Transformation activities related to project selection and funds flow management. The board appointed the Medicaid Waiver Finance Workgroup, which is charged with recommending the methodology for Medicaid Transformation funding, including identifying a set of policies to govern project funding, developing an Medicaid Transformation financial plan, distributing incentive funds, and providing oversight of activities to ensure waiver compliance. The Board Finance Committee reports to the board on finances and performance compared to the annual budget and provides oversight of fund distribution. BHT has engaged the Empire Health Foundation for “back office” services, including accounting and financial support services.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. The BHT Rural and Spokane County Collaboratives will serve as the experts to address Domain 1 focus areas to support Domains 2 and 3. The ACH identified foundational investment or infrastructure needed to execute projects in Domains 2 and 3:

- Value-Based Payment: Increasing VBP adoption by identifying and addressing barriers (e.g., access to comprehensive data), serving as a resource to identify best practice partners, and providing broader communication and education to the community to establish and clarify intent to address

this important area of system transformation. The BHT Rural and Spokane County Collaboratives will develop a provider-by-provider plan to prepare the region for VBP in partnership with the MCOs.

- **Workforce Strategies:** Collaborating and sharing data with the Collaboratives, preparing for implementation of models at the Collaborative level within each project with trainings to support existing workforce, supporting efforts to expand workforce capacity through training and identification of new workforce models; and targeted conversations with partnering providers to understand priorities, including the workforce capacity of behavioral health providers.
- **Population Health Management Systems:** Use the Collaborative structure to incent shared accountability tied to HIE/HIT adoption and outcomes for population health, subcontracting with Providence CORE to create a community dashboard that will provide a broader view of community health and connect information about social determinants and clinical care, and exploring information sharing and strategy development with the Washington State Hospital Association (WSHA).

Findings for Section I

Table 9 provides findings for Section I, including examples of strengths and opportunities.

Table 9. Better Health Together Section I Findings

Findings for Better Health Together	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • To address health equity, BHT intends to initiate the Community Voices Council (CVC). The composition of the CVC is to include Medicaid beneficiaries (minimum 50 percent), and community advocates with lived experience who support others in need of community services. The CVC will support and advise on project planning, setting health equity goals, and monitoring results. • The BHT Board developed the Tribal Partners Leadership Council to ensure a meaningful collaboration with regional tribes, Indian Health Service facilities, tribal organizations, and Urban Indian Health Programs. The council includes representatives from the Kalispel Tribe of Indians, Confederated Tribes of the Colville Reservation, Spokane Tribe of Indians, The NATIVE Project, The Healing Lodge of the Seven Nations, and the American Indian Community Center. BHT will collaborate with the council to ensure projects are 	<ul style="list-style-type: none"> • BHT has multiple workgroups, teams, and committees that will support the projects. Recommendation: While the ACH described the roles and responsibilities of each, Myers and Stauffer recommends BHT provide information to HCA about finalized processes for sharing of information internally across these groups. • BHT identified issues related to patient access and provider-to-population ratios, especially for mental health and SUD treatment services. Recommendation: As project planning continues in DY 2, it may be beneficial for BHT to provide information on how proposed workforce strategies are intended to meet the needs of their region.

Findings for Better Health Together	
<p>culturally appropriate. Further, the council will have a key role in implementation planning, monitoring, and evaluating the impact on health equity as it relates to American Indian/Alaska Native health.</p> <ul style="list-style-type: none"> • BHT is utilizing a Community Health Transformation Collaborative approach through the development of two Community Health Transformation Collaboratives: a Rural Collaborative (e.g., Ferry, Stevens, Pend Oreille, Lincoln, and Adams counties) and Spokane County Collaborative. Each Collaborative will develop community-based system of care plans and monitor performance and provide shared learning. The Collaboratives will be guided by a Collaborative Compact, which includes activities and strategies needed to implement the selected projects. 	

2. Project Plan Section II Overview and Findings by Project¹⁰

As noted earlier, BHT is pursuing four Medicaid Transformation projects. Below is a high-level overview of BHT’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. The project is designed to improve the whole person care and health outcomes by using approaches of care for high-needs populations, while increasing capabilities of current physical and behavioral health integration activities. BHT intends to use approaches, such as the Bree Collaborative or the Collaborative Care Model. BHT will leverage HIT and existing care coordination infrastructure to launch integration efforts.

Preliminary Target Population. Initially, the target population is high-risk Medicaid beneficiaries with comorbid conditions. Over time, the target population will expand to the more general Medicaid membership. BHT expects that by increasing the integrated care provided to targeted members, providers will gain experience collaborating in the delivery of patient care, increase whole person care, improve results in diagnosis, treatment, and opportunities to move care upstream and prevent conditions from worsening.

¹⁰ BHT is utilizing a Community Health Transformation Collaborative approach through development of two Community Health Transformation Collaboratives: a Rural Collaborative and Spokane County Collaborative. Throughout the Project Plan Section for BHT, references to “Collaborative” or “Collaboratives” are intended to apply to these approaches.

Partners. BHT met with high-volume providers throughout the region who work on physical and behavioral health integration. Through the use of inventory surveys, the ACH was able to identify providers interested in the project areas. BHT indicated that they have engaged a broad range of providers, including physical and behavioral health providers, tribal partners, county providers, social service agencies, and MCOs.

Project 2B: Community-based Care Coordination

General Approach. The Project Plan defines the Community-based Care Coordination project as a strategy to connect the project portfolio and to develop “accountable linkages between clinically based health care services with the community-based services” that play a key role in improving health outcomes.

BHT will utilize the Pathways Community HUB model to focus on empowering individuals to develop a care plan that meets their needs, increase access to a network of culturally informed providers, and utilize a data infrastructure that can be used to monitor care, gaps in care, and provider quality. The region has shown some experience with the Pathways model through Spokane being awarded a \$1 million grant to utilize Pathways with the local initiative to reform the local criminal justice system.

BHT based this project on experiences of the Ferry County Jail Transitions Pilot, which was funded by the Washington SIM. The pilot offered opportunities to work with providers from criminal justice, the hospital, clinics, and community health workers to develop a model to support individuals exiting jail.

Preliminary Target Population. High-risk pregnant mothers and people transitioning out of jail. BHT selected these populations as they typically have poor health outcomes, are high utilizers of community services, and generate high health care costs. BHT may expand to additional Medicaid groups in future years.

Partners. The Letter of Intent (LOI) process identified numerous provider organizations interested in pursuing the Pathways model, including physical and mental health providers, housing and social services, law enforcement, and the justice system.

Ensuring Health Equity¹¹

- Community Health Transformation Collaboratives ensure focus on local disparities.
- Community Voice Council includes Medicaid beneficiaries or low-income community members.
- Target populations using an equity lens by disaggregating data when possible.
- Lived experience through community health workers.
- Equity Accelerator Payment, which provides incentive to providers who serve a greater proportion of high-risk clients.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. BHT is committed to the promotion of prevention, access to treatment, overdose prevention, and recovery of opioid misuse. BHT is focusing on local needs and resources. The Collaboratives (as described in Project 2A) will identify community-level social determinants of health that are potential areas to target. Education of providers, consumers, and community members will increase

¹¹ Text boxes across all ACH Project Plan overviews are reflective of information in the Project Plans.

understanding about the causes of opioid misuse, alternatives for pain management, and opportunities to receive treatment and recovery assistance.

BHT intends to address opioid issues in the region through four interconnected initiatives:

1. **Prevention:** Improving provider prescribing practices through the Transformation Collaboratives by using the Six Building Blocks for Clinic Redesign for Safer Opioid Prescribing and Transformed Care for Chronic Pain; training and coaching opportunities; and non-opioid pain management practices.
2. **Treatment:** Supporting providers and increasing access to services by educating providers to identify potential opioid misuse, opioid use disorder (OUD), and treatment options; targeting high-impact patients for specialized interventions and education (including pregnant and parenting mothers).
3. **Overdose prevention:** Increasing availability and use of Naloxone; education of targeted consumers on how to recognize an overdose.
4. **Recovery:** Improving access to recovery supports and long-term stabilization.

Preliminary Target Population. Medicaid beneficiaries, specifically adult and youth beneficiaries who use, and/or misuse prescription opioids or heroin.

Partners. Collaboratives will be comprised of key partners, including clinics, Federally Qualified Health Centers (FQHCs), hospitals, mental health and substance use providers, public health, tribal health systems, EMS, jails, and county commissioners. Also, through the use of inventory surveys and LOIs, the ACH was able to identify provider interest in the project areas. BHT commented that 17 organizations that completed a Health Systems Inventory expressed interest in serving as a partnering provider on an Opioid Response project. They noted that providers and organizations involved serve the majority of Medicaid beneficiaries in the region. BHT also plans to collaborate with the ARCORA Oral Health Spokane Local Impact Network Opioid Task Force.

Project 3D: Chronic Disease Prevention and Control

General Approach. Each Collaborative is responsible for aligning the Chronic Care Model with their providers, Medicaid population, and other factors.

BHT intends to accelerate efforts to improve health with an initial focus on controlling and preventing Type 2 diabetes. BHT selected Type 2 diabetes based on the following:

- The significant impact controlling the disease can have on the overall health of the Medicaid population.
- The cost of health care shown through the bending of the disease's cost curve.

Specific project strategies include increasing access to care, educating consumers and their families, identifying risks earlier, increasing coordination of services that link clinical providers and services to social supports and other service needs, supporting healthy choices, and developing a regional approach to community paramedicine.

Preliminary Target Population. Individuals with Type 2 diabetes are the initial target population for which each Collaborative will develop an integrated plan to address the target population based on data from individual counties. BHT indicated that they anticipate an additional emphasis on individuals with comorbid behavioral health needs and diabetes. BHT also noted that it is considering focusing on childhood asthma.

Partners. BHT indicated that they identified potential partners by requesting stakeholders submit optional LOIs and received responses from providers in each county. Additionally, 39 organizations in the BHT region, representing most major health and social service systems, completed the ACH’s inventory surveys.

Findings and Scoring for Better Health Together

Table 10 provides findings, including examples of strengths and opportunities.

Table 10. Better Health Together Findings

Findings for Better Health Together	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> The Health System Inventory (HSI) and Care Coordination Inventory (CCI) indicate that BHT’s partnering providers serve a significant number of Medicaid beneficiaries (i.e., over 80 percent of Medicaid billings). The MCOs are members of the BHT leadership board and councils to promote alignment between MCO goals and activities with BHT selected projects. MCO representatives are on the BHT Regional Integration Planning Team, Waiver Finance Workgroup, Provider Champions Council, and Community Voices Council. BHT, PCACH, and SWACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under the Medicaid Transformation, such as alignment with current MCO goals, provider support related to delivery system reform and value-based payment, beneficiary overview, engagement, and education, etc. BHT is launching a Provider Champion Council to gain practicing provider perspective and to inform project planning proposed by the Collaboratives. The council 	<ul style="list-style-type: none"> Mitigation of project duplication will be managed at the local level with the Community Health Transformation Collaborative. Recommendation: As project planning progresses, it may be beneficial for BHT to assess the effectiveness of the Collaboratives in avoiding duplication. BHT’s Health Systems Inventory indicated a strong provider interest in the expansion of telemedicine services. Recommendation: Although the ACH intends to continue to explore options for expanding these services, especially for providers in rural areas, it may be beneficial for HCA to obtain updates as planning and implementation progresses. Specific to Project 3A, although a significant number of Medicaid beneficiaries are served by providers identified in the HSI and CCI, BHT continues to pursue additional providers, such as SUD and OUD providers. Recommendation: As the ACH’s planning and implementation

Findings for Better Health Together

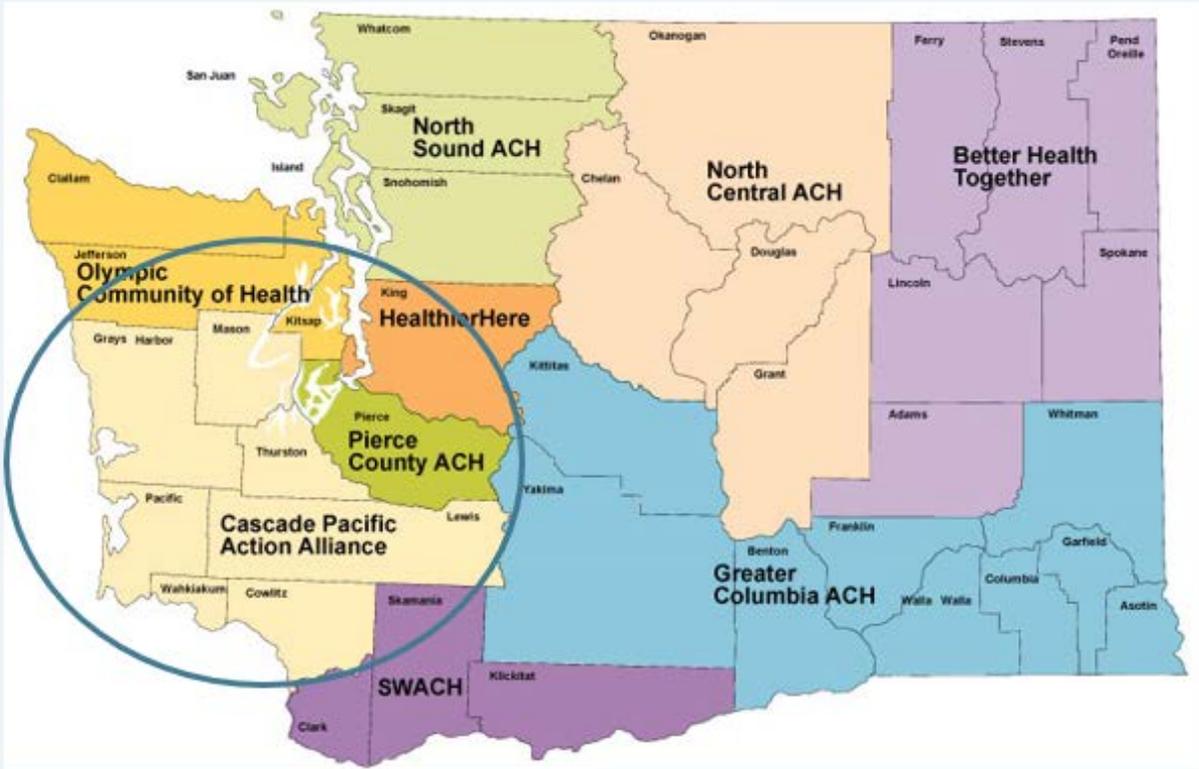
<p>will monitor trends in performance across the Collaboratives and advise on technical assistance needs.</p> <ul style="list-style-type: none"> • Providence CORE will coordinate with BHT staff, the Provider Champion Council, and others to provide timely information, data interpretation expertise, technical assistance, and strategic support for peer learning and continuous improvement. • BHT intends to implement Equity Accelerator Payments, an incentive to support providers that serve a greater proportion of high-risk clients. The metrics tied to these payments will be determined by the Waiver Finance Workgroup, vetted by Provider Champions Council and Community Voices Council, and approved by the BHT Board. • Specific to Project 2A, BHT is exploring potential telehealth options for behavioral health services to provide access for Emergency Department (ED) consultations, medication management, support of the primary care team, and for ongoing care of individuals with chronic behavioral health issues. • Specific to Project 2B: <ul style="list-style-type: none"> - BHT will leverage Pathways’ experience with the Ferry County Jail Transitions Pilot funded by the Washington SIM. The pilot offered opportunities to work with providers from criminal justice, hospital, clinics, and community health workers to support individuals exiting jail. - The Care Coordination Inventory survey detailed existing coordination efforts across 29 agencies. The Collaborative will build on this information to outreach to associated providers critical to the project's success. • Specific to Project 3A: <ul style="list-style-type: none"> - The Six Building Blocks for Clinic Redesign for Safer Opioid Prescribing and Transformed Care for Chronic Pain are approaches selected by the BHT. Similar to other ACHs, BHT stated the inclusion of the proposed program is based on provider support, including support from tribal partners. - BHT participates in a statewide weekly call with tribal health providers and other ACH tribal engagement staff to discuss a coordinated strategy to address the opioid crisis. 	<p>continues, it may be beneficial for the ACH to confirm the adequacy of the number and geographic location of SUD providers to ensure that the region is fully served.</p>
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Myers and Stauffer submitted one write-back request to BHT as part of the assessment process. *Table 11* provides an overview of the resulting scores. At the end of the process, the ACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 11. Better Health Together Scoring

Better Health Together		
	Initial Score	Score After 1st Write-Back
Section 1 Score	82.92%	100%
Section 2 Score	93.16%	100%
<i>Section 2 Projects:</i>		
2A	90.53%	100%
2B	95.79%	100%
3A	86.32%	100%
3D	100.00%	100%
Total Score	90.09%	100%
Bonus		0%
Final Score		100%

Cascade Pacific Action Alliance Accountable Community of Health



Summary Findings for Cascade Pacific Action Alliance

Cascade Pacific Action Alliance	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Cowlitz ○ Grays Harbor ○ Lewis ○ Mason 	<ul style="list-style-type: none"> ○ Pacific ○ Thurston ○ Wahkiakum
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: Seven federally recognized tribes are in located in the CPAA region (Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinault Indian Tribe, Shoalwater Bay Indian Tribe, Squaxin Island Tribe, and Skokomish Indian Tribe). 	
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 165,422 	
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects 	
<ul style="list-style-type: none"> Selected: ○ 2A: Bi-directional Integration of Care ○ 2B: Community-based Care Coordination ○ 2C: Transitional Care 	<ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3B: Reproductive and Maternal and Child Health ○ 3D: Chronic Disease Prevention and Control

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. Cascade Pacific Action Alliance’s (CPAA) Regional Health Needs Inventory was found to be comprehensive. CPAA noted use of updated regional health needs data and data review by Providence Center for Outcomes Research and Education (CORE). Examples of data sources/sets used included, but are not limited to: U.S. Census, Community Health Assessments, aggregate data products provided by HCA, data from community partners, WA First Steps Database, Employment Security Department Reports, Healthier Washington dashboard, and Washington Department of Health. CPAA documented that they also collected primary data through community surveys, provider focus groups, and local community meetings. CPAA provided statistics about the region’s health needs to support the six projects selected.

Funding Allocation. CPAA’s Board of Directors has ultimate decision-making authority for which implementation partners will receive funding, and the Finance Committee has primary accountability for ensuring oversight of CPAA finances. The CHOICE Board may override CPAA LLC decisions if they interfere with CHOICE’s nonprofit status. CPAA adopted the CHOICE Network’s Accounting and Financial Policy and Procedures, which include:

- Review and Update: Annual review of existing Financial and Accounting Policies for completeness and necessary revisions.

- **Transparency:** All CPAA meetings are open to the public, except executive sessions of the board. The public may comment at meetings. Meeting minutes and financial statements are posted to the website for review.
- **Budget Revisions:** Initiated in the event of a substantial deviation greater than 10 percent of CPAA’s board-approved annual budget.
- **Financial Performance:** Monthly and year-to-date statement of financial performance versus budget will be produced and reviewed with the management team and Finance Committee.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. CPAA provided a table of Domain I foundational investments or infrastructure needed at the provider level to carry out projects in Domains 2 and 3. Examples of foundational investments or infrastructure needs per Project Plan category include:

- **Value-Based Payment:** Training for partnering providers on VBP, convening payers to align expectations for providers and outcomes, and identify and work with agencies such as Qualis and the Practice Transformation Hub to prepare providers for VBP.
- **Workforce:** Telemedicine expansion, Learning Collaboratives for partnering providers, and tuition support for key shortage areas.
- **Population Health Management Systems:** Provider registries, care coordination software, and Health Information Technologies (HIT) systems that support partnering providers to participate in VBP and that allow for cross-system data sharing between partnering providers, MCOs, and HCA.

Findings for Section I

Table 12 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 12. Cascade Pacific Action Alliance Section I Findings

Findings for Cascade Pacific Action Alliance	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • CPAA documented that they performed robust stakeholder engagement in determining project selection: consumer focus groups, an online community survey, and requesting public comments on project selection through its website and social media platforms, among other activities. • CPAA appointed a consumer representative to both CPAA’s board and council to ensure a consistent consumer viewpoint in decision making. • CPAA hired a Community and Tribal Affairs Liaison to outreach to tribal health directors and tribal councils 	<ul style="list-style-type: none"> • CPAA has multiple workgroups, teams, and committees (e.g., CPAA Support Team, Clinical Provider Advisory Committee) that will support the projects. Recommendation: While CPAA described the roles of each, Myers and Stauffer recommends CPAA incorporate information into its communication plan about finalized processes for sharing of information internally between these groups.

Findings for Cascade Pacific Action Alliance	
<p>to begin discussions around strengthening the partnership between tribes in the region and CPAA. The liaison has modified CPAA’s tribal engagement plan, set up tribal health trainings and discussions for the board and council, as well as meetings between CPAA staff, board members, and tribal partners.</p>	

2. Project Plan Section II Overview and Findings by Project

As noted earlier, CPAA is pursuing six projects for the Medicaid Transformation. Below is a high-level overview of CPAA’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. CPAA plans to address physical and behavioral health needs of children and adults through an integrated system of care that centers on whole-person health. Partnering providers will use shared care plans, track treatments in new patient registries, use evidence-based screening tools and treatment, and receive compensation for quality of care and clinical outcomes through VBP. CPAA will use all the approaches listed in the Medicaid Transformation Toolkit, the Collaborative Care Model, and Bree Collaborative Behavioral Health Integration Recommendations, within the primary care setting. CPAA stated that in behavioral health settings, primary care integration approaches focus on implementing off-site, enhanced collaboration; co-located, enhanced collaboration; or co-located, integrated care, along with the core principles of collaborative care.

