SWACH Portfolio Narrative for Implementation Plan

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REQUIRED PORTFOLIO NARRATIVE

HCA is seeking a deeper understanding of ACH implementation planning across ACHs' portfolio of projects for Medicaid Transformation. The questions below are intended to assess ACHs' preparation and current activities in key implementation areas that span the project portfolio. ACHs must provide clear explanations of the activities to be completed, timing of activities, and how they intend to progress the implementation of projects from DY 2, Q3 through DY 3, Q4. ACHs are required to provide responses that reflect the regional transformation efforts by either:

- The ACH as an organization,
- The ACH's partnering providers, or
- Both the ACH and its partnering providers.

ACHs should read each prompt carefully before responding.

Partnering Provider Project Roles

HCA is seeking a more granular understanding of the Medicaid Transformation work being conducted by partnering provider organizations. Imagine the Independent Assessor is conducting a site visit with your partnering providers; how would a partnering provider organization explain its role in the transformation work. What does the provider need to be successful?

Using at least four examples of partnering provider organizations, respond to the questions and provide a detailed description of each organization, and what each organization has committed to do to support of the transformation projects from DY 2, Q3 through DY 3, Q4.

In total, examples must reflect:

- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.[1]
- All projects in the ACH's portfolio.

ACH Response
Responses must cover the following: 1. What is the name of the partnering provider organization? 2. What type of entity is the partnering provider organization? 3. In which project/project(s) is the partnering provider organization involved? 4. What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

[1] Traditional providers are those traditionally reimbursed by Medicaid (e.g. primary care providers, oral health providers, mental health providers, hospitals and health systems, nursing facilities, etc.). Non-traditional providers are those not traditionally reimbursed by Medicaid (e.g. community-based and social organizations, corrections facilities, Area Agencies on Aging, etc.).

5. What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

SWACH Response

*(***Note***: Based on input from the local chapter of the NAACP, SWACH made the decision to use the term Transformation Year abbreviated as TY, rather than DY for Demonstration Year)*

During SWACH's engagement with clinical and non-clinical partners, many providers expressed interest in participating in Medicaid Transformation Projects.

Example #1: The following example illustrates two partnering providers' engagement with project 2A, Bi-directional Integration.

Q #1-3 - What is the name of the partnering provider organization, what type of entity are they, and which project/project(s) are they involved in?

Child and Adolescent Clinic (CAC) provides primary care for children, adolescents and families in Clark County. Children's Home Society (CHS) of Washington is a specialty mental health provider in Clark County and focuses on children and families in need of mental health support. Both providers are considered traditional Medicaid providers. In the beginning of 2017, SWACH, CAC and CHS began planning a partnership between CAC and CHS to develop and implement an integrated care model, consistent with project 2A.

Q #4 - What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

CAC and CHS submitted their respective Clinical Transformation Plans (CTPs) to SWACH during TY 2,* Q2. The CTPs inform SWACH and our partners of their plans for implementation of specific transformation objectives. Providers are responsible for developing their CTPs within the strategic framework developed by SWACH. Overall, CAC and CHS share a responsibility for developing the care model, implementing the model and conducting continuous quality improvement strategies. While the care settings are different, each organization has similar roles and responsibilities.