Preliminary Target Population. Individuals who are homeless or new to the area, those without a primary care provider (PCP) using the ED as their main access point for care, those with transportation barriers in urban and rural settings, patients in hospice seeking care, Hispanic families with fear around accessing care, elderly individuals, young parents ages 18 to 24, and the geographic area of eastern Lewis County.

Partners. Partners include, but are not limited to: FQHCs, Critical Access Hospitals, behavioral health agency, tribal health clinic, Community Action Council, and a private physician-owned pediatric clinic. Some implementation partners currently serve on CPAA project workgroups.

Project 2B: Community-based Care Coordination

General Approach. CPAA will implement the Pathways Community HUB to improve care coordination between systems of care. CPAA will serve as the HUB Administrator, and use a phased project implementation approach initially with up to six Care Coordinating Agencies, which over time will increase in number and caseloads.

Preliminary Target Population. Pregnant mothers, homeless individuals, and frequent Emergency Medicaid Service (EMS) utilizers as populations of particular concern that could lead to significant regional savings as they improve health outcomes with the Pathways model.

Partners. Potential partners including, but not limited to: Area Agency on Aging and Disability, child and adolescent clinic, fire district, hospitals, behavioral health organization, housing assistance organization and medical clinic(s).

Project 2C: Transitional Care

General Approach. CPAA developed a regional action plan for improving transitions of care with key health care providers and payers. The regional action plan lists five main action areas that need to be addressed to achieve improved health outcomes for patients, avoid preventable ED visits and hospital readmissions, and decrease health care costs. The five areas are: target the intervention, identify key care providers, notify key care providers, coordinate transitions, and activate patients. CPAA will implement the following approaches listed in the Medicaid Transformation Toolkit: Intervention to Reduce Acute Care Transfers, Transitional Care Model, the Care Transitions Intervention, and Care Transitions Interventions in Mental Health. Their aim is “to improve care transitions so that community members are getting the right care in the right place at the right time.”

Preliminary Target Population. Individuals who are homeless; those without a PCP using the ED as the main access point for care; dual-eligible Medicaid and Medicare beneficiaries; individuals who frequently use EDs, urgent cares, or inpatient hospitalizations; individuals involved with the juvenile justice system; and isolated, rural communities. Target population(s) may be refined to include populations for all-cause 30-day readmissions, avoidable ED utilization, psychiatric inpatient 30-day readmission, and others.

Partners. Partners include, but are not limited to: hospitals, fire district, Community Action Program, family health center, and physicians. Additional partners CPAA is reaching out to support the project: skilled nursing facilities, Area Agencies on Aging, criminal justice partners, EMS, DSHS community service offices, local public health, tribal and IHCPs, and other CBOs.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. CPAA documented that they may implement evidence-based approaches and promising practices included in the Medicaid Transformation Toolkit for Project 3A. In addition to employing Medication Assisted Treatment (MAT) and Harm-Reduction, CPAA will work with the Opioid Response Workgroup to identify additional strategies that may need to be included to reach the desired outcomes. CPAA wrote this project “... will support sustainable health system transformation for the chosen target populations by assisting providers to adopt a whole-person approach to care that is patient-centered and focused on providing accountable care. This will require changes in partnering providers’ work flow, business practices, and staffing patterns to support team-based care, treatment to target, and population-based care. Investments in this project will be supported by the other projects that CPAA is implementing, including Bi-directional Care Integration, Community Care Coordination (Pathways HUB), and Maternal and Child Health.”

Preliminary Target Population. Incarcerated populations, injection drug users/individuals who utilize needle exchange programs, individuals with Hepatitis C, individuals with HIV/AIDS, homeless populations, pregnant and parenting women with OUDs, individuals with inadequate control of SUD and behavioral health issues (e.g., multiple ED visits and hospital readmissions related to drug use), and individuals living in rural areas with limited access to OUD treatment. CPAA noted the target population(s) will be refined during implementation planning.

Partners. Potential partners include, but are not limited to: hospitals, short- or long-term inpatient chemical dependency programs, outpatient chemical dependency treatment programs, multi-site behavioral health care organizations, syringe exchange programs, and public health departments.

Project 3B: Reproductive and Maternal and Child Health

General Approach. CPAA stated that through this project and related interventions, they plan to pursue the following approaches listed in the Medicaid Transformation Toolkit for Project 3B:

- Reduce adverse childhood experiences (ACEs) passed down to the next generation in the region by coordinating and expanding home visiting programs.
- Expand primary care and reproductive care through One Key Question[®], pregnancy intention screening, training on trauma informed practices, and highly effective contraceptive methods, including long-acting reversible contraception (LARC).
- Expand implementation of Bright Futures guidelines or Enriched Medical Home Intervention into clinical models, as well as work with MCOs, pediatricians/family practitioners, and children's stakeholder groups to improve well-child visits.

Preliminary Target Population. High-risk obstetric patients, patients with SUD diagnosis, families in Kinship Care, individuals who are homeless or at risk for homelessness, and patients with serious mental illness (SMI) diagnosis.

Partners. Potential partners within the region that have participated consistently in planning for the Reproductive and Maternal and Child Health project include but are not limited to: MCOs, tribes, public health agencies, Community Care Action Council, Sea Mar CHC, health care systems and hospitals, Northwest Venture Philanthropy, NAMI of Southwest Washington, Planned Parenthood, Centralia College, Department of Early Learning, Capital Region Educational Services District 113, Child and Adolescent Clinic, and Behavioral Health Resources.

Project 3D: Chronic Disease Prevention and Control

General Approach. CPAA stated that they are considering the Chronic Care Model, The Community Guide, Community Paramedicine, Chronic Disease Self-Management, and Million Hearts[®] interventions to improve chronic disease prevention and management. CPAA noted the Domain 2 Workgroup identified the Chronic Care Model as the approach, along with several specific strategies, to address chronic disease prevention, treatment, and management. CPAA will collaborate with partnering providers and advisory

committees to establish best practices for implementing the Chronic Care Model approach, specifically to improve health of those living with asthma, diabetes, and heart disease. Other approaches CPAA is considering include: The Community Guide, Community Paramedicine, Chronic Disease Self-Management, and Million Hearts® interventions.

Target Population. Medicaid beneficiaries in the CPAA region with one or more chronic diseases or with one or more chronic disease and a comorbid behavioral health disorder; Medicaid beneficiaries in Mason, Thurston, and Grays Harbor counties with diabetes; Medicaid beneficiaries in Thurston, Lewis, and Mason counties with heart disease; and Medicaid beneficiaries in Grays Harbor, Lewis, and Wahkiakum counties with asthma.

Partners. Active and potential partners include, but are not limited to: FQHCs, Area Agency on Aging and Disabilities, MCOs, hospitals, tribal health clinic, Independent Physician Association, and public health and social services. CPAA noted recruitment of specific clinical and community-based partnering providers will be directed by their decisions about target population(s) and sub-regions for this project.

Findings and Scoring for Cascade Pacific Action Alliance

Table 13 provides a listing of findings, including examples of strengths and opportunities.

Table 13. Cascade Pacific Action Alliance Findings

Findings for Cascade Pacific Action Alliance	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> CPAA stated that they will convene all partnering providers once per quarter to participate in a peer-learning collaborative that will provide an opportunity to share successes as well as to raise implementation challenges that the partners can then engage on jointly to resolve. CPAA noted learning collaboratives will occur for all six projects. A noted strength across several projects is the use of a Project Champion. CPAA stated that in instances where engagement from missing key Medicaid partners should prove challenging, they will ask their Provider Champions from the Clinical Provider Advisory Committee and Transitional Care Workgroup to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. Specific to Project 2A, all partnering providers who are interested in implementing collaborative care principles have electronic health record (EHR) systems, some of which may have interoperability with other data systems. 	<ul style="list-style-type: none"> Attribution is listed as a barrier across applicable projects, with CPAA noting they need to assure accurate, agreed-upon patient-provider attribution to support VBP mechanisms. CPAA has not elaborated on how it will address this challenge. Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends HCA continually work with CPAA and other ACHs to understand if and how attribution will apply. Specific to Project 2B, CPAA is working to obtain and implement a new care coordination health information software platform to support region-wide improvement. CPAA stated that rather than looking at aggregated populations or at data from individual providers, the care coordination software will allow the region to understand service utilization at the individual patient level. Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends CPAA further consider if and how such a platform will

Findings for Cascade Pacific Action Alliance

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| <ul style="list-style-type: none"> • Specific to Project 2B: <ul style="list-style-type: none"> ○ CPAA noted they will pursue a rigorous HUB certification process as well as seek technical assistance from national Pathways model and community health worker experts to inform planning and implementation. ○ For smaller providers, especially social services providers, CPAA may handle Medicaid billing and reimbursements. This initiative may remove a major barrier to provider capacity expansion and provide a stable funding source for the Pathways HUB. • Specific to Project 2C: <ul style="list-style-type: none"> ○ CPAA will utilize an agreed-upon regional action plan that is already in place to address key action areas required to achieve improved transitions of care. ○ CPAA noted quarterly reports from Qualis Health for five of the seven counties in the region have provided important insights into care transition processes and key metrics. • Specific to Project 3A, CPAA noted existing syringe exchange programs in three counties will be a benefit given CPAA's focus on efforts for people to utilize needle exchanges where trusted relationships help facilitate Harm Reduction strategies. Also, connecting people who are ready for addiction recovery services and treatment is another way to reach people living in rural areas with limited OUD services. • Specific to Project 3B: <ul style="list-style-type: none"> ○ The ACE Workgroup, established prior to the Medicaid Transformation, identified strategies to reduce and mitigate the effects of ACEs. CPAA plans to build on an environmental scan conducted by the ACE Workgroup to determine current state analysis for this project. ○ For smaller providers, especially social services providers, CPAA may handle Medicaid billing and reimbursements. This initiative may remove a major barrier to provider capacity expansion and provide a stable funding source for the Pathways HUB. | <p>integrate with other systems that are in use by providers or are being considered for the region/ statewide.</p> <ul style="list-style-type: none"> • Specific to Project 2C: <ul style="list-style-type: none"> ○ Recommendation: As partner engagement continues in DY 2, Myers and Stauffer recommends CPAA assures sufficient outreach to seek commitments from social services partners. ○ CPAA listed expansion of the number of community health workers as a required infrastructure investment. Per review of the documentation, community health workers are discussed at a high level.
Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends CPAA provide details to HCA about the approach for utilizing and expanding the number of community health workers. • Specific to Project 3A, CPAA indicated that they do not yet have a youth-specific OUD intervention, but are working to identify prevention and recovery organizations and providers to participate. They note this has been challenging, as many providers are struggling to recognize their connection to this project area. CPAA noted opportunities they plan to leverage, and indicated they are working to identify prevention and recovery organizations and providers who work with youth.
Recommendation: As partner engagement continues in DY 2, Myers and Stauffer recommends HCA request additional information about CPAA's progress in addressing this challenge. • Specific to Project 3B, CPAA noted the lack of standardized referrals for home visiting programs as a challenge. A noted mitigation strategy is to connect the RMCH project with the Pathways HUB project to support coordination of referrals.
Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends CPAA |
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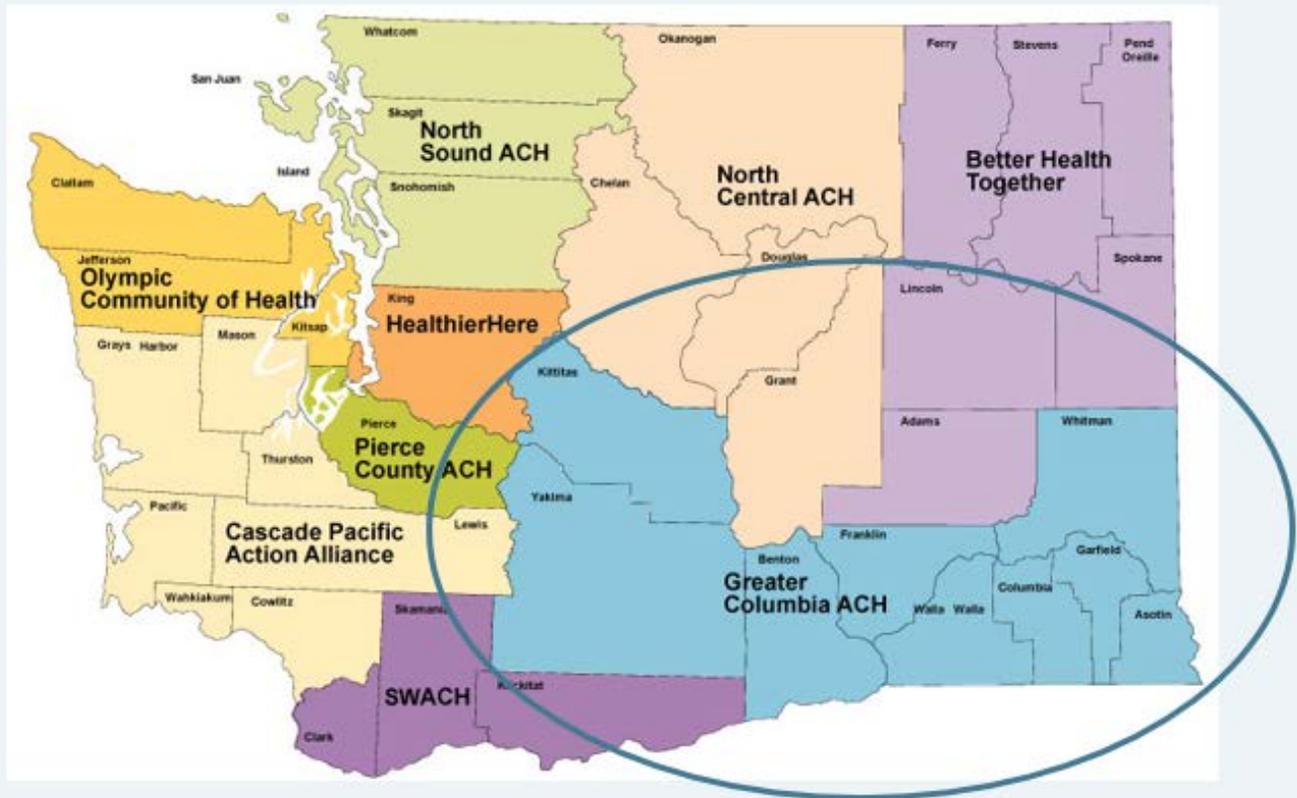
Findings for Cascade Pacific Action Alliance	
<ul style="list-style-type: none"> Specific to Project 3D, to address geographic challenges, CPAA listed a potential mitigation strategy as developing a transportation assistance program by leveraging transit systems and using gas vouchers. 	provide details to HCA as to the finalized approach to connect the RMCH project with the Pathways HUB project.

Myers and Stauffer submitted one write-back request to CPAA as part of the assessment process. *Table 14* provides an overview of the resulting scores. At the end of the process, CPAA was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 14. Cascade Pacific Action Alliance Scoring

Cascade Pacific Action Alliance		
	Initial Score	Score After 1st Write-Back
Section 1 Score	94.17%	100%
Section 2 Score	91.40%	100%
<i>Section 2 Projects:</i>		
2A	93.68%	100%
2B	93.68%	100%
2C	93.68%	100%
3A	85.26%	100%
3B	88.42%	100%
3D	93.68%	100%
Total Score	92.23%	100%
Bonus		10%
Final Score		100%

Greater Columbia Accountable Community of Health



Summary Findings for Greater Columbia ACH

Greater Columbia ACH	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Asotin ○ Benton ○ Columbia ○ Franklin ○ Garfield 	<ul style="list-style-type: none"> ○ Kittitas ○ Walla Walla ○ Whitman ○ Yakima
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: The Yakama Indian Reservation is located in Yakima County. 	
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 227,331 	
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects 	
<ul style="list-style-type: none"> Selected: <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2C: Transitional Care 	<ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3D: Chronic Disease Prevention and Control

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. Greater Columbia ACH (GCACH) completed a Regional Health Improvement Plan (RHIP) in 2016, which built upon previous work by GCACH stakeholders. The RHIP utilized previous and new data sources to inform project selection and planning, including HCA eligibility and claims data, socio-economic and demographic maps and statistics, community partner data, and hospital data and statistics. Data analysis identified high-level areas of health concern for the region and assisted in support of the four projects selected.

ACH Theory of Action and Alignment Strategy. Phase II certification noted a lack of specificity regarding leveraging the Medicaid Transformation to advance regional health priorities for the entire population. GCACH responded that it held strategy sessions to identify opportunities for alignment across projects, shared target populations, and connections to broaden efforts within the region. GCACH employed a two-pronged strategy to support a robust regional health needs assessment: Data-driven evaluation of regional and county-level health needs and broad cross-sector, region-wide collaboration and engagement to develop solutions addressing these needs.

High-level Areas of Health Concern
<ul style="list-style-type: none"> ■ Potentially avoidable ED visits ■ Opioid abuse among chronic users (>30 days) across genders, ages, and ethnic groups ■ Mental health and chemical dependency/substance abuse treatment penetration ■ Well-child visits ■ High teen pregnancy and sexually transmitted disease rates

Governance. GCACH lists the following changes since the Phase II Certification:

- The Workforce, Data and HIE, Budget and Funds Flow, and Communications Committees assisted in developing the Project Plan and provided guidance on specific strategies, particularly in Domain 1.
- The open seat for a representative to the consumer sector on the GCACH Board was filled.
- A Sector Representation Policy was developed that defines the expectations of GCACH Directors who represent their sectors.

Community and Stakeholder Engagement. Based on Phase II certification reviews, HCA requested defined indicators of success for meaningful community engagement and specific examples of how provider input informed project planning and selection. Multiple stakeholder and partner meetings were attended by GCACH. Issues learned through the community engagement process shaped projects chosen, especially regarding barriers in the existing system. GCACH indicated three key elements shaped by community input:

- **Integration:** The Bi-directional Integration Project Team chose to adopt all four approaches based on community input that there be multiple entry points in the system, data must be sharable, and care would be coordinated.
- **Coordination:** Stakeholders and providers requested latitude to implement care coordination approaches to match needs and characteristics of their patient populations and providers' capabilities.
- **Use of Community Health Workers:** There are disparities of care throughout the region due to poverty, education, and cultural barriers. Using community health workers provides strong social supports within the community to address cultural differences and reduce barriers to care.

Funds Allocation. The GCACH Board of Directors serves as the primary decision-making body that includes the approval of funds flow allocation and distribution. The ACH has hired Chief Financial Officer (CFO) leadership to oversee and direct the budget and funds flow development. Currently, the ACH has retained Health Management Association to provide interim financial support during staff recruitment for direction and management of finance department functions.

The Finance Committee is responsible for developing and overseeing processes to support the financial success of GCACH and for the establishment of financial controls to ensure compliance with DSRIP program requirements. Under the Finance Committee is a Budget and Funds Flow Committee that recommends a funds flow approach and distribution plan while also developing provisions for monitoring and modifying the funds flow methodology during the Medicaid Transformation.

Policies and procedures are under development and will address accounting procedures, the monthly financial statement preparation and presentation, budget preparation and modification, and the budget-to-actual reporting. An existing procedure allows the Executive Director and Finance Manager to make

budget changes up to a certain threshold. The Finance Committee and Board must approve any changes above the threshold.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. GCACH

identified investments and infrastructure needed to carry out projects in Domains 2 and 3, and how capacity building in Domain 1 will support selected projects. Examples include:

- Investments in workforce will need to happen prior to project implementation so training and integration can happen in care teams. This will assist with increased access to primary care. The GCACH Workforce Committee is developing a plan in six stages for the next Medicaid Transformation year.
- Investments in population health management infrastructure, such as business intelligence tools to aggregate data and provide patient level information, will be needed across the care coordination network early to build capacity and support for providers. This will help the region collaborate and share needed information to support population health management.
- A regional health directory is envisioned to help beneficiaries easily find services and supports.
- Investment in VBP provider education will ramp up in 2019-2020 to support the VBP goal by 2021. There will also be allocated funding for subject matter experts and speakers to support projects and provide education to help them develop VBP readiness plans and better understand VBP models.

Six Stages of Workforce Plan Development

- Conduct comprehensive assessment of existing workforce needs and cross-walk to the four project areas.
- Identify options and alternatives for addressing workforce needs.
- Map options and alternatives to each community through the LHINs.
- Identify resources necessary for each community to implement identified strategies.
- Create workforce workplan for each LHIN and a master workplan for entire region.
- Create process for ongoing monitoring and course correction.

Findings for Section I

Table 15 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 15. Greater Columbia ACH Section I Findings

Findings for Greater Columbia ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> GCACH is creating Local Health Improvement Networks (LHINs) to advance health initiatives in their own communities. The LHINs have existing relationships with local health care delivery systems and can address specific community needs. Using the Area Deprivation Index, LHINs will measure neighborhood socioeconomic deprivation and determine priority neighborhoods to address health disparities for target populations. The Data Management and Health Information Exchange Committee will conduct a data assessment project to inventory HIT/HIE system capabilities of partnering providers. This inventory will be used to assess the systems and processes in place to facilitate future integration across the region. Tribal representatives have communicated the need for HIT infrastructure support and a desire to develop a tribal Medicaid Transformation project plan. GCACH has committed funds to support tribal HIT infrastructure and consultation as well as a tribal transformation plan. 	<ul style="list-style-type: none"> GCACH has identified issues related to patient access, including low provider-to-population ratios for primary care, dentistry, and behavioral health; low penetration of mental health and SUD treatment; and supportive housing. Social service needs must be addressed for improved health care utilization to be sustainable. Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends HCA review GCACH’s progress in developing workforce strategies that will meet the needs of their region in these identified areas. Attribution is listed as a significant challenge with GCACH noting that “Attributing the patient to some sort of medical home is vital for accountability, report, and incentive funds flow and has already been an area of discussion with HCA, the MCOs, and ACHs.” GCACH did not elaborate further on how it will address this challenge. Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends HCA continually work with CPAA and other ACHs to understand if and how attribution will apply.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, GCACH is pursuing four projects for the Medicaid Transformation. Below is a high-level overview of GCACH’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. This project will support providers to adopt a continuum of complementary integration approaches to optimize delivery system resources, tailor services based on patient complexity levels, and increase access to behavioral health services. GCACH has elected to utilize all approaches identified in the Medicaid Transformation Toolkit to allow for the differing practice needs of partnering providers. Based on the current state capacity assessment, GCACH and the Bi-directional Integration Project Implementation Team will support adoption of these models based on regional needs.

Preliminary Target Populations. High-risk Medicaid beneficiaries with co-occurring behavioral health and one or more chronic conditions. An estimated 37,000 Medicaid beneficiaries, including both children and adults, in the region have a mental health or substance abuse disorder and one or more chronic diseases.

Partners. Active and potential partners represent all counties in the region and multiple sectors, including: behavioral health, primary care, hospital systems, fire departments, and social service agencies. Many have been identified as high-volume Medicaid providers.

Key Project Components

- Analysis of current system integration resources and gaps.
- Development of data sharing systems to support integrated care.
- Hiring, training, and supporting providers to adopt integration models targeting regional needs.
- Toolkit approaches (Bree Collaborative, Collaborative Care Model) serving patients with varied levels of care needs.

Project 2C: Transitional Care

General Approach. This project will support at-risk enrollees during transitions from acute to less intensive care settings. It builds upon existing regional programs that have been successful, but can be enhanced and grown through the Medicaid Transformation. The project will implement proven tools to support management of acute changes in condition without transport to the hospital. GCACH is implementing the following approaches listed in the Medicaid Transformation Toolkit: Transitional Care Model and INTERACT 4.0.

Preliminary Target Population. Medicaid beneficiaries discharging from hospital to home, health home agency, skilled nursing facility, or other place of residence and those transitioning from those settings to somewhere with a lower level of care.

Partners. Active and potential partners include: skilled nursing facilities, long-term care facilities, assisted living facilities, first responders that have Community Paramedicine programs, home health agencies, and care coordination agencies. Many have been identified as high-volume Medicaid providers.

Key Project Components

- Adoption of Interventions to Reduce Acute Care Transfers (INTERACT).
- Expansion of collaborative community paramedicine efforts.
- Leveraging and expansion of existing family and patient-centered interagency interdisciplinary collaborative care models.
- Expansion of use of field-based nurse care coordinators, community health workers, and community paramedics.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. GCACH proposes to develop community-based Opioid Resource Networks to advance strategies in dependence prevention, treatment, overdose prevention, and recovery. Each Network will be a resource for local communities by providing trauma-informed case management for individuals with opioid dependence. GCACH will utilize the Six Building Blocks for Clinic Redesign for Safer Opioid Prescribing and Transformed Care for Chronic Pain model for the region. Project strategies are detailed for the four areas: prevention, treatment, overdose prevention, and recovery.

Opioids Crisis Project Goals

- Increase insurance enrollment among opioid injectors.
- Comprehensive case management services with MAT partner providers.
- Reduce inpatient hospital utilization and ED overutilization.
- Increase SUD treatment penetration (with Bi-directional Integration Project).

Preliminary Target Population. Medicaid beneficiaries receiving over 120 MED (Morphine Equivalents) of any opioid with a concurrent sedative prescription and Medicaid beneficiaries with co-occurring mental health, substance abuse disorder, and more than one chronic condition. GCACH plans to target the top 5 percent (approximately 350) of the 6,740 beneficiaries with a co-occurring mental health condition, substance abuse disorder, and more than one chronic condition in the GCACH region.

Partners. Active and potential partners include: behavioral health providers, FQHCs, county public health departments, managed care plans, community based organizations, housing agencies, local coalitions, and educational institutions. Many have been identified as high-volume Medicaid providers.

Project 3D: Chronic Disease Prevention and Control

General Approach. This project will target prevention and management of chronic disease through collaboration and partnerships emphasizing obesity and diabetes. Efforts will emphasize prevention, patient education and engagement, and utilization of community health workers and other community-based resources. GCACH is implementing the Chronic Care Model listed in the Medicaid Transformation Toolkit for primary care practices. The project will also focus on specific strategies of evidence-based diabetes and obesity chronic disease prevention and treatment including:

- Community Paramedicine Model
- Million Hearts® Campaign
- Chronic Disease Self-Management Program
- Diabetes Prevention Programs

Key Project Components

- Implement evidence-based approaches through existing local community resources and health care providers.
- Develop regional project management and resources to support local implementation.
- Provide outreach and education to clinical providers, community health workers, and outreach coordinators through trained facilitators in each county.
- Conduct place-based dissemination of evidence-based programs.
- Build on existing Community Paramedicine program infrastructure and develop cost-effective strategies to implement models in rural areas.
- Use hot spotting and GIS mapping to identify areas of greatest need and gaps in services and resources.

Preliminary Target Population. Children and adult Medicaid beneficiaries in high-risk populations with health disparities. The ACH plans to target the top 5 percent of the 36,890 beneficiaries identified with one or more chronic disease and a co-occurring behavioral health disorder. Likely subpopulations include Medicaid beneficiaries with: three or more chronic conditions and absence of PCP visits; two or more (non-OB) admissions in last year with priority if one is in the last six months; six or more ED visits in the last year; five or more prescription medications.

Partners. Active and potential partners include: the region’s public health districts, public safety, hospital systems, FQHCs and other clinical providers, education districts, and social services providers. Many have been identified as high-volume Medicaid providers.

Findings and Scoring for Greater Columbia ACH

Table 16 provides a listing of findings, including examples of strengths and opportunities.

Table 16. Greater Columbia ACH Findings

Findings for Greater Columbia ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • Resources have been allocated to support partnering providers, such as establishment of a Strategic Planning Committee, development of a staffing plan and hiring of project director/managers and Clinical Director, and development of technical assistance and systems for shared learning. • GCACH is exploring a partnership with Providence CORE and/or HealthierHere to develop a monitoring system to include timely data for project implementation and continuous improvement. • Specific to Project 2A: <ul style="list-style-type: none"> ○ GCACH is working with the Pediatric-transforming Clinical Practice Initiative through the state Department of Health to support pediatric primary care and behavioral health providers and to perform outreach and support expanded bi-directional, and possibly tri-directional (which would include oral health), and integrated care for children and youth. ○ GCACH will facilitate learning collaboratives for peer learning opportunities. Another potential consideration is to provide opportunities for providers to “shadow” other providers to facilitate shared learning across disciplines. • Specific to Project 2C: 	<ul style="list-style-type: none"> • Specific to Project 2C, GCACH indicated the Executive Director will meet with hospital leadership to determine what barriers may exist to implement a transitional care model, and if appropriate, offer financial incentives to get programs started. Recommendation: As project design continues in DY 2, Myers and Stauffer recommends that GCACH provide additional information if they find that barriers are identified by hospital leadership that will adversely impact their implementation of the model. • Specific to Project 3A: <ul style="list-style-type: none"> ○ GCACH intends to explore development of Opioid Resource Networks in each of the nine counties. The networks will provide both client-centered, trauma-informed case management to empower individuals with opioid dependence to access treatment. Recommendation: As project design and planning continues in DY 2, Myers and Stauffer recommends GCACH further define the role of the Opioid Resource Networks and provide information about these roles to HCA given their crucial role. ○ GCACH identified a narrow target population of approximately 350 beneficiaries over the

Findings for Greater Columbia ACH

<ul style="list-style-type: none"> ○ GCACH will partner with providers who have significant experience working with racial and ethnic minorities to address disparities among the population. ○ Many GCACH partners have implemented programs to address poor transitions of care and have demonstrated success and garnered community and partner support. ● Specific to Project 3A, GCACH noted the importance of establishing working relationships between professional services and opioid-dependent people. They plan to co-locate community health workers at clinical practices to help mediate doctor-patient relationships, advocate for the patient, and help the patient follow and continue treatment. ● Specific to Project 3D, smaller communities and rural areas have a shortage of community health workers. GCACH plans to identify and use existing local workforce, such as community paramedics, to support the project. They also will seek opportunities to increase and train the community health workforce, which may include “Train the Trainer” to facilitate trainings. 	<p>course of the Medicaid Transformation.</p> <p>Recommendation: As GCACH further defines target populations, Myers and Stauffer recommends GCACH consider potential impacts to the project related to a narrow population.</p> <ul style="list-style-type: none"> ● Specific to Project 3D: <ul style="list-style-type: none"> ○ Smaller communities and rural areas have a shortage of community health workers. GCACH plans to identify and use existing local workforce, such as community paramedics, to support the project. They also will seek opportunities to increase and train the community health workforce, which may include “Train the Trainer” to facilitate trainings. ○ GCACH identified a narrow target population of approximately 1,900 beneficiaries over the course of the Medicaid Transformation. <p>Recommendation: As GCACH further defines target populations, Myers and Stauffer recommends GCACH consider potential impacts to the project related to a narrow population.</p>
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Myers and Stauffer submitted two rounds of write-back requests to GCACH as part of the assessment process. *Table 17* provides an overview of the resulting scores. At the end of the process, GCACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 17. Greater Columbia ACH Scoring

Greater Columbia ACH			
	Initial Score	Score After 1st Write-Back	Score After 2nd Write-Back
Section 1 Score	94.58%	100%	100%
Section 2 Score	72.76%	92.63%	100%
<i>Section 2 Projects:</i>			
2A	73.68%	85.26%	100%
2C	73.68%	100%	100%
3A	83.16%	100%	100%
3D	60.53%	85.26%	100%
Total Score	79.31%	94.84%	100%
Bonus			0%
Final Score			100%

HealthierHere

Accountable Community of Health



Summary Findings for HealthierHere

HealthierHere	
■ Counties:	
○ King	
■ Tribal Reservation/Trust Land:	The Cowlitz Indian Tribe, Muckleshoot Indian Tribe, and Snoqualmie Tribe are located in King County.
■ Medicaid Population Size (November 2017 Client Count):	358,022
■ Medicaid Transformation Toolkit Projects	
Selected:	
○ 2A: Bi-directional Integration of Care	○ 3A: Addressing the Opioid Use Crisis
○ 2C: Transitional Care	○ 3D: Chronic Disease Prevention and Control

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. HealthierHere developed an online Regional Health Needs Inventory, including health, social, and demographic information on Medicaid and non-Medicaid individuals, along with care-client data, measures, and a performance gap analysis. The Inventory was used to identify health needs and disparities across the region and to evaluate which strategies would most likely drive improved outcomes. Both existing and new provider data types were utilized to inform decision-making including, but not limited to: official population estimates, demographic and social determinants of health data, Behavioral Risk Factor Surveillance System, birth and death records, Title X trends, all-payer hospitalization data, Medicaid eligibility and claim data, jail health data, EMS data, and dental service utilization data. ZIP code-level maps were generated to assess geographic distribution and have been helpful in assessing target populations and areas. HealthierHere provided numerous statistics about the region’s health needs to support the six selected projects.

Governance. Since Phase II Certification, HealthierHere has completed the following:

- Hired a Chief Financial Officer, Director of Programs, Project Manager, and Executive Assistant. Two additional postings have been made for a Clinical Innovations Manager and Community and Tribal Engagement Manager.
- Shifted responsibilities from Public Health — Seattle and King County (PHSKC) to HealthierHere for program management, strategy development, financial planning/budgeting, and administrative support as HealthierHere has hired and grown the organization.
- Has processes under way with Governing Board members, the Community/Consumer Voice Committee (CCV), and the newly formed Provider Engagement Workgroup to strengthen community/provider representation and communication.

Funds Allocation. The Budget and Funds Flow Workgroup will handle the technical aspects of funds allocation, which includes projection of revenues, prospective methodology for funds distribution, timing of distribution, and analysis of funds flow performance data. The Finance Committee will review, amend, and approve recommendations of the Budget and Funds Flow Workgroup. Final decision authority lies with the Governing Board.

HealthierHere is establishing a limited liability corporation under fiscal sponsorship of the Seattle Foundation and is utilizing the foundation's accounting system, procedures, and personnel for financial reporting.

HealthierHere has adopted a set of funds flow principles to guide their allocation of funding. These principles are:

- Collaborative processes
- A transparent approach
- Adaptability and responsiveness to variability
- Distribution decisions made in a thoughtful, objective manner
- Consideration of consumers and community
- Addressing health disparities and social determinants of health
- Accountability of HealthierHere and its partnering organizations

HealthierHere has a service contract with PHSKC to provide staffing for HealthierHere activities since inception and while HealthierHere is establishing its own administrative infrastructure. The contract is \$1.3 million of the \$6 million design funds.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. HealthierHere is facilitating and supporting multi-stakeholder committees to guide and provide input into the Domain 1 strategies. Infrastructure investments have been identified to carry out projects in Domains 2 and 3, and how capacity building in Domain 1 will support selected projects. A percentage of HealthierHere earnings will be set aside for Domain 1. Examples include:

- Information technology investments to support shared care planning and information across clinical and community-based providers.
- Workforce assessment shows the need for training and technical assistance in multiple evidence-based interventions.
- Integration of community health workers and peer support specialists into person-centered health teams.
- Support providers through technical assistance and capacity building to transition to VBP.

Findings for Section I

Table 18 provides a listing of findings for Section I, including examples of strengths opportunities.

Table 18. HealthierHere Section I Findings

Findings for HealthierHere	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> The Performance Measurement and Data Committee is developing a data-sharing agreement with the Crisis Clinic to gather data on social services providers to assess available services, needs, and gaps. An environmental scan is planned for early 2018 to assess community-based care coordination in the region. The four selected projects aim to reduce outpatient ED visits and inpatient hospital stays, and also closely align with the quality metrics in the King County MCO contracts. A HealthierHere Social Equity and Wellness Fund is planned to focus on social determinants of health. This fund can be expanded through shared saving arrangements to result in additional resources to contribute to continued investments in prevention activities and social determinants after the Medicaid Transformation ends. The Performance Measurement and Data Committee will draft a data strategic plan and meet with partners to discuss and review data strategies and recommendation for implementation. HealthierHere will participate in a workgroup with other ACHs and the state to seek partnership opportunities on common data strategies and data investments. 	<ul style="list-style-type: none"> Gentrification and Puget Sound’s soaring real estate market are pushing lower-income families further away from urban cores and needed services. Pushing these families away from education, employment, and health and human service resources impacts factors, such as housing and transportation, and therefore impacts their health and well-being. Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends HealthierHere include provide detail to HCA about the strategies it will use to address issues such as affordable housing and transportation.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, HealthierHere is pursuing four projects for the Medicaid Transformation. Below is a high-level overview of HealthierHere’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. HealthierHere will allow partnering providers to select from the following approaches listed in the Medicaid Transformation Toolkit: Core practice recommendations detailed in the Bree Collaborative Behavioral Health Integration Report, the Collaborative Care Model, and the Milbank report on primary care in behavioral health care settings. HealthierHere will work to integrate physical and behavioral health care, including oral health, and pregnancy intention screenings. HealthierHere seeks to support sustainable health system transformation by:

- Strengthening provider's ability and capacity to provide client-centered, whole-person care through training, technology, and workforce capacity will lead to long-term transformation.
- Building on existing efforts, rather than forcing providers to adopt one particular model.
- Addressing unmet need in treating identified mental health and SUD through increased screening and access to care.
- Transitioning to fully integrated managed care, and working with MCO partners to align VBP with models and outcomes associated with bi-directional care.

Preliminary Target Population. Individuals within primary care settings with either a depression diagnosis or OUD and within behavioral health settings, individuals with a diabetes diagnosis. After implementation of the initial target populations, HealthierHere plans to assess expansion to include additional physical and behavioral health conditions.

Partners. Active and potential partners include: all five MCOs, community health centers, hospitals, behavioral health providers, housing providers, long-term care providers, and local government. HealthierHere is working with the top 50 providers of Medicaid services, which includes organizations that see large volumes of ethnic and culturally diverse populations.

Four Key Project Goals

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

Project 2C: Transitional Care

General Approach. HealthierHere is implementing the following approaches listed in the Medicaid Transformation Toolkit: APIC Model for all three target populations and the Care Transitions Intervention/Coleman Model for high-risk Medicaid beneficiaries transitioning from hospitals. HealthierHere seeks to support sustainable health system transformation in the following ways:

- Investing in evidence-based transitional care approaches to improve quality of care and building strong linkages to CBOs resulting in more stable transitions to prevent readmission.
- Investing in training, technology, and workforce capacity.
- Decreasing readmissions and incarcerations to result in savings that can be reinvested in the community.
- Increasing access to multidisciplinary care teams and community-based care coordination upon transition.

Current Transitional Services to be Leveraged

- Post-hospital respite locations: Coordinate with resources for individuals unable to directly return to a safe home.
- Medical support in coordination with supportive housing: Coordinate with housing programs serving individuals coming out of homelessness with mental health or SUD.
- Transitional care innovations led by the King County Area of Aging: Coordinate existing services, such as health home enrollment, transitional care coordination with long-term service providers, and a statewide community learning collaborative on care transitions.

Preliminary Target Population. Medicaid beneficiaries who are: returning to community from jail; have a SMI or SUD who have been discharged from inpatient care, with a goal of serving 40 percent of individuals in the target population, which is double the current service level; or high-risk and transitioning from hospitals, including older adults and people with disabilities.

Partners. Active and potential partners include: MCOs, hospitals, behavioral health providers, FQHCs, individuals with lived experience in the criminal justice system, CBOs, correctional facilities, fire departments, philanthropy, recidivism policy advisors, and other representatives from relevant county and city agencies. HealthierHere is working with the top 50 providers of Medicaid services which includes organizations that see large volumes of ethnic and culturally diverse populations.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. HealthierHere will use a multi-pronged approach utilizing four essential components: prevention, treatment, overdose prevention, and recovery. HealthierHere seeks to support sustainable health system transformation as follows:

- Support providers to prescribe opioids appropriately and increase the number of providers trained on Washington State Agency Medical Directors Group (AMDG) Interagency Guideline of Prescribing Opioids for Pain.
- Increase access to MAT and overall SUD treatment and support individuals to receive treatment.

- Work with MCO partners to identify VBP models that support easier access to MAT.
- Support community partners and stakeholders through education and distribution of Naloxone kits.
- Provide ongoing recovery support for Medicaid beneficiaries with OUD and linkage to a primary health home.

Preliminary Target Population. Medicaid beneficiaries with OUD and those screened for OUD who are not yet diagnosed. During the write-back process, HealthierHere clarified that these individuals may not yet be diagnosed with an OUD, but can be screened and diagnosed through system engagement and then provided a pathway to treatment. Additional beneficiaries targeted would be those "where some service is rendered that would indicate a possible OUD, for example, showing up with signs/symptoms of OUD in ED, needle exchanges, primary care offices, etc."

Partners. Active and potential partners include: physicians, dentists, behavioral health and SUD providers, hospitals, community members, MCOs, human services, public health, state hospital and medical associations, tribal governments, first responders, public safety, drug courts, public defenders and federal attorneys, civil rights organizations, needle exchanges, pharmacy, and community action alliances, and outcomes and quality organizations.

Project 3D: Chronic Disease Prevention and Control

General Approach. HealthierHere is implementing the Chronic Care Model listed in the Medicaid Transformation Toolkit, and reviewing additional approaches to target selected conditions (e.g., cardiovascular and respiratory diseases). They indicated that this will build upon local experience and uptake of evidence-based approaches and best practices (e.g., Diabetes Prevention Program, the Chronic Disease Self-Management Program, National Asthma Education and Prevention Program, etc.).

HealthierHere seeks to support transformation by:

- Using community health workers with more than 20 years of proven efficacy in chronic disease prevention and treatment as a bridge between clinical and community-based strategies and providers and integrate community health workers in an individual's care team.
- Support practice transformation that aligns with VBP arrangements focused on achieving quality and outcome measures.
- Partnership with MCOs to develop chronic disease bundles to be sustained through VBP arrangements.

Project Implementation Plan Activities

- Work with MCOs and HCA on initial prescribing guidelines by adopting, disseminating, and incorporating them into MCO payment structures.
- Inviting MAT providers to help plan and develop funding mechanism for building on existing local and state MAT expansion funding.
- Scaling up Naloxone distribution effort.
- Building on work of existing Opiate Task Force working groups.
- Providing incentives for providers to coordinate care where people live and in culturally appropriate ways.

Preliminary Target Population. Medicaid beneficiaries (adults and children) with or at-risk for two high-prevalence and high-cost complexes: chronic respiratory disease (including asthma) and cardiovascular disease (including diabetes), with a focus on individuals who are at the highest risk of experiencing disproportionate outcomes and areas with a high proportion of Medicaid beneficiaries (e.g., people of color with uncontrolled chronic disease, who show up in ED for their chronic disease condition, and who live in south King County).