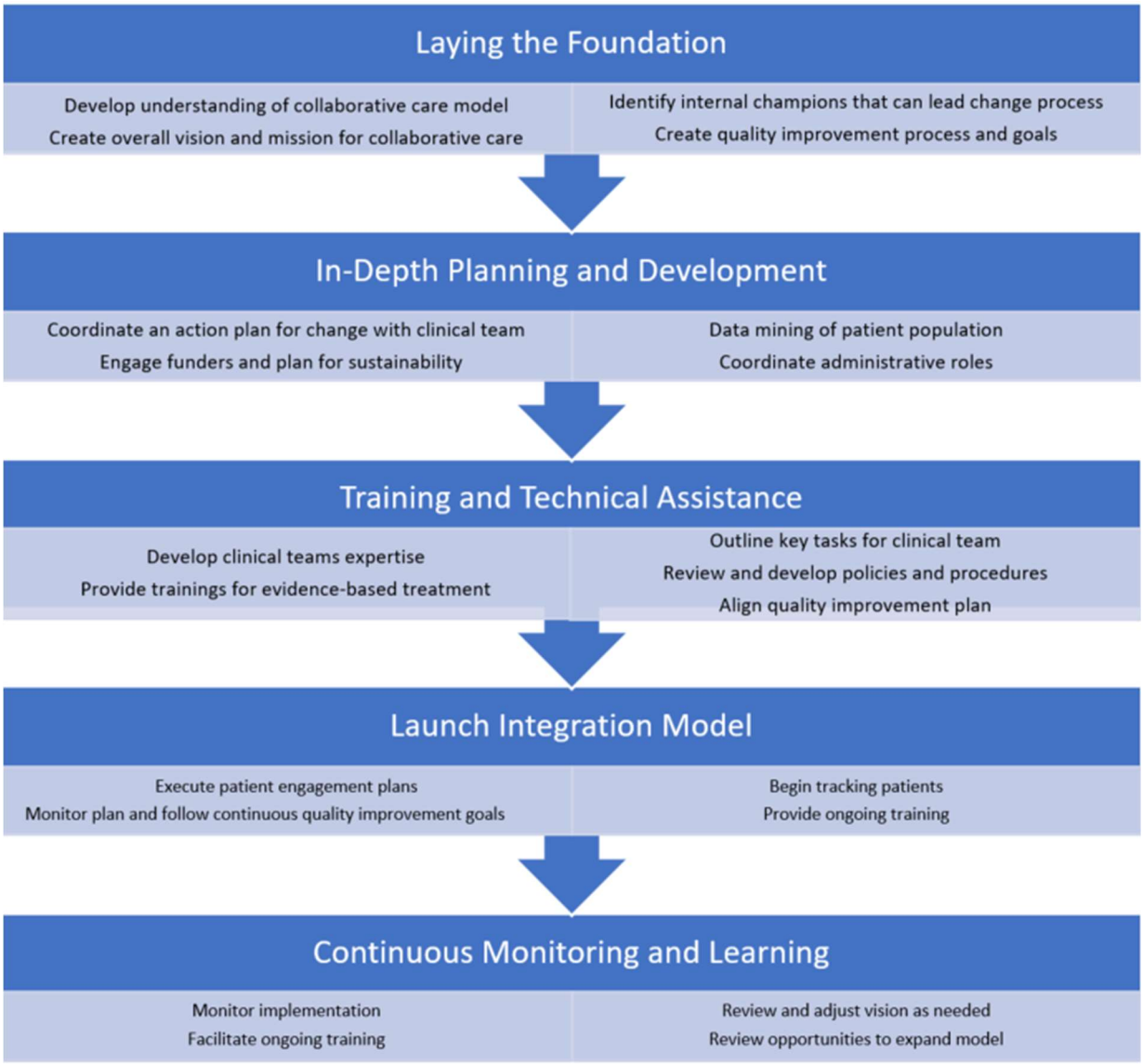
At the time of SWACH engagement in 2017, both organizations made an internal commitment to develop an integrated care model in their respective care settings to address their patient needs. Both organizations were enthusiastic about the development of ACHs to help support implementation of their model and had internal champions to see it through. Preliminary planning, due diligence, engagement with external experts and support from managed care organizations were in development upon SWACH's involvement in 2017. The table below is an illustration of both providers' joint roles and responsibilities relative to TY 2, Q2 through TY 3, Q4.

Providers: Child and Adolescent Clinic, Children's Home Society

	Roles	Responsibilities
TY 2, Q3	• Participate in Clinical Integration Workgroup • Review clinical provider assessment data • Prepare organization for change • Support internal champion • Develop overall mission statements • Create a vision for integration model with respect to overall mission and quality improvement efforts	• Participate in CTP learning sessions • Complete CTP • Accountable for change processes • Collaborate with external partners
TY , Q4	• Participate in Clinical Integration Workgroup • Consult with Managed Care Organizations (MCO) -data, contracting • Prepare for binding agreement negotiations with SWACH	• Engage with SWACH in negotiations to finalize binding agreements
TY 3, Q1	• Prepare internal processes and procedures for reporting and monitoring progress to SWACH • Develop internal workplan • Develop sustainability plan • Formalize Memorandum of Understanding (MOU) between CAC and CHS	• Align internal systems to be able to transmit reporting and monitoring requirements • Execute MOU
TY 3, Q2	• Participate in Collaborative Care training • Recruit personnel • Complete implementation plans	• Employ adequate personnel with adequate training
TY 3, Q3	• Prepare Electronic Medical Records system (EMR) for new registries, codes, clinical notes	• Secure adequate IT expertise • Test and refine EMR
TY 3, Q4	• Refine sustainability plan • Refine continuous quality improvement plan	• Establish process for internal continuous quality improvement