Partners. Active and potential partners include: health systems, health providers, community organizations, advocates, community health workers, and researchers. HealthierHere is working with the top 50 providers of Medicaid services, which includes organizations that see large volumes of ethnic and culturally diverse populations.

Findings and Scoring for HealthierHere

Table 19 provides a listing of findings, including examples of strengths and opportunities.

Table 19. HealthierHere ACH Findings

Findings for HealthierHere	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> HealthierHere is using the Equity Impact Assessment Tool (Equity Tool) developed by the Community/Consumer Voice Committee. The Design Team used the Equity Tool to examine disparities in outcomes by race/ethnicity, gender, geographic location, and income level as well as exploring strategies to engage impacted individuals. In-depth training during the planning phase will use the Equity Tool to apply an "equity lens" on the significant disparities noted in King County. Regular forums will be conducted to discuss successes and challenges of participating providers. There will be a learning session collaborative where providers can share lessons learned and provider community meetings with providers to discuss HealthierHere developments and identify resources. There are Medicaid providers in King County who specialize in best practices in the care of minority and foreign-born populations and have culturally diverse staff. HealthierHere will leverage their expertise and other partners to ensure beneficiaries have access to culturally and linguistically appropriate services and resources. Technical assistance will be a priority for partnering providers struggling to meet performance goals. 	<ul style="list-style-type: none"> Specific to Project 2A, HealthierHere acknowledged the need to enlist additional providers and stakeholders during the planning, implementation, and scale-and-sustain phases. They will conduct broad formal outreach via medical societies and professional organizations, community and stakeholder forums, tribal meetings, the Behavioral Health Council, and the MCOs. Recommendation: As outreach activities occur, HealthierHere may want to ensure Medicaid beneficiaries and advocates are also included in this effort to understand any issues and experiences from the beneficiary viewpoint. Specific to Project 2C, institutional racism is listed as a challenge with HealthierHere stating “Addressing institutional racism and racial disproportionality may be a challenge in the project’s efforts to ensure a culturally responsive approach to communities of color and marginalized communities.” Recommendation: As project planning continues in DY 2, Myers and Stauffer recommends HealthierHere provide additional information about its plan to address the challenge of institutional racism.

Findings for HealthierHere

HealthierHere will seek partners to provide technical assistance with expertise in both quality improvement science and project-specific subject matter. Example organizations include: Quality health, the UW AIMS Center, and the Arcora Foundation.

- Specific to Project 2C:
 - The project design team included four of the five top hospitals for Medicaid admissions, ED visits, and outpatient visits, which represents over half of all hospital utilization by Medicaid beneficiaries in the region.
 - All three target populations are supported by providers already working with the Transitional Care Design Team throughout 2017 and are ready to move to implementation in 2018.
- Specific to Project 3A, the Heroin and Prescription Opiate Task Force (Opiate Task Force) was formed in 2016 by King County, the city of Seattle, and city of Burien. Details of the process and recommendations of the Opiate Task Force were included. The Medicaid Transformation will "build upon and accelerate strategies recommended by the Opiate Task Force."
- Specific to Project 3D:
 - The region has a 20-year history with the community health worker model, particularly with asthma and diabetes. There has been lower use of rescue medication and fewer urgent care visits and hospitalizations resulting from community health worker education and support.
 - A chronic disease management incentive payment program will be developed to begin focus on disease bundles such as respiratory and cardiovascular (including diabetes). These would include a range of services, such as self-management programs, community health worker services, and outside activities. In the long term, the bundles would be part of VBP arrangements to achieve chronic disease quality and outcome measures.

- Specific to Project 3A, HealthierHere has not yet determined an evidence-based approach or practices to use per the initial Project Plan submission, but is considering the following: MAT, Collaborative Care, Expanded recovery supports through Peer Support Specialists, Six Building Blocks, and/or Hub and Spoke model.
Recommendation: As project planning continues and approaches are determined, further consideration and review of the approach(es) to determine which were selected and whether HealthierHere has followed Medicaid Transformation Toolkit specifications may be required.

Myers and Stauffer submitted one write-back request to HealthierHere as part of the assessment process. *Table 20* provides an overview of the resulting scores. At the end of the process, HealthierHere was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 20. HealthierHere Scoring

HealthierHere		
	Initial Score	Score After 1st Write-Back
Section 1 Score	96.67%	100%
Section 2 Score	95.53%	100%
<i>Section 2 Projects:</i>		
2A	95.79%	100%
2C	100.00%	100%
3A	95.79%	100%
3D	90.53%	100%
Total Score	95.87%	100%
Bonus		0%
Final Score		100%

North Central Accountable Community of Health



Summary Findings for North Central ACH

North Central ACH	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Chelan ○ Douglas ○ Grant ○ Okanogan 	
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: Part of the Confederated Tribes of the Colville Reservation is located in Okanogan County. 	
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 82,531 	
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects <ul style="list-style-type: none"> Selected: <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2B: Community-based Care Coordination ○ 2C: Transitional Care ○ 2D: Diversions Interventions ○ 3A: Addressing the Opioid Use Crisis ○ 3D: Chronic Disease Prevention and Control 	

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. North Central ACH (NCACH) provided a strong explanation of the data and processes used to inform project selection and planning. Data was also used to provide a thorough description of existing health care resources available in the region, as well as community-based resources to address the social determinants of health, inclusive of level of access to care and potential barriers. NCACH notes that it will continue leveraging data to inform additional project planning and implementation, and cites a dedicated data team to support such efforts.

Funds Allocation. All budgetary items are approved by the NCACH Board annually and as needed for non-budgetary expenses.

Workgroups are tasked with developing a process to allocate funding associated with the projects and to recommend partners who will receive funding related to the project the workgroup manages. Funding processes approved by the board must outline initial funding for each workgroup; NCACH partners needed to implement the projects; and anticipated funds the project will need over the course of the Medicaid Transformation to scale and sustain projects.

Stewardship and transparency of every category of funds over the Medicaid Transformation will follow the same principles and policies of the NCACH. To ensure stewardship, it is NCACH’s policy to not fund direct service costs, or other project activities that are not sustainable beyond the Medicaid Transformation. Funding transparency will be addressed through open board meetings. No funding decisions will be made

Four Guiding Principles/Strategies

- Ensure culturally appropriate services across the continuum.
- Promote integrated care.
- Plan for long-term sustainability beyond the Medicaid Transformation.
- Leverage population health data to identify, target, and reduce health disparities.

outside of an open board meeting, with meeting minutes published on the NCACH website and distributed to community partners.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. NCACH notes Domain 1 area capacity-building activities, beginning in Q1 2018, designed to support all selected projects. Activities include, but are not limited to:

- Convening a workgroup to educate providers on available resources as they transition to value-based contracts and to develop a regional strategy to align with the work of the Medicaid Transformation.
- Working with community colleges and providers to explore workforce development programming opportunities.
- Investing in interoperable systems and assessing the feasibility of a regional EHR or HIE platform.

NCACH also anticipates investments or infrastructure necessary to carry out Domain 2 and 3 projects, including a structure of shared best practices/data/tools, a 24/7 nurse call line, a VBP workgroup, and a HIT/HIE workgroup to determine alignment with the statewide HIT/HIE initiative, including review of possible regional EHR system and working with Pathways HUB software vendor to ensure integration with provider systems.

Findings for Section I

Table 21 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 21. North Central ACH Section I Findings

Findings for North Central ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • NCACH anticipates utilizing the Robert Wood Johnson Foundation’s "Key Steps to Advancing Health Equity" and to work with local Coalitions for Health Improvement during implementation planning to obtain local perspective on causes of health disparities. 	<ul style="list-style-type: none"> • NCACH noted it is assessing HIT/HIE systems currently utilized by participating partners (anticipated completion Q4 2018), and has outlined a series of deliverables to assist partners (e.g., IT and data gap/needs assessment; identification of provider IT requirements to advance VBP and new care models; and identification of potential HIT solutions). It should be noted that ACHs may be taking unique approaches to HIT/HIE issues, which may result in statewide inefficiencies and/or duplicative financial expenditures.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, NCACH is pursuing six projects for the Medicaid Transformation. Below is a high-level overview of NCACH's approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. NCACH described a strong approach for accomplishing project requirements, listing specific tactics/tasks with associated deliverable dates. NCACH is creating documentation to prescribe requirements for provider change plans identifying options for evidence-based approaches and promising practices, specifically the Bree Collaborative and Milbank Memorial Fund report. An ACH advisory board/workgroup will manage the project, with implementation support provided by contracted vendors who will assist clinical members in implementing projects, evaluating effects, sharing results, and pursuing further improvements. NCACH will leverage a number of assets to support this project including, but not limited to, support from national experts and a full-time data analyst, and evaluation and technical assistance support from the Center for Outcomes Research and Education (CORE) and two other vendors. To support partnering providers, NCACH will:

- Design and implement a learning collaborative.
- Coordinate with HCA, MCOs, and other ACHs to obtain data.
- Provide direct support to behavioral health providers on change plan submissions, scoring, etc.
- Work with academia to assess best practices for recruitment.

Preliminary Target Population. Beneficiaries with SUD treatment needs and/or mental illness treatment needs, though NCACH anticipates that system-wide changes will impact all 94,000 beneficiaries in the region.

Partners. NCACH provided a complete listing of providers, as well as Medicaid beneficiaries served, that have shown some level of interest in participation. To facilitate partner involvement, NCACH describes engaging all major health care provider organizations in the region, and plans to outreach to social services providers by the end of January 2018. At present, NCACH's Whole Person Care Collaborative (WPCC) (consisting of 20 organizations providing behavioral and physical healthcare, MCO and EMS representatives, and hospitals partners) is responsible for project governance, and meets regularly with members to establish a workgroup charter, member agreement, and goals.

Project 2B: Community-based Care Coordination

General Approach. NCACH described a strong approach for accomplishing project requirements, listing specific tactics/tasks with associated deliverable dates. NCACH will implement the Pathways Community HUB for this project, and both ACH and consultant resources will be used to support partnering providers during project implementation. NCACH will leverage a number of assets to support this project including,

but not limited to, support from national experts and a full-time data analyst, and evaluation and technical assistance support from CORE and two other vendors. To support project sustainability, NCACH cites a number of specific strategies including, but not limited to:

- Initiating a social services focus group to develop a strategic plan on how to better align CBOs with the project.
- Soliciting consultant expertise regarding payer identification and engagement, contracting, as well as financial forecasting and pro forma budgeting to inform long-term sustainability plans.

Preliminary Target Population. Medicaid beneficiaries with one or more chronic diseases or a behavioral condition; however, NCACH plans to refine this population over the next seven months by focusing on high ED utilizers who intersect with the following projects: Transitional Care, Diversions Interventions, Bi-directional Integration and Chronic Disease. NCACH will select its priority population by March 2018, though it hopes to reach all Medicaid high ED utilizer adults, expanding to serve residents released from EDs and hospitals based on a primary diagnosis of mental health and behavioral health disorders, and beneficiaries with an asthma or diabetes diagnosis.

Partners. NCACH provided a complete listing of providers that have shown some level of interest in participating in the project. To facilitate partner involvement, NCACH describes soliciting participation from providers serving the Medicaid population through care coordination services, with a focus on sector representatives who serve a significant portion of the Medicaid population (e.g., criminal justice, housing, employment, education, care coordination, FQHC, MCO).

Project 2C: Transitional Care

General Approach. NCACH described a strong approach for accomplishing project requirements, listing specific tactics/tasks with associated deliverable dates. NCACH is considering the following approaches for this project, which will be selected and recommended to NCACH's Board by Quarter 2 (Q2 2018):

- Care Transitions Intervention
- Care Transitions Interventions in Mental Health
- Evidence-Informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

NCACH will leverage workgroup participants and two contract vendors to support this project. NCACH anticipates mitigating potential barriers through using new staff hires, consultants, an HIT/HIE workgroup, and a social services focus group specifically designed to inform investments related to social determinants of health. In addition, NCACH is working with Amerigroup, which is overseeing the delivery of supportive housing and supported employment services under the Medicaid Transformation.

Preliminary Target Population. Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care, beneficiaries with SMI discharged

from inpatient care, or incarcerated clients returning to the community. NCACH proposes to eventually reach all Medicaid beneficiaries incarcerated in county jail and detention facilities and residents released from EDs and hospitals based on primary diagnosis of mental and behavioral health disorders.

Partners. NCACH provided a complete listing of providers that have expressed interest in participating in project development and/or implementation. Project workgroup members include regional primary care and behavioral health providers, representatives from therapeutic courts, juvenile courts, housing authority, and law enforcement. Pilot partnering providers will be identified in Q2 2018.

Project 2D: Diversions Interventions

General Approach. NCACH described a strong approach for accomplishing project requirements, listing specific tactics/tasks with associated deliverable dates. Two approaches are noted for this project: ED diversion and Community Paramedicine. NCACH will leverage workgroup members, regional councils, community coalitions, and contract vendors supporting its data analysis/HIT and learning collaborative efforts to support this project. To mitigate identified barriers, NCACH proposes to work with regional councils, engage MCOs to refine funding strategies relative to project-specific barriers, and develop a social services focus group to specifically address improved alignment of CBOs with the Medicaid Transformation. NCACH is looking into private solutions to address data concerns.

Preliminary Target Population. There are two target populations:

- ED Utilization: Medicaid beneficiaries presenting to the ED for non-acute conditions.
- Community Paramedicine: Medicaid beneficiaries who access EMS services for non-acute issues.

Partners. The ACH provided a complete listing of providers that have expressed interest in participating in development and/or implementation of the project. The ACH has engaged a comprehensive group of providers (e.g., FQHCs, physical and behavioral health care providers, MCOs, skilled nursing facility, home health, education, public health, hospitals, criminal justice, law enforcement, CBOs, and local government) and notes that staff will routinely connect with additional partners serving the Medicaid population through key informant interviews and regional meetings.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. NCACH's approach for accomplishing project requirements included specific tactics/tasks with associated deliverable dates. NCACH proposes to determine an approach informed by regional health needs (considering areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse and abuse) in Q2 2018; however, the Project Plan suggests consideration of AMDG's Interagency Guideline on Prescribing Opioids for Pain, CDC Guideline for Prescribing Opioids for Chronic Pain, and the State Interagency Workplan. NCACH describes both internal resources and consultant resources that will be used to support partnering providers during project implementation (initial and ongoing).

Specifically, NCACH anticipates providing the following:

- Educational services to 25 percent to 50 percent of the 29 school districts in the region.
- Increasing access to MAT.
- Expanding use of medication take-back boxes.
- Providing outreach to users, prescribers, and pharmacists.
- Expanding distribution of Naloxone to first responders, law enforcement, and patients.

NCACH notes that the primary charge of the project workgroup is to support local groups already in existence and leverage existing capacity, aligning project initiatives with existing local opioid coalitions, opioid Regional Councils, and regional law enforcement workgroups. Also, given the rurality of the region, NCACH indicates it will work to improve access to care through bi-directional integration, improving workforce capacity, and advocating tele-health payment policy changes for SUD and rural providers.

Preliminary Target Population. The initial target population includes Medicaid beneficiaries who use or abuse opioids, and those at risk for using or abusing opioids. NCACH acknowledges potential disparities in use, abuse, overdose, and mortality patterns based on geography, gender, and race/ethnicity. As such, the ACH will further consider how it can implement projects that address such disparities, and will include cultural considerations in planning and implementation.

Partners. The ACH provided a complete listing of providers that have expressed interest in participating in development and/or implementation of the project. NCACH cites an outpouring of support from clinical providers, EMS, law enforcement, corrections, education, public health, MCOs, behavioral health administrative service organizations, dental, pharmacy, and tribal partners. Each of these specified sectors is noted as currently represented on the project workgroup except tribal partners, which is pending appointment of a new representative.

Project 3D: Chronic Disease Prevention and Control

General Approach. NCACH will evaluate the approaches in the Chronic Care Model in the coming months, with selection by Q2 2018. To support providers, NCACH will:

- Design and implement a learning collaborative as a means to disseminate best practices and create peer accountability for performance.
- Coordinate with HCA, MCOs, and other ACHs to obtain data.
- Provide direct support to behavioral health providers on change plan submissions, scoring, etc.
- Work with academia to assess best practices for recruiting.

NCACH also describes the necessity of effectively managing change in support of project sustainability, citing collaborative learning; stable and capable quality improvement processes to sustain change; and support for providers who do not have quality improvement processes in place.

Preliminary Target Population. Medicaid beneficiaries with diabetes, respiratory issues, and heart disease. NCACH acknowledges the need to address health disparities through this project, specifically citing differences in diabetes incidence relative to race/ethnicity, age, and education level, as well as a high prevalence of asthma for Native Americans, compared to 10.1 percent for the broader population.

Partners. NCACH provided a complete listing of providers that have expressed interest in participating in development and/or implementation of the project. NCACH will leverage an existing workgroup infrastructure to oversee the project, and will reach out to all major health care provider organizations and social services providers in the region, by the end of January 2018. NCACH has been meeting monthly with members to establish a workgroup charter, member agreement, goals, etc. At the time of Project Plan submission, representatives include 20 organizations providing behavioral and physical health care, as well as MCO representatives, representatives from EDs, and hospital partners.

Findings and Scoring for North Central ACH

Table 22 provides a listing of findings, including examples of strengths and opportunities.

Table 22. North Central ACH Findings

Findings for North Central ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • Specific to Project 2A: <ul style="list-style-type: none"> ○ NCACH notes that all partners will be expected to specifically outline health disparities in their patient population and articulate, in their change plans, how they will address health equity issues. ○ NCACH describes a number of activities under way to ensure the project does not duplicate existing initiatives (e.g., provider meetings and surveys, participating local Coalition for Health Improvement [CHI] meetings and regional rural Washington State Hospital Association [WSHA] meetings). • Specific to Project 2B, NCACH proposes working with bordering ACHs to ensure alignment, minimize burden, and avoid duplication for providers. • Specific to Project 2C: <ul style="list-style-type: none"> ○ NCACH indicates that more Medicaid beneficiaries in the region identify as Hispanic compared to the state average, and a high percentage in one particular county identify as Native American. As 	<ul style="list-style-type: none"> • Specific to Project 2C, NCACH elaborated on the current involvement of corrections, law enforcement, and drug court representatives and why they are critical to the project's success. They noted recruitment of justice system representatives for the Transitional Care and Diversion Interventions Workgroup, and that opportunities exist for staff to connect with justice system stakeholders from the Opioid Workgroup. Recommendation: Given the critical importance of engaging justice system stakeholders in this particular project, Myers and Stauffer recommends that NCACH consider in its ongoing planning impacts to the project should staff continue to not successfully connect with these identified stakeholders. • Specific to Project 2D, NCACH cited EMS reimbursement challenges may limit the number of EMS providers who can participate, and that decreasing ED volume in critical access hospitals

Findings for North Central ACH

<p>target populations are refined, the ACH will assess where geographically it can implement projects that will address health disparities, what projects can target those identified health disparities, and how it can include cultural considerations into the direct implementation and planning of its targeted populations.</p> <ul style="list-style-type: none"> ○ Regional Councils specific to diversion projects (North Central Hospital Council and North Central Emergency Care Council) will be leveraged to train key partner organizations on the principles of each evidence-based approach or practice they may implement in their organization. NCACH will ensure appropriate subject matter expertise is available to provide the training, will work directly with providers to address any specific concerns around training, and will provide funding to pay staff for trainings. ● Specific to Project 2D, NCACH suggests that its project workgroup will assess expanding the scope of work of current medical professionals. For example, underutilized EMS providers could be leveraged to expand Community Paramedicine programs. ● Specific to Project 3A, NCACH describes strong engagement with the largest health system in the region, which is independently pursuing initiatives to address the epidemic (e.g., incentivizing providers to become buprenorphine prescribers, creating an opioid oversight committee, establishing workgroups, and instituting new chronic opioid agreements with a lowered morphine equivalent dose) and pursuing enhancements to the region’s data analytic capacity. ● Specific to Project 3D, NCACH notes that all participating providers have been assessed using the PCMH-A tool and a baseline report has been established regarding level of integration. 	<p>will likely decrease revenue and impact operational budgets. As these barriers may require highly technical expertise, reviewers requested that NCACH describe its capacity to address such barriers. NCACH described several resources including: (1) the Healthier Washington Rural Multi-Payer Payment Model; (2) Caravan Health, which is working with local critical access hospitals; (3) existing Community Paramedicine providers in the regions; (4) MCOs; and (5) the Care Coordination Project. Considerable detail is provided to address how these resources will provide technical expertise to support the NCACH. Recommendation: As planning and implementation progresses, Myers and Stauffer recommends consideration for whether these statewide mitigation strategies identified/ developed would be beneficial as shared learning opportunities across ACHs.</p> <ul style="list-style-type: none"> ● Specific to Project 3D, NCACH notes that the potential for duplication exists in the selection of quality metrics, as HCA-prescribed metrics may differ from Medicare or those required for MCO or commercial payer contracts. However, the ACH is currently working to crosswalk metrics targeted through its projects to minimize burden on partners. Recommendation: As planning and implementation progresses, Myers and Stauffer recommends NCACH work with providers to ensure proper reporting of state required metrics.
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Myers and Stauffer submitted one write-back request to NCACH as part of the assessment process. *Table 23* provides an overview of the resulting scores. At the end of the process, NCACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 23. North Central ACH Scoring

North Central ACH		
	Initial Score	Score After 1st Write-Back
Section 1 Score	88.33%	100%
Section 2 Score	87.54%	100%
<i>Section 2 Projects:</i>		
2A	86.32%	100%
2B	84.21%	100%
2C	85.26%	100%
2D	85.26%	100%
3A	93.68%	100%
3D	90.53%	100%
Total Score	87.78%	100%
Bonus		10%
Final Score		100%

North Sound Accountable Community of Health



Summary Findings for North Sound ACH

North Sound ACH	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Island ○ San Juan ○ Snohomish 	<ul style="list-style-type: none"> ○ Skagit ○ Whatcom
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: The Lummi Nation, Nooksack Tribe, Samish Indian Nation, Sauk-Suiattle Tribe, Swinomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe are located in the region. 	
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 245,308 	
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects 	
<ul style="list-style-type: none"> Selected: <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2B: Community-based Care Coordination ○ 2C: Transitional Care ○ 2D: Diversions Interventions 	<ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3B: Reproductive and Maternal and Child Health ○ 3C: Access to Oral Health Services ○ 3D: Chronic Disease Prevention and Control

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. North Sound ACH’s Regional Health Needs Inventory was found to be comprehensive, including information about the types of data sources used to inform decision-making and project planning: Medicaid data, public data sources, workforce information, community assessments, and community improvement plans. They provided a framework for how data is driving project planning and implementation. North Sound ACH also described a detailed process for data analysis to provide to workgroups to inform project considerations, as well as an overall framework for each workgroup to use in its decision process.

Governance. North Sound ACH indicated the following changes to the governance structure since the Phase II certification: The ACH launched the Community Leadership Council (CLC) in September 2017. The majority of CLC members are Medicaid beneficiaries or their family/caregivers. North Sound ACH will use this council to learn perspectives of Medicaid beneficiaries and to advise on community engagement strategies and policy decisions impacting Medicaid beneficiaries.

Community and Stakeholder Engagement. As part of Phase II Certification findings, HCA noted, and North Sound ACH addressed in its Project Plan, the lack of clarity regarding its approach to obtain input from Medicaid enrollees. North Sound ACH provided the following narrative to address the identified areas for improvement:

- Translation of “HCA/ACH-speak” into plain language to address literacy and health system literacy, as this will enhance understanding of our approaches. This strategy was executed with the

guidance of a public health communication consultant who developed audience-specific PowerPoint and presentation materials tailored to 1) professionals, 2) community leaders (i.e., community councils or advisory councils) and 3) general public and other non-healthcare professional community members, including those receiving services paid for by Medicaid.

- Providing financial resources to address barriers, such as limited transportation and child care. For CLC council and guests, childcare and a transportation stipend are provided.
- Alternate locations/times for engagement opportunities, including scheduled forums and public engagement events throughout the day and on weekends. Public forums have been scheduled in the evenings to be mindful of families including working families. Throughout the engagement process, plans include a focus on community engagement activities in rural or geographically isolated areas including eastern Whatcom County, eastern Skagit County, eastern Snohomish County and the islands of San Juan County. CLC council members from these regions will play a role in planning engagement activities in these regions.

Tribal Engagement and Collaboration. North Sound ACH provided the following narrative to address work after the Phase I certification:

- In July 2017, following the Phase I application, Councilman Nickolaus Lewis (Lummi Nation) provided a training on tribal Sovereignty to the North Sound ACH Board of Directors. The materials from the training are being made available to board members to facilitate continuous learning. This training is part of a series of planned trainings, with board members requesting follow-up to learn about tribal nations, assets and project focus areas, and population health statistics.

The board has expressed interest in learning more about the disparities faced by tribal members across the region, and the ACH will support this request by providing data, particularly for specific project areas, when available.

In addition to trainings and tribe-specific data, the board is exploring opportunities to rotate meeting locations to be onsite at tribal locations. This would provide an opportunity to increase tribal engagement, continue to build meaningful relationships, and offer board members an opportunity to learn more about specific tribes and the impact of ACH decisions and actions. The board also has added the Tribal Alignment Committee to the governance structure, to ensure board decisions are evaluated by tribal partners.

Funds Allocation. The North Sound ACH Board is responsible for ensuring that they have a robust understanding of the funds flow process. Most of that process is delegated to the Executive Director's oversight. The Board's Finance Committee has the responsibility of reviewing draft budget versions, providing insight to the Executive Director, and approving the final budget, which is submitted to the Board for final approval.

The ACH has engaged a local financial firm, Powell Business Solutions, to act as the financial management firm and provide Chief Financial Officer (CFO) services. This company, along with the Finance Committee and the Executive Director, will oversee stewardship of DSRIP funds and assure transparency of how funds are allocated to partners and reporting on a quarterly basis to the Board of Directors in a public meeting.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. North Sound ACH indicated it has received technical assistance from the Healthier Washington Practice Transformation Support Hub (via Qualis), Providence CORE, and the Center for Evidence-based Policy in planning to address Domain 1 focus areas to support Domains 2 and 3. Examples of leadership roles the ACH identified are as follows:

- **Value-based Payment:** Increasing VBP adoption by identifying and addressing barriers, disseminating content for capacity building where possible, serving as a resource to identify best practice partners, and providing broader presentations to the community to establish and clarify intent to impact this important area of system transformation.
- **Workforce Strategies:** Collaborating and sharing data with local workforce development councils and networks; participating with other ACHs in development of a statewide strategy specific to Medicaid Transformation priorities; preparing for implementation of models within each project with trainings to support existing workforce and strategies to support team-based care; supporting efforts to expand workforce capacity through training and identification of new workforce models; and having targeted conversations with partnering providers to understand priorities.
- **Population Health Management:** Providing clinical practice assessment to develop understanding of current Population Health Management systems capability, capacity, and gaps; sharing data with project planning teams to inform required strategies; training clinical staff in evidence-based approaches of integrated care and HIE; identifying best practice regional engagement and training strategy and options for interoperability; collaborating with other ACH, MCO, and statewide partners to identify shared HIT needs and opportunities and, where possible, expanded purchasing power.

Findings for Section I

Table 24 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 24. North Sound ACH Section I Findings

Findings for North Sound ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> Although North Sound ACH noted data challenges, they have identified improved data sharing agreements and interoperability between the ACH and partnering providers as a priority in improving access to high quality, timely data. The ACH indicated the region’s data sharing capacity has increased due to the Snohomish Health District’s award of the WADOH Chief Health Strategist funding that requires development of collaborative data sharing agreements among the five local health jurisdictions and the North Sound ACH. North Sound ACH developed a Community Leadership Council (CLC) as part of the governance structure, including a representative from the CLC on the board. The CLC provides perspectives of Medicaid beneficiaries, as more than 50 percent of the 22 members are Medicaid beneficiaries or a family member/caregiver. North Sound ACH is implementing multiple annual learning opportunities specific to health equity and reducing disparities that will be available to participating partners, board, and Committee members. The ACH is exploring opportunities to partner with other ACH regions that have expressed interest in the trainings. North Sound ACH has filled five of the eight board seats for tribes in the region, and the Director of the Northwest Indian Health Board serves on the ACH’s Program Council. The Tribal Alignment Committee will guide, focus, and advise the board. North Sound ACH has looked to initiatives and experiences of tribal partners for opportunities within selected projects, including innovative approaches tribal partners have implemented for housing as related to physical and behavioral health care. North Sound ACH discussed incorporation of learnings from tribal partners in several areas (e.g., Opioids, Bi-directional Integration, and Oral Health). 	<ul style="list-style-type: none"> At the time of Project Plan submission, North Sound ACH indicated continued recruiting for three positions within the governance structure: a third Project Manager, a Tribal and Community Liaison, and the Pathways HUB Director. Recommendation: It may be beneficial for HCA to confirm as planning progresses that North Sound ACH has successfully hired these individuals. Given the level of coordination conduct of eight projects will require, we recommend the ACH continually assess staffing and organization needs as planning continues.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, North Sound ACH is pursuing all eight projects for the Medicaid Transformation. Below is a high-level overview of North Sound ACH’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. North Sound ACH intends to use the Collaborative Care model to normalize integration of physical and behavioral health services. Both behavioral and physical health outpatient care settings will use the five core model elements: creating a patient-centered care team, measuring symptoms and treating to target, using population-based care tools, accountable care, and using evidence-based treatment.

Preliminary Target Population. All Medicaid enrollees (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or SUD.

Partners. Key partners are identified as the Health Systems Advisory Coalition (HSAC) and the North Sound Behavioral Health Organization (BHO).¹² The HSAC is an advisory body to the ACH that includes leadership from the largest hospital systems providing physical health care in the North Sound ACH region, regional FQHCs, a large independent physician practice, and a smaller pediatric practice. Leadership from large physical health care practices has agreed to implement Collaborative Care model methods.

Integration Activities
Practices will incorporate the following:
<ul style="list-style-type: none"> ■ Screenings ■ Interventions ■ Patient registry ■ Treat-to-target individuals with identified conditions ■ Consultations ■ Referral mechanisms ■ MATs for depression and opiate abuse (physical health practices)

Project 2B: Community-based Care Coordination

General Approach. North Sound ACH plans to pursue a Care Coordination project using the Pathways Community HUB model, with the ACH serving as the Pathways HUB. The Pathways Community HUB model will provide community-based care coordinators, provide a formal structure for reducing duplication of care coordination services, achieve better health outcomes, address social determinants of health, and reimburse services through payers. North Sounds plans to start with a pilot program by:

- Selecting a pilot target population.
- Designing a project to identify lessons learned to apply in scaling Pathways to additional populations and payers.

¹² HSAC is involved in all eight projects. A description of the coalition is provided only in Project 2A to avoid duplication.

- Identifying and engaging care coordination agencies and training a cohort of at least 20 care coordinators.

Preliminary Target Populations. Medicaid beneficiaries (adults and children) with one or more chronic diseases or conditions, or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization). North Sound ACH will select a target population appropriate for Pathways and for non-duplicative collaboration with health homes, and that meets specified criteria.

Partners. North Sound ACH states that it has engaged health homes, hospital and health care delivery systems, EMS, government services, and CBOs. North Sound ACH also indicates broad engagement from regional stakeholders for the Pathways framework, including tribal nations, CBOs, and others able to leverage community health workers and clinical and other partners to serve as referral sources.

Project 2C: Transitional Care

General Approach. North Sound ACH has identified three areas of care transitions based on the Medicaid Transformation Toolkit, the high cost of patient care in these settings, and priorities identified by partners: transitions from inpatient hospitalization, from inpatient mental health and SUD treatment facilities, and from incarceration. North Sound ACH plans to build upon and add to existing regional work through the following potential strategies: address infrastructure gaps across all care transition strategies; coordinate with hospital partners to explore CTI model implementation and evaluate feasibility of model enhancements; consider medical respite care for people experiencing homelessness; and improve transitions for the jail population.

Preliminary Target Population. Medicaid beneficiaries transitioning from intensive settings of care or institutional settings, including enrollees discharged from acute care to home or to supportive housing, and enrollees with SMI discharged from inpatient care, or clients returning to the community from prison or jail.

Partners. North Sound ACH has engagement from clinical inpatient partners, community-based organizations, tribal nations, county governments, among others.

Project 2D: Diversions Interventions

General Approach. North Sound ACH will support creation of community supports for high-risk, high-utilizer Medicaid beneficiaries that prevent and provide alternatives to the ED and incarceration. Project strategies will focus on reducing unnecessary ED utilization, homelessness, and criminal justice encounters. North Sound ACH will support coordinated and wrap-around care through the following:

Project Goals	
■	Improve health outcomes for target population by supporting development and implementation of coordinated systems that address the complex needs of high utilizers.
■	Includes improving access and care coordination for people with complex needs, which should also result in reduction of unnecessary cost and inappropriate utilization in health care, social service, criminal justice, and emergency systems.

expansion of existing pilot Community Paramedicine programs and Care Coordination Collaboratives for Complex Cross-system Cases. North Sound ACH also indicates that it plans to build on successes in other regions, such as the Harborview High Utilizer Case Management Team in King County and a high utilizer care collaborative through Pierce County Fire and Rescue.

Preliminary Target Population. Medicaid-eligible and Medicaid-enrolled persons in the region who have complex medical and social needs, and frequent contact with law enforcement and/or EMS providers. This population will include individuals with complex co-occurring diagnoses, including mental health challenges, SUDs, or chronic illnesses (such as diabetes, heart disease, or asthma); and individuals who access the EMS system for a non-emergent condition, who may also be experiencing social barriers to health, such as housing instability, transportation barriers, and lack of employment.

Partners. There has been a high level of engagement from EMS leadership, especially Fire Chiefs, and county government representatives responsible for institutional oversight for target facilities. The ACH has engaged partners in five communities (Everett, South Snohomish County, Lynnwood, Whatcom County, and Skagit County), including first responders (fire, paramedic, and law enforcement), hospital systems, health providers, social services providers, corrections, housing agencies, and local government.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. North Sound ACH will build upon the North Sound BHO Opioid Reduction Plan (ORP), a comprehensive regional plan developed to mirror the state’s plan, with regional, county-level and tribal coordination activities designed to support state-level strategies and help further the four goals of prevention, treatment, reduction of overdose deaths, and enhanced data capacity. The North Sound ACH plans to partner with the BHO and other partners to execute the ORP and implement collaborative strategies beyond the current scope of the BHO’s efforts. Building on the ORP, the North Sound ACH indicates it will implement community-prioritized strategies based on evidence-based approaches and the recommended resources for identifying promising practices as outlined in the Medicaid Transformation Toolkit: Prevention: Prevent Opioid Use and Misuse; Treatment: Link Individuals with Opioid Use Disorder (OUD) with Treatment Services; Overdose Prevention: Intervene in Opioid Overdoses to Prevent Death; Recovery: Promote Long-Term Stabilization and Whole-Person Care. They also align with the 2017 Washington State Interagency Opioid Working Plan.

Opioid Reduction Plan
<p>North Sound BHO developed the ORP with the following, among others:</p> <ul style="list-style-type: none"> ■ Consultants ■ Regional partners in public health, behavioral health systems, physical and behavioral health providers ■ County human services ■ Nonprofit SUD treatment providers ■ University of Washington experts

Preliminary Target Population. Medicaid beneficiaries, including youth, who currently use, misuse, or abuse opioids, or are at-risk of using, or are otherwise negatively impacted by the opioid epidemic.

Partners. Development of partnerships has benefited from existing extensive collaboration led by the North Sound BHO with partners from criminal justice, social services, health care, and other systems to

develop innovative responses to this crisis and related homelessness, crime, and overdose deaths. Those already engaged with the North Sound ACH and BHO include North Sound Counties’ Human Services and Health Departments, tribal partners, drug courts and law enforcement, and numerous local primary and behavioral health care providers.

Project 3B: Reproductive and Maternal and Child Health

North Sound ACH will support PCPs, specialty providers serving women, children, and families, and CBOs implementing the selected strategies by building on existing work in the region, around the state, and nationally through the following strategies:

- Increase capacity of physical and behavioral health care practices to reduce unintended pregnancy and support healthy planned pregnancies by establishing systems and supports to integrate and evaluate One Key Question® pregnancy intention screening, counseling and support, and linking pregnancy intention screening and counseling with access to effective contraception (particularly LARCs), preconception care, counseling, and risk reduction for those planning for pregnancy.
- Increase capacity of physical health practices to support health and development of young children and their families, implementing HealthySteps in targeted practices serving large numbers of pediatric Medicaid beneficiaries, including implementation of Bright Futures recommendations.
- Ensure vulnerable children and families are considered high-priority populations across all Medicaid Transformation efforts, particularly behavioral health integration and care coordination efforts.

Project Goals
<ul style="list-style-type: none"> ■ Reduce unintended pregnancy. ■ Increase healthy planned pregnancies. ■ Strengthen and support young families. ■ Promote early childhood health and well-being, setting the foundation for good health across the life course.

Preliminary Target Populations. Medicaid eligible and enrolled women of reproductive age (15 to 44 years of age) and their partners, and Medicaid eligible and enrolled children (under 19 years of age) and their families.

Partners. Engagement of counties, FQHCs, Planned Parenthood, tribal health centers, home visiting programs, PCPs, military bases, behavioral health and SUD treatment providers, needle exchanges, state and federal programs, early intervention specialists, community action agencies, hospital systems, service providers to immigrant communities, housing and transportation providers, local health jurisdictions, among others. The ACH is also partnering with agencies including, but not limited to: Upstream USA, the National Campaign to Prevent Teen and Unplanned Pregnancy, the Bixby Center for Global and Reproductive Health, and the Washington Department of Health Family Planning Program. North Sound ACH will also partner with and build on the work of the Pediatric Transforming Clinical Practice Initiative.

Project 3C: Access to Oral Health Services

General Approach. North Sound ACH has identified two sets of project strategies: implementation of population health management tools in dental settings and building oral health capacity by expanding access and utilization of dental care based on existing regional pilot projects. North Sound ACH will engage with each tribal nation to assess interest in workforce expansion using the Dental Health Aide Therapist (DHAT) program, leveraging work with the Swinomish Tribe and Skagit Community College, and partnering with Northwest Indian Health Board and Olympic Community of Health (OCH) to bring DHAT training to Washington State. Other strategies include providing mobile dental hygiene by recruiting underutilized dental hygienists and implementing an Oral Health Delivery Framework through integration of dental services into medical primary care.

Preliminary Target Population. Key subpopulations at higher risk due to underutilization of services and oral-systemic links between oral diseases (such as caries and periodontitis) and health outcomes, including children ages 6 to 14 at elevated risk of caries and not already receiving sealants; adults with chronic periodontitis not already receiving treatment; adults and children in primary care medical practices who are not accessing dental services; pregnant women; and individuals with diabetes. North Sound ACH notes there is potential to impact all North Sound Medicaid beneficiaries, particularly those not receiving any dental care or sufficient recommended dental preventative services.

Partners. High levels of engagement from regional providers of oral health services, including FQHCs, tribal nation partners, foundations, and oral hygienists. Additionally, North Sound ACH notes engagement of CHC Snohomish, Sea Mar, and Unity Care, which together represent 100 percent of regional FQHC capacity; two hygienist societies and key leaders within the region's dental hygiene professional community; the Swinomish Tribe; and key advocacy and coordinative groups, such as health departments and the Whatcom Alliance for Health Advancement. The ACH plans to work to include more diverse partners, outreaching to private dentists to increase participation and collaboration in serving Medicaid patients.

Project 3D: Chronic Disease Prevention and Control

General Approach: North Sound ACH will support partners directly serving Medicaid enrollees who are at-risk or diagnosed with chronic diseases to implement project strategies based on the Chronic Care Model, and to implement several evidence-based change strategies, such as Self-Management support, Delivery System design, Decision Support, Clinical Information Systems, Community-based Resources and Policy, and Health Care Organization strategies. Work will build on existing community programs, such as a pilot of the Family Care Network, to prevent and manage chronic diseases by integrating health system and evidenced-based community approaches to improve chronic disease management and control. Focus will be on asthma, diabetes, and hypertension.

Preliminary Target Population. Medicaid beneficiaries (adult and children) with, or at risk for, chronic respiratory disease (asthma), diabetes, and hypertension, focusing on populations experiencing the greatest burden of chronic disease in the region.

Partners. North Sound has had high levels of engagement from community-based and clinical partnering providers, CBOs, a regional health system, and an MCO partner.

Findings and Scoring for North Sound ACH

Table 25 provides a listing of findings, including examples of strengths and opportunities.

Table 25. North Sound ACH Findings

Project Approaches

- Training providers on clinical guidelines and local community-based chronic disease prevention and management programs.
- Implementing population health management techniques.
- Recalling identified at-risk or diagnosed patients.
- Using available billing options and processes for referring or prescribing patients to home- or community-based programs.
- Implementing practice improvement and provider education activities.