Q #5 - What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe? What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

Alongside SWACH, both CAC and CHS have partnered with the University of Washington (UW) AIMS Center, both formally and informally. This partnership led to a collective understanding of and alignment across the organizations in following the key steps to implement a collaborative care model of integration that is consistent with UW AIMS Center guidelines.



*Adapted from UW AIMS Center

Example #2: The following illustrates Community Voices Are Born (CVAB) as one of the partnering providers engaged in project 2B, Care Coordination, SWACH's Pathways Community HUB implementation.

Q #1-3 - What is the name of the partnering provider organization, what type of entity are they, and which project/project(s) are they involved in?

CVAB is a peer-run organization that encourages self-determination and self-sufficiency for people in mental health and addictions recovery. The heart of CVAB is peer-to-peer support, people with lived experience and in recovery. CVAB supports people who are vulnerable, in crisis, or wanting to experience healing, recovery and wellness. Of their participants, 68 percent are covered by Medicaid. CVAB recently started providing traditional Medicaid services and secured Medicaid contracts with MCOs. CVAB is one of five organizations that initially applied to SWACH's Request for Application (RFA) to become a contracted Care Coordination Agency (CCA) in the Pathways HUB model implementation. After a scoring process by community members, CVAB was selected as one of three partners to move forward as a CCA. In the application process, interested partners responded to questions about their organization. The following, taken directly from CVAB's RFA response, describes the organization's identity and participation as a partner in SWACH efforts:

Mission/Vision	CVAB is a community-based, peer-run organization committed to sharing hope and empowering individuals. As an organization of people living in mental health and addiction recovery, the heart of our agency is peer-to-peer support for people wanting to experience healing, recovery and wellness, especially those who are vulnerable or in crisis. At CVAB, we take a strengths-based approach to holistic beings. CVAB intends to ensure quality community-based peer services of all types are delivered throughout Washington state.
How does becoming a CCA within the SWACH Pathways Community HUB support the strategic goals of the organization?	CVAB supports some of the most vulnerable and at-risk individuals in Southwest Washington. As part of CVAB's ongoing strategies, the agency has acted to engage and empower individuals seeking resources to improve their quality of lives based on our knowledge and use of needed resources including healthcare, human services, safety supports, legal systems, transportation, employment, education and more. In addition to work CVAB already does through its six regional programs, CVAB has supported the development of community-based Community Health Workers (CHWs) through a partnership with the Healthy Living Collaborative (HLC) in three Southwest Washington counties. CVAB has supported the HLC CHWs to accomplish community-coordinated activities. Becoming a CCA offers CVAB opportunity to build on current strengths and increase opportunities for at-risk populations this project is intended to support.

Q #4 - What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

Within SWACH's Pathways Community HUB implementation, CVAB will serve as a contracted Care Coordination Agency (CCA). SWACH will contract CVAB to train and support two community care coordinators (CHWs or peers) and at least a .5 FTE supervisor to support Pathways Community HUB implementation. As a CCA within SWACH's Pathways Community HUB, CVAB's additional responsibilities include:

Expected Timeline	CCA Responsibility
TY 2, Q3	Attend the strategic implementation planning meeting
TY 2, Q4	Participate in implementation meetings to build work plans and outline education and training requirements
TY 2, Q4	Provide input necessary from a CCA partner (CVAB's) perspective to inform the details in creating a strong regional Pathways Community HUB
TY 3, Q1 and will continue through TY3, Q4	CVAB staff (supervisor and CHWs) receive Pathways Hub training
TY 3, Q1 (March 2019)	SWACH HUB go-live
TY 3, Q1 through TY 3, Q4	Participate in CCA technical assistance and monthly check-ins with SWACH and other consultants
TY 3, Q2 and to continue beyond Transformation	CCAs will share learnings with each other and participate in cross-ACH cohorts, as they are learning about implementing the Pathways model and will share best practices