Findings for North Sound ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • The Health Systems Advisory Coalition (HSAC) acts as an advisory body to the North Sound ACH. HSAC has participated in planning for integration efforts and will be involved in implementation. It includes leadership from the largest hospital systems providing physical health care in the North Sound ACH region, regional FQHCs, a large independent physician practice, and a smaller pediatric practice, and brings a self-reported 205,000 attributed Medicaid beneficiaries. • The North Sound BHO is engaged in multiple projects and brings a network of 37,202 Medicaid beneficiaries. 	<ul style="list-style-type: none"> • While North Sound ACH is partnering with entities bringing a high number of Medicaid beneficiaries, the Project Plan notes continuing further outreach to other partnering providers, including those located in more rural settings and smaller in size. Recommendation: As planning progresses, more information to help further understand involvement of partners in rural areas and of smaller sizes will be beneficial. • Contradictory information was provided as to whether evidence-based approaches have been determined. Recommendation: Approaches submitted to HCA in DY2 will need to be reviewed

Findings for North Sound ACH

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| <ul style="list-style-type: none"> • North Sound ACH indicated a thorough and collaborative process for defining target populations. They plan to work with implementation planning teams, the Community Leadership Council, and the Data and Learning Team to use the best available research, regional data, and community input to define target populations, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation period. North Sound ACH will continue to collaborate with ACHs across the state and the HCA AIM Team to identify shared data-driven processes and target population selection methodology. • North Sound ACH has engaged MCOs by including representatives on the Board of Directors, the Program Council and in each workgroup. MCO representatives served as workgroup leads for the Care Transitions and Chronic Disease projects. • North Sound ACH acknowledges the importance of health information sharing and that project success will be difficult to achieve without changing the way that health information is shared. North Sound ACH indicated a key transformative piece of the projects is the potential for organizing cross-system, patient-centered collaboration among local networks, supported by real-time data sharing and care planning technologies, as well as the opportunity to braid funding from multiple sources. • For several projects, such as Projects 2D, 3B and 3D, North Sound ACH notes alignment of populations or targeted issues with regional priorities that have been identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and CBOs. • Specific to Project 2A, North Sound ACH is considering partnering with the UW AIMS Center, Healthier Washington Practice Transformation Support Hub, and The National Council of Behavioral Health — Case to Care trainings, to enhance existing efforts, expand the scope of integration, and reduce duplication of services. | <ul style="list-style-type: none"> • to confirm compliance with Medicaid Transformation Toolkit requirements. • North Sound ACH’s initial submission specific to the Monitoring and Continuous Improvement subsection needed substantial clarification about the process and overall structure. North Sound provided more detailed information and streamlined some of the identified approaches that helped to clarify the approach.
Recommendation: Given North Sound is instituting multiple teams (implementation teams across the eight projects, Data and Learning team, Activity Teams) and that three Project Managers have many responsibilities across the eight projects, Myers and Stauffer recommends that the ACH continually monitor this structure to confirm how effectively these teams are able to coordinate across projects where applicable and where the ACH has identified overlap. • North Sound ACH noted throughout its Project Plan opportunities to coordinate across projects to support transformation. (e.g., Care Coordination and Transitional Care, Diversions Interventions with the regional Pathways HUB, Oral Health with Bi-directional Integration, Care Coordination and Diversions Interventions, etc.).
Recommendation: Given the plan is to have separate implementation teams for each project, Myers and Stauffer recommends North Sound ACH give thorough consideration for coordination across implementation teams and avoidance of duplicative or conflicting efforts. • Specific to Project 2B, North Sound ACH acknowledges that many care coordination efforts exist in the region. Additionally, as the ACH is pursuing all eight projects, there is potential for beneficiaries to fall into multiple project areas depending on the defined target populations selected. Recommendation: Myers and Stauffer recommends that North Sound ACH have a thorough process in place to assure not only non-duplication of services and funding, but also processes to identify coordination for |
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Findings for North Sound ACH

- Specific to Project 2B, North Sound ACH has collaborated with MCOs and other partners to develop a design for the HUB and a system that has payer buy-in to assure that the transformation lasts beyond the Medicaid Transformation period.
- Specific to Project 2D, to inform the challenges of homelessness in the region, North Sound ACH is looking to existing regional successes and local community planning and resources to help inform the project. There is recognition that collaborating across regions is essential to identifying and implementing best practices and lessons learned.
- Specific to Project 3A, given prior work of the North Sound BHO and other stakeholders, this project appears to be further along in development. Extensive stakeholder engagement has already been conducted. North Sound ACH cites that the ORP’s recommendations and proposed activities reflect information and ideas gathered from a total of 40 interviews, focus groups and conversations with key leaders and community groups.
- Specific to Project 3C, FQHCs are identified as providing the majority of dental services to Medicaid beneficiaries in the region, so they are critical to project success. The two entities that represent 100 percent of regional FQHC capacity in the region are engaged.
- Specific to Project 3D, Chronic respiratory disease (asthma), diabetes, and hypertension were the selected chronic diseases for this project due to associated opportunities for primary and secondary prevention of disease development, prevalence in the Medicaid population, cost to treat these conditions if unmanaged, and their association with the pay-for-performance metrics identified in the Medicaid Transformation Toolkit.

- beneficiaries to avoid, for example, multiple and conflicting care plans.
- Specific to Project 2D, North Sound ACH noted in the Project Plan that legislation is pending that would support Community Paramedics.
Recommendation: Should the legislation not pass, additional information from North Sound ACH about impact, if any, to the project will be beneficial.
 - Specific to Project 3C, Partnerships will be needed with educational institutions to train and develop a new and expanded workforce for providing dental care to the Medicaid population. The participation of private dental providers will be needed to meet the goals for the region.
Recommendation: As outreach continues, it may be beneficial to obtain updates from North Sound ACH as to their strategies for and success in obtaining private dental providers given specified linkage to noted goals in the region.

Myers and Stauffer submitted two rounds of write-back requests to North Sound ACH as part of the assessment process. *Table 26* provides an overview of the resulting scores. At the end of the process, North Sound ACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 26. North Sound ACH Scoring

North Sound ACH			
	Initial Score	Score After 1st Write-Back	Score After 2nd Write-Back
Section 1 Score	82.92%	88.33%	100%
Section 2 Score	77.50%	96.05%	100%
<i>Section 2 Projects:</i>			
2A	73.68%	88.42%	100%
2B	83.16%	97.89%	100%
2C	73.68%	92.63%	100%
2D	73.68%	97.89%	100%
3A	84.21%	97.89%	100%
3B	73.68%	97.89%	100%
3C	78.95%	97.89%	100%
3D	78.95%	97.89%	100%
Total Score	79.13%	93.73%	100%
Bonus			20%
Final Score			100%

Olympic Community of Health



Summary Findings for Olympic Community of Health

Olympic Community of Health			
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Clallam ○ Jefferson 	<ul style="list-style-type: none"> ○ Kitsap 		
<ul style="list-style-type: none"> ■ Tribal Reservation/Trust Land: The Hoh, Jamestown S’Klallam, Lower Elwha Klallam, Makah, Port Gamble S’Klallam, Quileute and Suquamish Tribes are located in this region. 			
<ul style="list-style-type: none"> ■ Medicaid Population Size (November 2017 Client Count): 73,719 			
<ul style="list-style-type: none"> ■ Medicaid Transformation Toolkit Projects 			
<ul style="list-style-type: none"> Selected: <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2D: Diversions Interventions </td> <td style="width: 50%;"> <ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3B: Reproductive and Maternal and Child Health ○ 3C: Access to Oral Health Services ○ 3D: Chronic Disease Prevention and Control </td> </tr> </table> 		<ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2D: Diversions Interventions 	<ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3B: Reproductive and Maternal and Child Health ○ 3C: Access to Oral Health Services ○ 3D: Chronic Disease Prevention and Control
<ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2D: Diversions Interventions 	<ul style="list-style-type: none"> ○ 3A: Addressing the Opioid Use Crisis ○ 3B: Reproductive and Maternal and Child Health ○ 3C: Access to Oral Health Services ○ 3D: Chronic Disease Prevention and Control 		

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. Olympic Community of Health (OCH) was found to have provided a thorough and detailed Regional Health Needs Inventory, using a variety of previous and new data sources to create a regional health data repository to identify the greatest regional health needs to inform project selection and planning. This data repository will continue to be used to inform the planning, implementation, and monitoring needs of the projects selected by OCH. They also utilized multiple data types to inform their decision-making including, but not limited to: Community Health Assessments from all three counties, Public Health data, Health Professional shortage area data, provider-level data, surveying partnering clinical and CBOs, workforce data, and vital statistics. OCH provided numerous statistics about the region’s health needs to support the six projects selected.

Governance. OCH documented that since Phase II Certification they have dissolved the Regional Health Assessment and Planning Committee and created two new committees. The first committee, the Community and Tribal Advisory Committee, is responsible to provide recommendations to OCH about project design and implementation, transparent communication strategies, regional whole-person health priorities, social justice, and health equity. The second committee, the Performance, Measurement, and Evaluation Committee (PMEC), will be responsible to provide recommendations regarding assessment, measurement, monitoring, management, interoperability, security, and performance tracking.

Funding Allocation. The OCH board has ultimate fiduciary responsibility for planning, management, and accounting of DSRIP funds. The Finance Committee oversees all financial and accounting policies, procedures, and practices to maintain and improve the organization’s financial health and integrity. OCH noted that staff has started to work with the Funds Flow Workgroup to develop allocation criteria, algorithms, timelines, and processes for DSRIP revenues. The Workgroup works with Natural Community of Care (NCCs) that review and provide feedback to refine the Workgroup’s recommendations to the Board.

Recommendations are reviewed by the Finance and Executive Committees and posted on the website for public comment before finalized.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. OCH provided a table of Domain I foundational investments or infrastructure needed at the provider level to carry out projects in Domains 2 and 3. Three categories are listed: Capacity Infrastructure Strategies, Workforce Strategies and Transformation Strategies. Examples of foundational investments or infrastructure needs per category:

- Capacity Infrastructure Strategies: health information sharing, bricks and mortar, development and management of tools such as registries and risk stratification, and data analytics (decision support technology).
- Workforce Strategies: telemedicine, curriculum development/support, recruitment, and retention.
- Transformation Strategies: care coordination including referral management, integrated team based care, patient centered medical home, and engaged leadership.

Findings for Section I

Table 27 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 27. Olympic Community of Health Section I Findings

Findings for Olympic Community of Health	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • OCH noted that since the Phase II Certification, they have employed numerous strategies to improve outreach and to solicit genuine community connection around the Medicaid Transformation. These strategies include strengthening OCH’s commitment to transparency, providing multiple modes for broad community input, engaging Medicaid beneficiaries through various means, and responding directly to community input, concerns, and questions. For example: <ul style="list-style-type: none"> ○ Board of Directors meetings are open to the public, both in person and via Go-to-Meeting. ○ OCH utilized several different surveys, developed by epidemiologists, to garner community input. ○ Emailing of a tribal survey to tribal partners on the Project Plan portfolio and health priorities in October 2017. 	<ul style="list-style-type: none"> • In comparing the region to Washington State for the rate of providers per 100,000 residents, the region has a lower rate for the following provider types: All physicians providing direct care, PCPs, advanced registered nurse practitioners, mental health care providers, and dental providers. Recommendation: As project planning continues in DY 2, it will be beneficial for OCH to provide information on how proposed workforce strategies are intended to meet the needs of their region. • Surveys of health care provider organizations indicated the two most frequently identified barriers for Medicaid beneficiaries were transportation and housing. While it was noted some consumer outreach has been performed, it was not clear if a comprehensive list of barriers was obtained from the consumer perspective.

Findings for Olympic Community of Health	
<ul style="list-style-type: none"> Public input received on the draft Project Plans was provided to project leads to incorporate as appropriate. 	<p>Recommendation: Myers and Stauffer recommends OCH validate this information further by working with consumers to identify a comprehensive listings of all barriers. When this list is complete, OCH should further identify methods to help address those barriers.</p>

2. Project Plan Section II Overview and Findings by Project

OCH is pursuing six projects for the Medicaid Transformation. Below is a high-level overview of OCH’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. OCH will allow partnering providers to select either of the following integration approaches listed in the Medicaid Transformation Toolkit for Integrating Behavioral Health into Primary Care Setting: the Bree Collaborative or Collaborative Care Model. The approach is to include:

- Access to a patient-centered medical home for integrated, whole person care
- Screening, early intervention, treatment, and/or referral to specialty care
- Disease management, including for comorbid conditions
- Care coordination for persons with comorbid conditions and/or social needs

For integration of primary care into behavioral health settings, OCH noted the Collaborative Care approach will be utilized with a focus on enhanced collaboration, including:

- Annual visit/well check
- Visits for complaints/acute illness
- Management of chronic conditions, including chronic pain
- Chronic disease patient self-management education and programs
- Care coordination for persons with comorbid conditions and/or social needs

Preliminary Target Population. Two target population groups are:

- Medicaid beneficiaries (adults and children) who qualify for services in primary care (including pediatric) settings (a) broadly screened and b) with recognized behavioral health concerns that did not require specialty behavioral health care.
- Medicaid beneficiaries (adults and children) who qualify for services in behavioral health settings (a) absent of a primary care medical home or b) without a yearly PCP visit, or c) with complex comorbid conditions, or d) receiving care at the ED or e) at discharge from jail.

OCH provided a listing of adult subgroups for specific consideration within the general target populations. OCH also noted that targeted sub-populations for children will be determined by the results from screening and early intervention.

Partners. Active and potential partners include, but are not limited to: FQHCs, hospitals, community behavioral health agencies, tribal health clinic, SUD treatment providers, MCOs, an elected official, a nonprofit organization, university, and pediatric clinic. Almost all key Medicaid providers have been highly active participants in shaping the project selections.

Project 2D: Diversions Interventions

OCH selected two approaches listed in the Medicaid Transformation Toolkit: 1) ER is for Emergencies and 2) Community Paramedicine. Additionally, pending further discussion with stakeholders, OCH stated two additional approaches are under consideration: 1) Law Enforcement Assisted Diversion and 2) Tribal Jail Re-Entry Program.

Preliminary Target Population. All Medicaid beneficiaries being discharged from the ED and released from jail. Targeted populations for the two approaches:

- ER is for Emergencies: Patients requiring housing services, without a patient-centered medical home, with a diagnosis of asthma, diabetes, hypertension, behavioral health disorder (emphasis on OUD diagnosis), or dental pain, or with a high recidivism rate, defined as greater than five ED visits per year or greater than three arrests per year.
- Community Paramedicine: Patients with chronic medical conditions referred from partnering providers. Examples provided were chronic heart failure, chronic obstructive pulmonary disease, diabetes, and/or with complex behavioral health conditions.

Partners. Active and potential partners include, but are not limited to: FQHCs, hospitals, community behavioral health agencies, tribal health clinic, SUD treatment providers, and Area Agency on Aging, EMS, jails, law enforcement, and fire department.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. OCH has worked as a region to address the opioid crisis for the past 18 months. Using SIM funding, OCH established a Steering Committee with representation from all three counties. OCH completed a high-level assessment of available data, surveyed PCPs, law enforcement, SUD providers, and other pertinent stakeholders and drafted a regional opioid response plan. OCH will utilize the Six Building Blocks for Clinic Redesign for Safer Opioid Prescribing and Transformed Care for Chronic Pain model, which is focused on:

1. Leadership and consensus: Building organization-wide consensus to prioritize safe prescribing practices; includes an initial clinic-wide self-assessment.
2. Revising policies and standardizing work: Revising and implementing clinic policies and defining standard work flows for health care team members.
3. Tracking patients on chronic opioid therapy (COT): Implementing proactive population management before, during, and between clinic visits for COT patients.
4. Conducting prepared, patient-centered visits: Preparing and planning for clinic visits of all patients on COT to support care that is safe, appropriate, and empathic.
5. Caring for complex patients: Identifying and developing resources and referrals for patients who develop complex opioid dependence.
6. Measuring success: Continuing monitoring and improvement over baseline assessment and clinic QIP.

OCH's Project Goals

- Prevention of opioid misuse and abuse by improving prescribing practices and community education.
- Improve access to the full spectrum of best practices for the treatment of OUD, including support for long-term recovery.
- Prevent opioid overdose deaths.

The Six Building Blocks for Clinic Redesign for Safer Opioid Prescribing and Transformed Care for Chronic Pain model approach is not listed in the Medicaid Transformation Toolkit. During the write-back process, Myers and Stauffer asked OCH to provide a rationale for the selection of this approach. OCH stated this model incorporates the adoption of the approaches in the Medicaid Transformation Toolkit in the refining of policies and revised work flows. The 3CCORP Prevention Workgroup and 3CCORP Steering Committee (SC) both recommended the Six Building Blocks model be funded and implemented region-wide in 10 clinics across the OCH region. The OCH Board unanimously approved this motion. OCH noted "This represents innovation with a cutting-edge, evidence-based practice that can result in better care and saved lives."

Preliminary Target Population. The following are in the target population:

- Beneficiaries with a diagnosis of OUD and their families, as well as beneficiaries not yet diagnosed with OUD.

- Beneficiaries without a cancer diagnosis with an opioid prescription in the last year, who are chronic opioid users, or who are on high dose prescriptions.
- Beneficiaries who have presented to the ED with an overdose.
- Beneficiaries under the age of 18 at risk for developing OUD.

OCH also stated the broader community (Medicaid and non-Medicaid) within the region, including families of the target population, is considered the secondary target population.

Partners. Active and potential partners including, but not limited to: FQHCs, hospitals, community behavioral health agencies, tribal health clinic, pediatric primary and specialty care, SUD treatment providers, local health jurisdiction, and fire department and a nonprofit organization. OCH noted the active partnerships they have established in the region to support work completed under the SIM funding is an asset for the Medicaid Transformation work ahead.

Project 3B: Reproductive and Maternal and Child Health

General Approach. As noted in Section I, OCH reported their regional rates for chlamydia screening, access to LARCs, and early prenatal care rates are lower than the state averages. OCH selected two approaches:

- CDC Recommendation for Preconception Health and Health Care.
- Coordinated, targeted outreach and engagement to increase well-child visits.

Strategies to increase awareness of the need for well-child checks and improve referral to health centers for visits were also provided in the documentation. For the coordinated, targeted outreach and engagement to increase well-child visits approach, OCH stated the evidence for this program is provided by Peninsula Community Health Services.

Preliminary Target Population. All sexually active men and women, men and women of reproductive age along with their partners, all pregnant women, all post-delivery women, all men and women during assessment visit, and children ages 0 to 6 and their parents or caregivers. Additionally, OCH noted the two subpopulations: men and women classified as high-risk through provider intake and assessment, and children assigned to a provider group with no well-child check.

Partners. Active and potential partners include, but are not limited to: FQHCs, hospitals, pediatric clinic, tribal health clinic, Human Services agency, local health jurisdiction, primary and specialty care, and school districts.

Project 3C: Access to Oral Health Services

General Approach. OCH stated that access to oral health services is one of the top five priority areas for the region, noting that “While total providers per Medicaid dental user are 5 percent below statewide averages, providers per eligible person are 35 percent lower than the state average.” OCH plans to

implement the mobile dental unit approach to include both restorative and preventive dental services. OCH’s identified strategies are listed in *Table 28*.

Preliminary Targeted Population. *Table 28* outlines targeted populations for each strategy.

Table 28. Olympic Community of Health Potential Strategies and Targeted Populations for Oral Health Services

Strategies	Target Population
Mobile Van	Medicaid beneficiaries (adults and children) without or with limited dental access
Expand use of integration of dental services in medical primary care settings	Medicaid beneficiaries (adults and children) during primary care visit
Develop new dental FQHC site in North Kitsap (est. operational date: 2019)	Medicaid beneficiaries (adults and children) in North Kitsap
Develop new dental Rural Health Clinic site in Jefferson County (est. operational date: 2020)	Medicaid beneficiaries (adults and children) in Jefferson County
Support and expand dental health aide therapist workforce for tribal clinics	American Indians/Alaska Natives served by tribal clinics
Offer preventive dental services to school-based clinics, beginning in Jefferson County (Port Townsend and Chimacum) with potential expansion to Clallam County	Children in school

Partners. Active and potential partners include, but are not limited to: FQHCs, hospitals, pediatric clinic, tribal health clinic, Human Services agency, local health jurisdiction, primary and specialty care and school districts.

Project 3D: Chronic Disease Prevention and Control

General Approach. OCH stated their vision is "to become a region where every person at-risk of or diagnosed with a chronic disease receives team-based care in a medical home that is linked to tailored disease self-management community-based interventions." OCH will implement the Chronic Care Model and National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) to guide practice transformation for management of diabetes, cardiovascular disease, hypertension, and asthma. OCH stated that existing regional efforts include chronic disease self-management (including Wisdom Warriors) and Diabetes Prevention Programs (DPPs), primarily through CBOs and tribal clinics. Also they note Kitsap Mental Health Services utilizes an approach to chronic disease management designed specifically for persons diagnosed with mental illness and/or substance use called Whole Health Action Management (WHAP).

Preliminary Target Population. See preliminary target populations related to strategies listed in *Table 29*.

Table 29. Olympic Community of Health Strategies for Chronic Disease Prevention and Control

Strategies	Evidence-based/ Best Practice	Target Population	Target Subpopulation
<ul style="list-style-type: none"> Organization of the health care delivery system community linkages Self-management support Decision support Delivery system re-design Clinic information systems 	<ul style="list-style-type: none"> Chronic Care Model DPP WHAM CDSM/ Wisdom Warriors 	Adult Medicaid beneficiaries	<ul style="list-style-type: none"> Persons with mild mental health issues Persons with SMI and/or SUD Persons with Congestive Heart Failure American Indian/Alaska Natives
<ul style="list-style-type: none"> Asthma assessment and monitoring Education for partnership in asthma care Control of environmental factors and comorbid conditions that affect asthma Managing asthma long-term (including use of EPA Asthma Environmental Checklist) 	<ul style="list-style-type: none"> National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for Diagnosis and Management of Asthma 	Adult and child Medicaid beneficiaries	<ul style="list-style-type: none"> Persons with SMI and/or SUD American Indian/Alaska Natives Children Older adults Smokers

OCH provided the following about the preliminary target populations: “Providers and community partners intending to participate in this project serve about 60,000 unduplicated patients. An estimated 11,880 Medicaid lives per year (about 23 percent of the adult Medicaid population) comprise the adult target population for the chronic care model project. Partners committed to improving identification and management of asthma will serve a target population of at least 2,700 adults and children (based on current number of patients diagnosed with asthma within two FQHCs and one community behavioral health agency (CBHA). Providers may choose to target subpopulations which experience a higher level of chronic disease burden, including:

- Persons with depression and anxiety diagnoses
- Persons with severe mental illness and/or SUD
- American Indians/Alaska Natives, who have higher risk of chronic illness than other minority groups
- For asthma: focus on children and older adults

Partners. Active and potential partners include, but are not limited to: FQHCs, public health, tribal health clinic, human services agency, housing agency, primary and specialty care, and community action agency.

Findings and Scoring for Olympic Community of Health

Table 30 provides a listing of findings, including examples of strengths and opportunities.

Table 30. Olympic Community of Health Findings

Findings for Olympic Community of Health	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • Specific to Project 2A: <ul style="list-style-type: none"> ○ The majority of primary care practices accepting Medicaid have committed to adopt either the Bree Collaborative or Collaborative Care approach. ○ Two tribal partners have committed to integrate health services with mental health and substance use services and facilities. • Specific to Project 2D, OCH will work with MCOs to leverage MCO diversion activities for this project. • Specific to Project 3A, to further support the project, OCH plans to focus on greater inclusion and input from low-income housing and anti-homelessness region campaigns. • Specific to Project 3B, OCH noted they are speaking with Kitsap Strong, an existing community initiative in Kitsap aimed at improving the health and well-being of all children, families, and adults, about providing education and training in NEAR sciences (Neuroscience, Epigenetics, ACEs, and Resilience) and trauma-informed practices to partnering providers. • Specific to Project 3C, OCH noted the Medicaid MCOs are an asset to this project as they can offer expertise with infrastructure to support population health management, incentives to foster medical and dental integration, and care management. • Specific to Project 3D, OCH plans on collaborating with MCOs to facilitate targeted outreach to Medicaid beneficiaries and linking with CBOs to assist in reaching target populations. 	<ul style="list-style-type: none"> • OCH stated in each individual project submission that they will hire a Compliance and Contract Coordinator who will perform provider oversight activities such as overseeing change plan compliance, conducting site visits, and performing annual audits. It appears OCH is stating one coordinator will perform all required activities across all six projects. Recommendation: Myers and Stauffer recommends OCH provide finalized roles and responsibilities to ACH for the Compliance and Contract Coordinator with details as to how they anticipate the coordinator will effectively perform all job requirements across all six projects. • OCH noted that partners will receive additional support through a change manager. Change managers will be responsible for offering regular progress check-ins with participants within each NCC, identifying cross-cutting implementation barriers among partnering provider organizations, making recommendations to address those barriers, and revising change plans appropriately. The change manager will be employed by the provider organization or OCH. Recommendation: As project planning continue in DY 2, Myers and Stauffer recommends OCH provide further information to HCA about how it will be determined who employs the change manager (OCH or NCC), how/if that will affect the roles and responsibilities of the change manager, and what infrastructure will be put in place to allow/encourage change managers for different projects to collaborate.

Findings for Olympic Community of Health

- Specific to Project 3B, OCH stated plans to use a coordinated, targeted outreach and engagement evidence-based approach to increase well-child visits. This approach is provided by Peninsula Community Health Services and is not listed in the Medicaid Transformation Toolkit.
Recommendation: As project planning continues and approaches are further defined, consideration and review of the approach may be required based on Medicaid Transformation Toolkit specifications.
- Project 3C: OCH indicated a potential challenge of the mobile van not attracting enough patients to be financially viable and noted potential solutions to include adding new sites and adjusting scheduling, adding outreach activities, and adding connector activities to assure patients make appointments. **Recommendation:** As project planning continues in DY 2, additional information about strategies that OCH plans to use to promote the mobile van services should be submitted to HCA.

Myers and Stauffer submitted one write-back request to OCH as part of the assessment process. *Table 31* provides an overview of the resulting scores. At the end of the process, OCH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 31. Olympic Community of Health Scoring

Olympic Community of Health		
	Initial Score	Score After 1st Write-Back
Section 1 Score	76.67%	100%
Section 2 Score	77.19%	100%
<i>Section 2 Projects:</i>		
2A	77.89%	100%
2D	83.16%	100%
3A	60.53%	100%
3B	60.53%	100%
3C	83.16%	100%
3D	97.89%	100%
Total Score	77.04%	100%
Bonus		10%
Final Score		100%

Pierce County Accountable Community of Health



Summary Findings for Pierce County ACH

Pierce County ACH	
■ Counties:	
○ Pierce	
■ Tribal Reservation/Trust Land:	The Puyallup Tribe and Nisqually Indian Tribe are located in Pierce County.
■ Medicaid Population Size (November 2017 Client Count):	203,383
■ Medicaid Transformation Toolkit Projects	
Selected:	
○ 2A: Bi-directional Integration of Care	○ 3A: Addressing the Opioid Use Crisis
○ 2B: Community-based Care Coordination	○ 3D: Chronic Disease Prevention and Control

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor's findings.

Regional Health Needs Inventory. Pierce County ACH (PCACH) implemented a Data and Learning Team (DLT) to show their commitment to data. The DLT is responsible for the development of data capacity strategies to ensure that PCACH and its partners can achieve shared goals. DLT committee members reviewed the Regional Health Needs Inventory data to identify priorities, make recommendations for target populations, and discuss process and outcome measurements. The DLT also serves as a liaison to other governing committees and boards through the translation and presentation of data.

PCACH used over 20 data sources to assist in informing nine decision areas, which include the projects to select, target population, and stakeholder engagement. Data sources included:

- Regional Health Needs Inventory
- Public Health's Community Health Assessment
- Community Health Improvement Plan
- Community Health Needs Assessment
- Working with the MCOs, health systems, provider groups, and CBOs
- Local public health departments
- Short online survey to acquire stakeholder input regarding which populations to prioritize

Funds Allocation. With input from the workgroups, committees and the PCACH Board, PCACH developed funding guiding principles. PCACH's guiding funding principles are that they will be flexible, equitable, locally responsive, compliant, simple, collaborative, and sustainable.

As for the governance of the funding mechanisms for the ACH, the Waiver and Investment Committee is the group primarily responsible for funding mechanisms. This committee finalized the framework for fund distribution and is responsible for reviewing and recommending periodic payments under the established model. Additionally, the Waiver and Investment Committee manages the funds flow process. The committee is responsible for developing recommendations related to allocations, investments, and oversight of the long-term PCACH strategy to invest in upstream, social determinants of health through the Community Resiliency Fund. The Finance Committee and Executive Committee review the Waiver and Investment Committee's recommendations before they are sent to the Board of Trustees for final approval or denial.

Required Health Systems and Community Capacity (Domain 1) Focus Areas. PCACH indicates that it has a Strategic Improvement Team that will be deployed to support capacity and capability building for providers and partnering organizations. PCACH noted that they will hire and deploy Strategic Improvement Advisors who will go through a 10-month Science of Improvement training program with the Institute for Healthcare Improvement that "intertwines PCACH's transformation of care and service delivery settings and project portfolio to support regional projects and infrastructure development efforts." PCACH cites that the Improvement Advisor programming places PCACH's projects into a rigorous improvement model that ensures capacity and capabilities are leveraged, built, and deployed within the region with partnering providers to secure engagement and long-term sustainability.

Finally, in response to Phase II certification submission areas identified by HCA as requiring improvement, PCACH addressed the following:

In the budget and funds flow section of Certification Phase II, it was noted that PCACH did not submit their financial statement; however, the financial statements were included in the original attachments. HCA also noted that additional detail regarding health system partner investments would be appreciated. The two health systems in the region (CHI Franciscan and MultiCare) and one of five payers, United Healthcare Community Plan, provided financial donations to support PCACH's infrastructure development, including the building of the community engagement system strategy and deployment. The two health systems provided approximately \$180,000 in cash plus in-kind resources that include: legal, financial, and original office space to formalize the structure of PCACH. The Phase II budget included anticipated Year Two SIM funding to be used to supplement efforts impacting social determinants of health that may not have been immediately addressed through Medicaid Transformation projects. PCACH noted that based on recent information about reductions in state funding, they no longer anticipate these funds being available. PCACH indicates that it continues to solidify relationships with agencies across the state to align social services resources with project work, and they have agreements for in-kind resources to support community health worker workforce development and supported employment services, and to assist in operationalizing their regional strategic improvement initiatives.

Findings for Section I

Table 32 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 32. Pierce County ACH Section I Findings

Findings for Pierce County ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> PCACH and SWACH appear to be collaborating in several areas. For example, they shared a Chief Information and Technology Officer (CITO). PCACH is implementing a Strategic Improvement Team that will support capacity and capability building with providers and partnering organizations, ensuring regional work is driven by improvement science. Strategic Improvement Advisors will attend a 10-month Science of Improvement training program with the Institute for Healthcare Improvement. 	<ul style="list-style-type: none"> PCACH noted that they are continuing to outreach to the Puyallup Tribe for participation, but as of Project Plan submission had not received a response. The Nisqually Tribe has elected to work with CPAA. Recommendation: Continued outreach is important, particularly given specified strategies, such as working with the Puyallup Tribe to assist, encourage, and incentivize members of their clinical residency program to be retained within the region’s workforce.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, PCACH is pursuing four projects for the Medicaid Transformation. Below is a high-level overview of PCACH’s approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. By the end of the Medicaid Transformation, PCACH’s plan is that all providers will have implemented the Collaborative Care Model with some elements of the Bree recommendations where flexibilities are necessary for the partnering providers. They note that integration efforts will help sustain system transformation by:

- Optimizing utilization and reducing system strain
- Reducing unnecessary ED and preventable hospital use
- Improving health and management of health

Preliminary Target Populations. Medicaid beneficiaries with a diagnosis of a behavioral health disorder, with half of them having a comorbid chronic health condition. PCACH wants to further subdivide the targeted population in 2018 (e.g., concentrating on members who had two or more visits to the ED within a specific time frame). Eventually, PCACH indicates that they plan to target all 230,000 Medicaid beneficiaries.

Partners. At time of submission, 38 partnering providers had submitted LOIs. Examples of provider types include behavioral and physical health providers, pediatric clinics, Planned Parenthood, fire and rescue providers, community partners, among others. Examples of providers include, but are not limited to:

Children's Home Society, Emergency Food Network, Samoan Nurses Organization, Pioneer Human Services, Northwest Integrated Health Care, and Lutheran Community Services.

Project 2B: Community-based Care Coordination

General Approach. PCACH is using the Pathways Community HUB to provide "community-based, culturally competent, and person-centered care coordination for identified vulnerable populations that promotes care coordination across the continuum of health services for Medicaid beneficiaries, ensuring that those with complex health needs are connected to the interventions and services needed to improve and manage their health." PCACH will begin the project as a pilot. Community health workers serving across four Care coordination agencies will be hired to work with the Pathways Community HUB on budgeting, VBP methodologies, tracking outcomes, and building sustainability modules. This pilot allows for community health workers to prepare prior to expansion. Care coordinators will assist individuals to navigate the health care system and community providers and will work with the patient's entire family.

Preliminary Target Population. Non-white pregnant Medicaid beneficiaries with an SUD. This focus was selected since this is the subgroup with the most disparity. In DY 3, PCACH indicates expansion to additional subgroups (e.g., new targets of OUD and individuals with co-occurring behavioral health disorders and chronic conditions), and by DY 5 the project will serve more than 4,000 members.

Partners. At time of submission, 36 providers were noted as committed to the project. Across all settings, PCACH indicated that partnering providers engaged to date are responsible for the majority 90 percent of Medicaid claims in the region. Also, PCACH engaged nearly 200 individuals from multiple sectors in planning, including MCOs, community members, medical providers, substance use disorder providers, EMS, housing, criminal justice, public health, early learning, among others. The ACH also commented that it has established a Care Coordination Advisory Workgroup to engage a broad spectrum of partnering providers.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. Providers will implement the 2015 AMDG Guidelines for Prescribing Opioids for Pain, the Washington Emergency Department Opioid Prescribing Guidelines, and/or the Substance Use During Pregnancy: Guidelines for Screening and Management. PCACH has the following objectives and strategies:

- Prevent inappropriate opioid prescribing and reduce use of opioids without a prescription or misused with a prescription.
- Increase access to treatment for people with OUD, link patients to treatments, increase access to MAT, and implement low-barrier methadone/buprenorphine program.
- Prevent deaths from overdose: Increase access to Naloxone in community settings, and evaluate appropriateness of co-prescribing Naloxone for pain patients.

- Provide recovery supports and promote long-term stabilization and whole person care: utilize community-based care coordination services (through Pathways HUB) to support linkages to recovery programs, housing, transportation, food, and other social determinants of health.

Preliminary Target Population. All Medicaid beneficiaries in the region, specifically, adults and children who use opioids (especially OUD) who are not receiving MAT. Targeted populations by objective area are as follows:

- Prevention: 180,000 Medicaid beneficiaries receiving care through partnering providers will receive broad prevention efforts. Focus will be on members at risk of transitioning from appropriate use to chronic use.
- Treatment: 6,500 Medicaid beneficiaries with OUD.
- Overdose Prevention: Medicaid beneficiaries with opioid prescriptions who are evaluated for a Naloxone co-prescription, which includes 6,870 with high dosage prescriptions and 2,812 people injecting heroin and do not have access to treatment or are not ready to recover.
- Recovery: Medicaid beneficiaries with a focus on risk for relapse, which includes 500 beneficiaries receiving MAT with buprenorphine and 1,075 using methadone, and those who recently completed inpatient care.

Partners. At time of submission, 38 providers had submitted LOIs to express interest in this project. PCACH indicated the Opioid Workgroup charged with project design includes representatives from BHOs, SUD providers, health systems, MCOs, CBOs, homeless shelters, community health workers, and the criminal justice system. Participating organizations include, but are not limited to: county and state agencies, Tacoma Recovery Café, law enforcement offices, Fire and Rescue, Korean Women's Association, Molina Health Care, Metropolitan Development Council, Northwest Integrated Health (Hub and Spoke), Northwest Physicians Network, Prosperity Wellness Center, Point Defiance AIDS Project — Tacoma Needle Exchange, Planned Parenthood, CHI Franciscan Health, Catholic Community Services — Nativity House, Community Health Care (CHC), Crisis Clinic, and Sea Mar Health Centers.

Project 3D: Chronic Disease Prevention and Control

General Approach. PCACH indicates a focus on implementation of the Chronic Care Model across diverse care settings. This project centers on the following drivers of change:

- Adoption of PCACH's Transformation Rules of Engagement, ensuring consistent guidelines across regional partners.
- Implementation of chronic disease self-management interventions.

Chronic Care Model Elements

- Systems of Care
- Self-management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Community-based Resources

- Provision of support for effective complex care and disease management for targeted population.
- Utilization of Communication Voice Council and PIP to support interventions.

Preliminary Target Population. Adults with diabetes, children and adults with obesity, children and adults with asthma/COPD, and adults with hypertension and cardiovascular disease.

Partners. PCACH noted that they have received more than 40 letters of interest from each major and minor provider in the region. PCACH noted extensive community conversations, including twice-monthly meetings of PCACH’s Provider Integration Panel with involvement of hospital systems, physical care, behavioral health, SUD providers, EMS organizations, CBOs, county government representatives, MCOs and the criminal justice system.

Findings and Scoring for Pierce County ACH

Table 33 provides a listing of findings, including examples of strengths and opportunities.

Table 33. Pierce County ACH Findings

Findings for Pierce County ACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • PCACH indicates that providers who serve 90 percent of the regional Medicaid population have signed LOIs with PCACH. • One strategy PCACH noted an effort to address workforce challenges is to work with the Puyallup Tribe to assist, encourage, and incentivize members of their clinical residency program to be retained within the region’s workforce. • BHT, PCACH, and SWACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under the Medicaid Transformation, such as alignment with current MCO goals, provider support related to delivery system reform and value-based payment, beneficiary overview, engagement, and education, etc. • PCACH indicates they are coordinating with HealthierHere to explore technical assistance cost sharing and to ensure alignment so that providers and MCOs have common requirements across regions. • A leading approach that PCACH indicates it will undertake to advance the communities’ work across projects is implementation of a Strategic Improvement Team, as described in Section I Findings. PCACH notes the team will provide trainings and support to 	<ul style="list-style-type: none"> • For Projects 2B and 3D, PCACH identified narrow target populations that will be expanded over time. Recommendation: As PCACH defines target populations, Myers and Stauffer recommends PCACH consider potential impacts to the project related to a narrow population depending on timing of expansions.

Findings for Pierce County ACH	
engaged providers to ensure their successful implementation of the projects. The team will establish learning collaboratives and other opportunities for shared learning across the project’s partnering providers. The team’s Improvement Advisor will provide support for providers across all projects to achieve continuous improvement.	

Myers and Stauffer submitted one write-back request to PCACH as part of the assessment process. *Table 34* provides an overview of the resulting scores. At the end of the process, PCACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 34. Pierce County ACH Scoring

Pierce County ACH		
	Initial Score	Score After 1st Write-Back
Section 1 Score	73.75%	100%
Section 2 Score	87.63%	100%
<i>Section 2 Projects:</i>		
2A	84.21%	100%
2B	88.42%	100%
3A	88.42%	100%
3D	89.47%	100%
Total Score	83.47%	100%
Bonus		0%
Final Score		100%

SWACH



Summary Findings for SWACH

SWACH	
<ul style="list-style-type: none"> ■ Counties: <ul style="list-style-type: none"> ○ Clark ○ Skamania ○ Klickitat 	
■ Tribal Reservation/Trust Land: Part of the Cowlitz Indian Tribe is located in the region.	
■ Medicaid Population Size (November 2017 Client Count): 115,708	
■ Medicaid Transformation Toolkit Projects	
<ul style="list-style-type: none"> Selected: <ul style="list-style-type: none"> ○ 2A: Bi-directional Integration of Care ○ 2B: Community-based Care Coordination ○ 3A: Addressing the Opioid Use Crisis ○ 3D: Chronic Disease Prevention and Control 	

1. Project Plan Section I Overview and Findings

Below is a high-level overview of specific Section I subsections and the Independent Assessor’s findings.

Regional Health Needs Inventory. SWACH provided a comprehensive summary of data used to inform project selection and planning (e.g., community health needs assessments, publicly available and HCA-provided data, regional pay for performance reports, local public health data, national reports/published research, and stakeholder input). Data was used to determine both general population and Medicaid beneficiary-specific demographics, health status, prevalence of chronic disease, health disparities, treatment penetration, and geographic variation in outcomes. Such data was also used to provide a thorough description of existing health care resources available in the region, as well as community-based resources to address the social determinants of health.

Funds Allocation. The SWACH Board of Trustees has ultimate fiscal oversight and will make all final funding decisions. The executive staff prepares annual budgets and other variance reports for review by the Finance Committee and board. In the near future, SWACH is developing an Incentives and Investments Committee to oversee the System’s Capacity Building Fund.

Stewardship is encapsulated in the funds flow guiding principles and the oversight committee’s checks and balances. With input from the workgroups, committees and board, SWACH developed funding guiding principles that are flexible, equitable, locally responsive, compliant, simple, collaborative, and sustainable.

SWACH met with four Participating Provider Systems currently implementing a Medicaid DSRIP project in New York State, and identified the following lessons learned:

- Funds required for infrastructure and capacity building and system design should not be distributed directly to providers, but paid by the DSRIP management organization (PPS in New York, ACH in Washington).
- It is extremely difficult to estimate the needs and expenses of the work ahead (the known unknowns) while in the planning phase.

- There is a need to ensure funds will be available for costs not currently anticipated because there will be many costs (the unknown unknowns).

Required Health Systems and Community Capacity (Domain 1) Focus Areas. The SWACH’s initial submission identified a comprehensive list of investments and infrastructure necessary to accomplish projects in Domain 2 and 3; however, SWACH did not appear to address how capacity building in Domain 1 areas would support its selected projects specifically. Following an initial write-back, SWACH noted several examples including, but not limited to, a description of how: (1) the clinical integration project would assist regional providers to assess, choose, implement, and fund HIE functionality that will support the clinical integration models being implemented under the bidirectional clinical integration project; (2) the community care coordination project would ensure community care coordination solutions are supported through appropriate technological platforms that interface with other population health strategies being implemented across the region; and (3) the opioid use project would assist regional providers to identify and support technological solutions to increase the use of the Prescription Drug Monitoring Program.

Findings for Section I

Table 35 provides a listing of findings for Section I, including examples of strengths and opportunities.

Table 35. SWACH Section I Findings

Findings for SWACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • SWACH’s Clinical Integration Committee is comprised of representatives of physical and behavioral health providers, hospitals, and MCOs serving over 90 percent of the region’s Medicaid population. Committee members include physicians, behavioral health and SUD specialists, integration specialists, payers, and senior administrators responsible for integration efforts within their own organizations. • SWACH’s analysis of VBP survey findings identified that: (1) Domain 1 areas are interdependent; (2) population health strategies need to support success for each project area, but also an increase in provider confidence to move to VBP arrangements; and (3) workforce strategies need to support providers in developing appropriate expertise in revenue cycle management to support value-based contracting. To this end, SWACH proposed to "work regionally and individually with providers to ensure they can successfully adapt to and adopt value-based contracting strategies." 	<ul style="list-style-type: none"> • SWACH has not yet quantified the extent to which providers and partners are meeting service gaps, and that it proposes to continue exploring this issue as part of the current state assessment in early 2018. Known barriers cited by SWACH include workforce capacity, length of time to access appointments (particularly for psychiatric services), transportation, affordability of care, geographic distance, hours of operation, lack of culturally/linguistically-appropriate services, and difficulty navigating a bifurcated system Recommendation: SWACH’s completed state assessment should address the identified barriers leading to service gaps cited in the Project Plan.