Q #5 - What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

As a CCA partner within SWACH's Pathways Community HUB, CVAB will complete key steps that include hiring (or reassigning) staff to fill the community care coordination (CHW/peer) role and the .5 FTE supervisory role. These staff are expected to complete initial training, a practicum and ongoing training and support (including shared learning, as mentioned above). CVAB will also be a primary partner in the HUB implementation group. A CVAB staff member is expected to serve on the HUB Advisory Committee. As an integral member of the HUB Advisory Committee, CVAB will help actively inform the implementation of the Care Coordination Systems (CCS) software and HIT/HIE tools from go-live in TY 3, Q1 through TY 3, Q4.

Example #3: The following example illustrated two partnering providers' engagement with project *3A, Addressing the Opioid Use Public Health Crisis*

Q #1-3 - What is the name of the partnering provider organization, what type of entity are they, and which project/project(s) are they involved in?

Klickitat Valley Health (KVH) is a rural, critical-access hospital located in Goldendale, Washington and is considered a traditional Medicaid provider. KVH offers emergency and acute inpatient care and a full scope of ancillary services, including general surgery, diagnostic imaging, laboratory, respiratory therapy and home health / hospice. The hospital also owns a busy, well-established primary care clinic located on its campus. Inpatient care is managed by 24/7 hospitalist staff. The on-campus Wellness Center offers physical and occupational therapy, as well as employee fitness. KVH has participated in Medicaid Transformation Project (MTP) initiatives including Bi-directional Integration, Opioid Crisis Response, Chronic Disease and Care Coordination.

Q #4 - What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

KVH has engaged with SWACH since September 2017 in the work of initiating an Opioid Taskforce. The KVH Opioid Taskforce has met regularly since October 2017 and has focused on prevention, treatment, overdose prevention and recovery strategies specific to KVH and Klickitat County. The taskforce has evolved to include community stakeholders beyond KVH such as behavioral health providers, prevention coalitions, peer recovery and law enforcement. As such, SWACH has supported KVH in the role of a coordinating champion of the Klickitat opioid response, working toward practice improvement and cross-setting collective impact.

Specific roles and responsibilities of KVH from TY 2, Q3 through TY 3, Q4 may include, but are not limited to, the following:

- Promote a culture shift to understand and treat Opioid Use Disorder (OUD) as a chronic disease affecting the brain. KVH intends to provide three training opportunities for all staff and the community.
- Prevention
    - Implement Washington State Medical Director Group Interagency Guidelines on Prescribing Opioids for Pain
    - Register current and new providers with Prescription Monitoring Program (PMP)
    - Participate in WSMA/WSHA Washington Opioid Reports Program
- Treatment
    - Train providers in MAT and initiate MAT treatment services at KVH
- OD Prevention

    - Provide overdose and naloxone training for care team and/or patients and/or community members
- Recovery
    - Develop partnerships across settings utilizing peers in outreach, engagement and ongoing support efforts for persons with OUD

Q #5 - What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

KVH key steps may include, but are not limited to the following:

- Provide trainings for staff and community stakeholders on OUD as a chronic brain disease and implications for treatment and prevention of OUD
- Provide leadership, providers, training and system support to initiate MAT services
- Develop policies and procedures for opioid prescribing and naloxone dispensation
- Outreach and partnership with peer organizations including providing training

Example #4: The following example illustrated two partnering providers' engagement with project *3D, Chronic Disease.*

Q #1-3 - What is the name of the partnering provider organization, what type of entity are they, and which project/project(s) are they involved in?

Sea Mar Community Health Centers is a Federally Qualified Health Center (FQHC) and provides community-based health and human services, including community and migrant primary medical and dental care, obstetrics and gynecology, minor outpatient surgery, laboratory and radiology services, outpatient and inpatient behavioral health and substance abuse treatment services, social services and case management, and maternity support services. Sea Mar is considered a traditional Medicaid provider. Sea Mar will be involved in all SWACH MTPs, including: Bi-directional Integration, Care Coordination, Opioid Crisis Response and Chronic Disease.

Q #4 - What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

SWACH will work with Sea Mar to explore regional leadership in the coordination and delivery of Stanford's Chronic Disease Self-Management Program (CDSMP) and/or Chronic Pain Self-Management Program (CPSMP) to community stakeholders.