2. Project Plan Section II Overview and Findings by Project

As noted earlier, SWACH is pursuing four projects for the Medicaid Transformation. Below is a high-level overview of SWACH's approach, preliminary target population, and providers for each project. Additionally, findings identified by the Independent Assessor are listed.

Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation (required)

General Approach. The project is built upon five core concepts of integration that are fundamental to the Collaborative Care Model and the Bree Collaborative. Providers will be allowed to develop practical models of integration that align with their strategic goals and the variety of clinical settings in which they operate. SWACH plans to invest in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes.

Preliminary Target Population. All Medicaid beneficiaries in the region, with a focus on those who have been diagnosed with behavioral health conditions, including mental illness and/or SUD, OUD, and/or chronic health conditions.

Partners. SWACH provided a complete listing of providers that have shown some level of interest in participating in the project. SWACH has outreached to primary care and behavioral health providers in both rural and urban communities, and is partnering with regional hospital systems and two Medicaid health plans. At time of submission, 27 individuals are participating in SWACH Clinical Integration Committee, all of whom are Medicaid providers and/or represent an organization that provides Medicaid services (represented organizations account for over 90 percent of Medicaid lives in the region).

Project 2B: Community-based Care Coordination

General Approach. SWACH will use the Pathways Community HUB for this project. As implementation of the HUB continues, the SWACH Vice President of Community Care Coordination will provide ongoing support and technical assistance to providers, including contracted care coordination agencies and their community health worker staff, referral partners and potential HUB partners/resources. SWACH describes a number of strategies to address siloed systems, partner preparedness, and data interoperability, including, but not limited to, diverse regional representation in the Pathways Community Advisory Council, and application of the national HUB certification, which provides a framework for standardization, tools to support implementation and monitoring, etc. SWACH intends to work with an experienced vendor to develop the Pathways Community HUB data platform to address data interoperability challenges.

Preliminary Target Population. Individuals ages 18 or over who experience a chronic physical health and a behavioral health condition (i.e., mental health and/or substance use condition). The ACH anticipates refining the population further, particularly related to physical health diagnoses.

Partners. SWACH provided a list of partners engaged in the project, and many are actively engaged in the SWACH Community Care Coordination workgroup. Partners were selected based on number of Medicaid beneficiaries served, types of services offered, and their opportunity to reach beneficiaries. While no

formal commitments to participate had been attained, three agencies have been selected to contract with SWACH as first-round care coordination agencies. The ACH has and will continue to engage all other providers and CBOs, as they will either be referral partners or potential care coordination agencies when the model grows in DYs 3 and 4.

Project 3A: Addressing the Opioid Use Public Health Crisis (required)

General Approach. SWACH will use AMDG and CDC prescribing guidelines for this project. SWACH proposes to leverage school and community-based prevention and education initiatives, increased access to treatment and peer support services in Clark County, and programs distributing Naloxone publicly and to law enforcement. SWACH will support partners through the following:

- Collaborative workshops
- Shared learning forums
- Dissemination of evidence-based guidelines and best practices
- Setting-specific advisory workgroups
- Data monitoring guidelines
- Technical assistance from consultants and staff

Strategies will include advances in HIT to support enhanced utilization of the prescription monitoring program, adoption of evidence-based approaches, increased access to treatment through capacity building (e.g., peer support, identification/referral for OUD, increased number of MAT providers, etc.), and increased enrollment and engagement of persons with OUD who are not receiving MAT.

Preliminary Target Population. Individuals without a cancer diagnosis who use opioids, particularly those with OUD, in addition to a subset of individuals with a diagnosis of opioid abuse who are not receiving MAT.

Partners. The Opioid Workgroup will serve as the SWACH's primary mechanism for engaging partnering providers. At the time of submission, this Workgroup consists of 27 members, representing 21 organizations across sectors, including both MCOs serving the region. While the ACH notes not all regional Medicaid providers have representatives on the Workgroup, outreach efforts continue and all regional providers will be invited to participate by the end of Q1 2018.

Project 3D: Chronic Disease Prevention and Control

General Approach. SWACH is considering adoption of the Chronic Care Model approach for possible use across the following settings: physical health and primary care; behavioral health and SUD; and law enforcement and criminal justice. Each partner must choose at least one target population and elemental category, and may also implement one or more additional activities alongside community settings: Stanford Chronic Disease Self-Management Program, Million Hearts® Campaign, CDC National Diabetes

Prevention Program, and Community Paramedicine. SWACH proposes the following will support the project:

- Technical assistance provided by staff and consultants, including proposed learning labs to address project barriers.
- SWACH team knowledge of and initial investments in the Pathways Community HUB Model.
- The region’s strong network of behavioral health/SUD providers, CBOs, and EMS providers.

Preliminary Target Population. Adults with diabetes (particularly Type 2), children and adults with obesity, and adults with hypertension and cardiovascular disease.

Partners. Three of the main health systems who provide care for most Medicaid beneficiaries in the region have indicated an interest in participating in the project. The ACH’s Clinical Integration Committee has been established to engage partnering providers, and it is anticipated that a subgroup of this committee will be formed to examine chronic disease prevention and treatment strategies and setting-specific integration.

Findings and Scoring for SWACH

Table 36 provides a listing of findings, including examples of strengths and opportunities.

Table 36. SWACH Findings

Findings for SWACH	
Examples of Strengths	Opportunities
<ul style="list-style-type: none"> • SWACH is working in partnership with multiple community organizations and community groups to develop an equity lens to inform its overall work. This work is supported by additional grant funding, and will use the Center for Racial Justice Innovation’s “Racial Equity Impact Assessment Guide” as a set of questions to inform decision-making. • BHT, PCACH, and SWACH have collaborated on meetings with MCO partners to learn about key crossover areas between ACHs and MCOs under the Medicaid Transformation, such as alignment with current MCO goals, provider support related to delivery system reform and value-based payment, beneficiary overview, engagement, and education, etc. • SWACH anticipates using multiple data sources: provider, stakeholder, and staff expertise; as well as peer learning to support its efforts. A robust plan for project monitoring and continuous improvement infrastructure is provided, in addition to a detailed 	<ul style="list-style-type: none"> • SWACH may serve as the quality improvement engine for smaller organizations. Recommendation. Myers and Stauffer recommends the ACH consider internal processes and monitor ongoing capacity to provide these services. • Specific to Project 2B, at the time of Project Plan submission, SWACH indicated that they did not have details for the number of Medicaid beneficiaries served for each Referral Partner as there are 20 referral pathways and many potential Referral Partners. Furthermore, SWACH does not currently have specific data/information about numbers served for some of the potential Referral Partners. For example, 2-1-1 would be considered a Referral Partner who may serve the larger community, including Medicaid; however, they may not be able to provide information about the number of Medicaid lives they serve.

Findings for SWACH

process to support achieving Medicaid Transformation outcomes. Of note, SWACH has contracted with the Providence Center for Outcomes Research and Education (CORE) to design and operate its monitoring system, which will bridge partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source.

- SWACH “Improvement Advisors,” in concert with Qualis Health and MCOs, will work with each partnering provider to determine the level of support desired and needed. For larger, more sophisticated organizations, SWACH will work with quality improvement teams already working within these organizations. Support provided may include training, technical assistance, or coaching. For smaller organizations, the ACH envisions being the quality improvement engine for these providers.
- The SWACH intends to provide support to clinical settings in a variety of ways, including clinic-level technical assistance along with region-wide technical assistance (e.g., work flow support, IT technical assistance, workforce development support, trainings, change management support and assistance with transitioning providers toward value-based payment arrangements).
- Specific to Projects 2A and 3A, SWACH has been working in partnership with statewide workgroups regarding Medicaid codes for Collaborative Care to help finance and sustain integrated care, and is working with MCOs to leverage the billing and coding work that has developed out of SB 5779 along with developments for new billing codes in rural health clinics and FQHCs. As planning and implementation continues, updates from the ACH regarding the impact of SB 5779 may be beneficial.
- Specific to Project 2B:
 - In an effort to identify current projects and initiatives (either current or planned) within the region, and to engage community and stakeholders in initial Pathways HUB model discussion, the ACH conducted an environmental scan to determine: (1) who the community

The SWACH may obtain more specific data and information at a later date after a partner’s role is clarified and an MOU is determined appropriate.

Recommendation: As planning continues, Myers and Stauffer recommends that SWACH provide information to HCA about its efforts to obtain referenced data and identified partners’ Medicaid client base.

- Specific to Project 3D, in the coming months, SWACH will analyze setting-specific provider surveys to determine readiness and capacity, and will gather information to address process and resource gaps. **Recommendation:** As planning continues, Myers and Stauffer recommends SWACH provide information about survey outcomes and strategies to address identified process and resource gaps.

Findings for SWACH

- identifies as care coordinators for various populations and at various touch points in the continuum of care; (2) what programs or initiatives currently exist and which ones are working well; (3) what gaps in access to care exist; and (4) who was missing from the care coordination resource list.
- SWACH will provide ongoing support and technical assistance to providers, including contracted care coordination agencies and their community health worker staff, Referral Partners, and potential HUB partners/resources. The ACH will also elicit support from the Healthy Living Collaborative to address training and understanding the needs of the community health worker workforce.
- SWACH notes that its self-monitoring system will allow providers to input data and give the ACH and its partners an early view of progress or need for improvement.
- Specific to Project 3A, SWACH created an Opioid Workgroup (the first in its region), that informed a comprehensive environmental scan of regional opioid initiatives across various sectors, including health care, prehospital, law enforcement/corrections, community services, and education.
- Specific to Project 3D:
 - As implementation continues, SWACH will support partners by creating an IT-enabled, sustainable shared learning system; partnering with local CBOs to augment providers’ existing staffing and capabilities; and use of consultants and staff to provide technical assistance.
 - SWACH has leveraged provider claims data to identify strategic partners, and is working with providers representing the highest Medicaid billers in each major setting (i.e., primary care, mental health/substance abuse, inpatient, and ED).
 - In addition to SWACH’s efforts to develop an equity lens to inform its overall work (as noted below), equity for this project will also be addressed and ensured by engaging multi-sector partners representing the cultural, linguistic, and

Findings for SWACH	
<p>geographic diversity of Clark, Skamania, and Klickitat counties’ Medicaid beneficiaries. These representatives have already directly informed discussions and decisions regarding the Chronic Care Model selection, identification of target populations, and ACH rules of engagement for the chronic disease prevention and control project.</p> <ul style="list-style-type: none"> ○ SWACH will leverage its Community Resilience Fund to focus on regional, community-led initiatives aimed at strengthening resilience through social determinant investments and key policies and system changes for overall population health. 	

Myers and Stauffer submitted two rounds of write-back requests to SWACH as part of the assessment process. *Table 37* provides an overview of the resulting scores. At the end of the process, SWACH was found to have Met or Exceeded Criteria for all Project Plan sections.

Table 37. SWACH Scoring

SWACH			
	Initial Score	Score After 1st Write-Back	Score After 2nd Write-Back
Section 1 Score	88.33%	97.08%	100%
Section 2 Score	88.68%	97.89%	100%
<i>Section 2 Projects:</i>			
2A	89.47%	97.89%	100%
2B	84.21%	97.89%	100%
3A	88.42%	97.89%	100%
3D	92.63%	97.89%	100%
Total Score	88.58%	97.65%	100%
Bonus			0%
Final Score			100%

Acronym List

Acronym	Term
ACEs	Adverse Childhood Experiences
ACHs	Accountable Communities of Health
AMDG	Washington State Agency Medical Directors Group
BHO	Behavioral Health Organization
BHT	Better Health Together
CBHA	Community Behavioral Health Agency
CBO	Community-Based Organization
CCA	Care Coordination Agencies
CCI	Care Coordination Inventory
CCV	Community/Consumer Voice Committee
CFO	Chief Financial Officer
CHC	Community Health Care
CITO	Chief Information and Technology Officer
CLC	Community Leadership Council
CMS	Centers for Medicare and Medicaid Services
CORE	Center for Outcomes Research and Education
COT	Chronic Opioid Therapy
CPAA	Cascade Pacific Action Alliance
CPAS	Collaboration, Performance, and Analytics System
CVC	Community Voices Council
DHAT	Dental Health Aide Therapist
DLT	Data and Learning Team
DPPs	Diabetes Prevention Programs
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medicaid Service
EPR-3	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
FQHC	Federally Qualified Health Center
GCACH	Greater Columbia Accountable Community of Health
HCA	Washington State Health Care Authority
HIE	Health Information Exchange
HSI	Health System Inventory
HIT	Health Information Technology
HSAC	Health Systems Advisory Coalition
IHCP	Indian Health Care Provider
INTERACT	Interventions to Reduce Acute Care Transfers

Acronym	Term
LARC	Long-Acting Reversible Contraception
LHINs	Local Health Improvement Networks
LOI	Letter of Intent
MAT	Medication Assisted Treatment
MCOs	Managed Care Organizations
MED	Morphine Equivalents Doses
NCACH	North Central Accountable Community of Health
NCC	Natural Community of Care
OCH	Olympic Community of Health
ORP	Opioid Reduction Plan
ODU	Opioid Use Disorder
PCACH	Pierce County Accountable Community of Health
PCP	Primary Care Provider
PHSKC	Public Health – Seattle and King County
PMEC	Performance, Measurement, and Evaluation Committee
PPS	Performing Provider System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
RMCH	Reproductive and Maternal & Child Health
SC	Steering Committee
SIM	State Innovation Model
SME	Subject Matter Expert
SMI	Serious Mental Illness
STCs	Special Terms and Conditions
SUD	Substance Use Disorder
VBP	Value-Based Payment
WHAP	Whole Health Action Management
WPCC	Whole Person Care Collaborative
WSHA	Washington State Hospital Association

Transformation Glossary



Healthier Washington Medicaid Transformation Glossary

Updated January 2018

Accountable Community of Health (ACH): An Accountable Community of Health is a group of people and organizations from a variety of sectors in a given region with a common interest in improving health. With support from the state, they are voluntarily organizing to make community-based decisions on health needs and priorities, and how best to address those priorities without duplicating services. ACHs develop, implement, and monitor transformation projects under Initiative 1* of the Medicaid Transformation, Transformation through ACHs. There are nine ACHs in Washington State.

Delivery System Reform Incentive Program/Payment/Pool (DSRIP): DSRIP is a strategy to accomplish delivery system reform. The term "DSRIP funds" refers to the type of money available to pay for regional transformation projects. These funds are a vital tool to transform the Medicaid delivery system to care for the whole person, and use resources more wisely. The funds will be administered by ACHs. DSRIP is not a grant. It is a performance-based incentive program for earning funds through achievement of milestones and outcomes. These projects must be self-sustaining by the end of the Medicaid Transformation in 2021.

Demonstration Year: Each year of the Medicaid Transformation is a 12-month period, beginning January 1 and ending December 31. Year 2 began January 1, 2018. The five-year Transformation ends on December 31, 2021.

Healthier Washington: Healthier Washington is a public-private, multi-sector effort to transform the health system to achieve better population health, reward high-quality care, and help curb health care costs. It represents patients, providers, payers, purchasers, community advocates, and others working together, supporting best practices, and using data to improve the lives of Washingtonians. The Medicaid Transformation is a key effort of Healthier Washington.

Healthier Washington Medicaid Transformation: In January 2017, the Centers for Medicare & Medicaid Services (CMS) approved a Section 115 waiver. In Washington State, this particular waiver is called the Healthier Washington Medicaid Transformation. Washington's five-year contract with CMS authorizes up to \$1.5 billion in federal investments to support the three Transformation initiatives.

- **Initiative 1: Transformation through ACHs:** One of three Medicaid Transformation initiatives. Each region, through its ACH, will pursue health improvement projects aimed at transforming the Medicaid delivery system to serve the whole person.



- **Initiative 2: Long-term Services and Supports:** The second of three Medicaid Transformation initiatives. This effort provides new eligibility categories that support unpaid family caregivers and people who are at risk of future Medicaid long-term services and supports who do not currently meet Medicaid financial eligibility.
- **Initiative 3: Foundational Community Supports:** The third of three Medicaid Transformation initiatives. This effort provides supportive housing and supported employment services for chronically homeless or unemployed people, or those who are at risk of being chronically homeless or unemployed.

Section 1115 Waiver: Refers to Section 1115 of the Social Security Act, which allows the U.S. Department of Health and Human Services to waive certain provisions of the Medicaid program in order to approve experimental, pilot, or Medicaid Transformation projects that promote the objectives of Medicaid and the Children's Health Insurance Program (CHIP).

Special terms and conditions (STCs): Section 1115 waivers are established under a contract between the federal government and the state. This contract includes terms and conditions that establish the base requirements for how the Medicaid Transformation will be implemented, evaluated, and financed.

STC protocols: Also referred to as "attachments," protocols are referenced in the STCs and generally developed in the weeks and months after STCs have been approved. STC protocols are the specific details and expectations the Medicaid Transformation must adhere to. Topics covered by STC protocols include, but are not limited to, the Project Toolkit for Initiative 1, Funding and Mechanics Protocol, and expectations for new services authorized by the Medicaid Transformation.

Project planning

ACH certification: ACHs are required to attest to and demonstrate their readiness to participate in the Medicaid Transformation through a two-phase certification process. All ACHs passed Phase I certification in May 2017, having successfully described how they will comply with Medicaid Transformation requirements such as governance, organizational capacity, and stakeholder engagement. Phase II certification submissions must demonstrate how ACHs have complied with Medicaid Transformation requirements, and forecast their approach to Project Plan development. Due date for Phase II certification submissions - August 14, 2017.

Implementation plan: In Year 2, ACHs will be required to develop implementation plans for each project approved by the state in Year 1. HCA will provide guidance on implementation plan requirements, following the approval of ACH Project Plans in late 2017.

Independent assessor: The state will contract with an independent assessor to review Project Plans, and to consider anticipated ACH project performance. The independent assessor has no affiliation with the ACHs



or their partnering provides. The independent assessor will make recommendations to the state regarding approvals, denials, or recommended changes to Project Plans to make them approvable.

Partnering provider: ACHs will partner with a variety of providers to support the development and implementation of transformation projects. Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. ACH project plans will describe how they have engaged partnering providers and the role partnering providers will play in selected projects. As specified by the STCs, partnering providers must have signed agreements with the ACH to receive incentive funding.

Practice Transformation Support Hub (Hub): The Hub is a resource provided under Healthier Washington. It connects health care providers with tools, training, and hands-on technical assistance to more effectively coordinate care, promote community linkages, and move to value-based care and payment. The Hub accelerates regional and statewide health improvement activities that focus on strengthening capacity, improving health outcomes, and increasing the overall health of the community.

Project Plan: ACHs are required to submit a single Project Plan, which includes the portfolio of transformation projects they and their partnering providers select. The Project Plan contains one section focused on ACH organizational and planning information, and a second section focused on project-level details. Project plans must be developed in collaboration with community stakeholders, be responsive to community-specific needs, and support the objectives of the Medicaid Transformation. They must be approved before the ACHs are eligible to receive Medicaid Transformation incentive payments.

Project Plan Template: ACHs used a template to describe their Project Plan. A draft of the Project Plan Template was released to the public on June 16. A public comment period closed June 30. ACHs submitted Project Plans in November 2017.

Project Toolkit: The Project Toolkit provides details about the transformation projects that will be eligible for DSRIP funding under Initiative 1 of the Medicaid Transformation. The draft Project Toolkit was developed with state and regional health priorities in mind, and includes input from cross-sector experts and stakeholders. For each project, the Project Toolkit outlines evidence-based approaches, progress measures, timelines and milestones, and outcome metrics. After federal review and approval, the final Project Toolkit will be released in summer 2017.

Data and analytics

Analytics, Interoperability, and Measurement (AIM): A Healthier Washington effort to improve existing health data systems by integrating data from multiple sectors. Better data systems enable Healthier Washington and its partners to perform more strategic analysis and make fact-based decisions about health care service delivery, policy and program development, and health care reform investment strategies.



Regional Health Needs Inventory (RHNI): Under the Medicaid Transformation, ACHs are expected to gather, review, and interpret information about the health status, systems, and capacity of their region. The purpose is to ensure ACHs take a data-driven approach to project selection, design, and implementation. This data inventory includes data provided by the state, but also by regional and local data sources (e.g., community health organizations, hospitals), as well as local providers, stakeholders, and partners. ACHs are expected to use their inventory to justify project selection and design in the Project Plan.

Funds flow & value-based payment

Design funds: ACHs are eligible to earn up to \$6 million in incentive funds upon successful completion of a two-step certification process during Year 1. Design funds are intended to support ACH-level investments required to coordinate transformation projects, such as technology, tools, and human resources.

Financial executor: In order to ensure consistent management of and accounting for the distribution of earned DSRIP incentive funds across ACHs, the state has selected, through a procurement process, a single financial executor. The financial executor will be responsible for the distribution of funds to ACHs and their partnering providers.

Integration incentives: Integration incentives are the type of incentive dollars an ACH can earn if their regions moves forward with integrated managed care by January 1, 2019. To be eligible, regions must complete two milestones:

- County submission of binding letter(s) of intent to the state Medicaid director by September 15
- Implementation of new integrated managed care organization(s) in the region

These incentives are in addition to the incentive dollars a region can earn for participation in transformation project activities.

Project incentives: Project incentives are funds that are earned from the pool of project funds. ACHs can earn project incentives for successful approval of project plans in Year 1, as well as demonstrated completion of project-specific milestones and metrics according to the timelines outlined in the Project Toolkit. Incentives earned will be adjusted based on actual performance against project milestones and metrics.