Sea Mar is a partner with a long history of administering or providing this program. SWACH intends to leverage Sea Mar's experience leading Stanford self-management programming in

other regions. SWACH and Sea Mar will explore workforce development of master trainers (MT's) and subsequent training coordination to develop a cohort of CDSMP program facilitators.

SWACH would support Sea Mar in participant outreach and retention, including:

- An information and outreach campaign promoting participation
- Active communications including social media, website and newsletters
- Direct collaboration with clinical partners to develop referral pathways to the chronic disease self-management programs

Q #5 - What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

Sea Mar key steps may include, but are not limited to:

- Trainings for staff as certified master trainers and certified facilitators of Stanford's self-management programs
- Creation of care guidelines assessing each patient's individual needs and referring to self-management programs as appropriate
- Training of clinical team members around Stanford's model of patient centered action planning for self-management
- Communication through SWACH across care settings and clinical partnering providers to support broad participation

Partnering Provider Engagement

Explain how the ACH supports partnering providers in project implementation from DY 2, Q3 through DY 3, Q4.

ACH Response

Responses must cover the following:

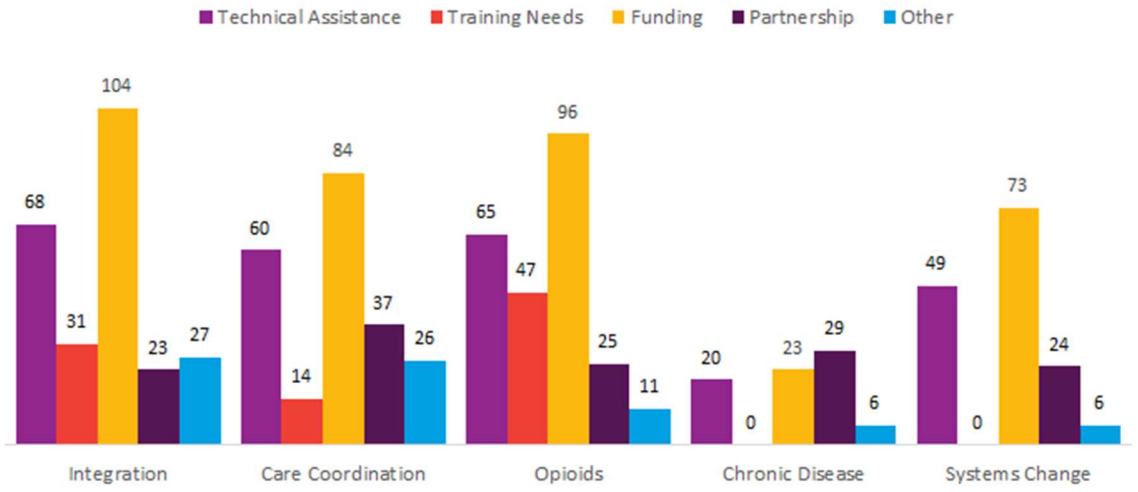
6. What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?
7. How is training and/or technical assistance resources being delivered within that timeframe?
8. How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?

9. What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)?
10. How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

SWACH Response

At the end of TY 2, Q2, SWACH received CTPs from 21 partnering providers. Within the CTPs, partners had an opportunity to identify their training and technical assistance (TA) needs across the projects. TA needs are high, particularly for Bi-directional Integration, Opioid Crisis Response and Care Coordination. Training needs are also high for the Opioid Crisis Response project.

# of training and technical assistance needs identified in partner CTPs, by project



Prior to receiving providers' CTPs, SWACH conducted an assessment of clinical partners that asked a variety of questions about anticipated training and TA needs.

SWACH is working closely with a variety of partners to provide the appropriate amount and type of training and TA during TY 2, Q3 through TY 3, Q4. SWACH's current and future training opportunities are provided in a variety of forums using a variety of methods. They range from topical, including collaborative care codes and trauma-informed care, to online training opportunities such as change management, integrated care models, Value-Based Payment (VBP) and integrating social determinants of health into a practice. Most of these trainings are provided by third parties and national organizations. SWACH also deploys a variety of strategies, such as through our communications and partnerships with stakeholders, to engage partners and promote training opportunities that are germane to their needs and future goals.

As an example, SWACH has oriented providers to the Department of Health Practice Transformation Hub and promoted its use by having representatives present to providers, highlighting the opportunities on our website and sharing materials with stakeholders. The Transformation Hub provides an online resource library and a clearinghouse for additional resources. Other examples include SWACH providing training by subject matter experts on the Patient-Centered Medical Home (PCMH) model, Collaborative Care Model and coding, Bree Collaborative and team-based care, as well as specific technical assistance to behavioral health organizations considering integration models of care. SWACH has also partnered with Qualis Health to provide practice transformation coaching for several of our partners in the region.

SWACH has scheduled and delivered numerous trainings related to opioid misuse during TY 2, Q3 through TY 3, Q4:

a) SWACH sponsored technical assistance: five-session "Taking on the Opioid Crisis" learning opportunity through the Institute for Healthcare Improvement. Partnered with North Shore Clinic and Klickitat Valley Hospital to offer sessions concurrently in Clark, Skamania and Klickitat counties.
    - Session 1: Safe and Competent Opioid Prescribing and the Model for Improvement
    - Session 2: Opioid Overdose Harm Reduction and Linkage with Community-Based Efforts
    - Session 3: Limiting Opioid Demand Through Use of Nonpharmacologic Pain Management Strategies
    - Session 4: Developing a Systematic Organizational Approach for Safe Opioid Prescribing
    - Session 5: Identification and Management of Patients with Opioid Use Disorders

b) WSMA/WSHA - *Opioids, Feedback Reports and Supporting Change in Provider Behavior*
c) UW AIMS - *Team Based Approaches to Medically Assisted Treatment for Opioid Use Disorder*
d) Regional Provider Panel: *Changing the Conversation About Opioid Treatment*
e) MAT Waiver Training
f) MAT provider shared learning and cross training - Provider Champion *Dr. Hart - Shared Learning Dinner Presentation: How to Use Suboxone in a Clinical Setting*
g) Provider Champion - Jim Jensen *Addiction and the Brain presentation to Klickitat Valley Hospital providers and community partner*
h) Provider Champion - Jim Jensen *Addiction and the Brain presentation to Skamania Public Health and community stakeholders*
i) MAT provider shared learning and cross training (explore partnership with UW and Project Echo) - November and ongoing

j) SWACH sponsored provider attendance - *11th annual John D. Loeser Pain Conference: Strategies for Chronic Pain Management*

SWACH is also considering other prospective trainings related to opioid misuse through TY 3, Q4:

- Provide training for support and management of people with SUD
- Provide trainings for providers to receive MAT Waivers
- Provide trainings on pain management
- Provide trainings on SUD management and stigma reduction
- Provide overdose and naloxone training for care team and/or patients and/or community members
- Provide training in recovery coaching for peers
- Provide trauma-informed care training for providers and peers

To engage smaller community-serving organizations and assess their capacity, SWACH developed a Request for Information (RFI) for community-serving organizations. The RFI will identify community-serving organizations interested in partnering with SWACH and clinical partners to address equity and the whole-person health needs of the SWACH region. The RFI asks about capacity and technical assistance needs, as well as the ability of smaller organizations to assist in supporting transformation projects related to chronic disease and opioids.

Recognizing that community-serving organizations are key to assisting our region in Medicaid Transformation efforts through community-clinical Linkages, SWACH created two "paths of engagement." This allows flexibility and innovation. It also helps identify community-serving organizations that are potential leaders in equity, as well as partners who assist Medicaid clients in areas such as:

- Social services (food, housing, domestic violence, shelter, transportation, utility assistance, etc.)
- Emergency response (emergency medical services, fire and rescue)
- Education or workforce development
- Community-based peer support for substance use and recovery
- Public health, social justice
- Complimentary alternative medicine

In addition to the RFI, SWACH has engaged several smaller partners, including those in rural counties, to participate in the Pathways Community HUB implementation planning.

SWACH collaborates closely with each of the ACHs to increase efficiencies for providers whenever possible. Four examples of processes implemented to help support increased efficiencies and alignment for providers that cross over ACH boundaries include:

- Monthly, all nine ACH executive directors meet for shared peer learning and through this process have identified areas that will support a more streamlined approach with

partnering providers. This includes sharing of assessments and training forums, identifying potential cross-ACH partnerships and collaborating to identify opportunities and strategies to address barriers. ACHs have worked together closely to develop a shared crosswalk document that identifies each partnering provider and the regions they work in.

- ACHs meet weekly to collaborate and strategize on a variety of topics and elevate opportunities to support providers across ACHs. As an example of an output from this process, a statewide training resource document has been created.
- SWACH coordinates on a regular basis with specific ACHs in which overlap of providers is most prevalent. We have established communication channels and regularly share developments and approaches that relate to our shared partners and are especially relevant for large health systems that cross multiple ACHs. Specifically, SWACH is in regular contact with Greater Columbia, Cascade Pacific Action Alliance (CPAA) and Pierce County. These regions share our two major health systems, FQHC and largest behavioral health provider.
- SWACH participates in bi-monthly program lead meetings that support cross-ACH collaboration, problem solving and peer-to-peer learning.
- SWACH established an ad hoc provider advisory group to determine the most efficient ways to report into SWACH and options for virtual learning platforms, and to gather input from partnering providers.

Partnering Provider Management

Explain how the ACH ensures partnering providers are driving forward project implementation from DY 2, Q3 through DY 3, Q4.

ACH Response

Responses must address both traditional and non-traditional Medicaid providers and cover the following:

11. What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?
12. What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?
13. What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?
14. How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

SWACH Response

SWACH expects partnering providers to be committed to the goals set by the SWACH region. While SWACH has not yet entered into formal agreements, partnering providers will be expected to participate and contribute in the region's learning collaboratives, identify provider champions, coordinate with other organizations, and meet all reporting

expectations and fiduciary expectations set forth in a binding agreement. SWACH also expects providers will leverage SWACH to develop or further enhance partnerships between clinical and non-clinical (community-serving) partners.

To monitor implementation, SWACH intends to require quarterly reports from partnering providers. Reports will likely be submitted online to SWACH. The required reporting schedule and mechanism will be finalized and included in the binding agreements, which SWACH intends to put in place with clinical partners before the end of TY 2. SWACH will likely begin requiring quarterly reporting from clinical partners first, while community-serving organizations will be rolled in in TY 3, after the RFI process is complete.

These quarterly reports will include the standardized Pay for Reporting (P4R) metrics for Projects 2A (Bi-directional Integration) and 3A (Opioid Crisis Response). While SWACH originally intended to identify a select number of project-specific metrics that could be standardized across partnering providers, SWACH is still considering whether this approach is feasible. To date, no standard indicators that can be used for all partners have been identified.

In the CTPs, SWACH asked clinical partners to suggest measures for each of the selected tactics within a project area. SWACH is reviewing these suggested measures. However, as this was an open-ended field, rather than a menu of options, preliminary review suggests limited metric alignment across partners. Some partners proposed using additional HEDIS measures (e.g. depression remission or diabetes measures), while most proposed process measures that will likely require qualitative, narrative progress reporting.

This narrative reporting can be specific to each partner's proposed tactics and will accommodate variation in timelines across partners. SWACH does not expect all partners to be in the same place throughout implementation. Nor are all partners taking the same approach to their selected tactics. SWACH's reporting must be flexible to account for this variation and similar to the state's approach with the Semi-Annual Reports (SARs). SWACH may ask its partners to report on different things throughout the course of the Transformation. This reporting will likely focus on whether partners are progressing on the specific tactics and key tasks that they outlined in their CTPs.

SWACH intends to continue asking partners to report on training and technical assistance needs across the projects and be accountable for how transformation dollars have been used. SWACH will reserve the right in binding agreements to follow up with partners beyond the quarterly reports for additional documentation or explanation. This could include additional emails, phone calls, site visits or conversations at workgroup or cohort meetings. SWACH does not intend to institute required site visits for partners, although SWACH does intend to have other "participation" requirements such as engagement in learning collaboratives or sharing best practices with others in a cohort.

As part of its monitoring activities, SWACH will compile partner reporting each quarter. Summary reports, including whether partners have successfully submitted reports, whether partners have successfully included required P4R measure reporting and general themes and concerns from the narrative reporting, will be created and made available for staff and leadership review. These reports will enable SWACH to identify partners at risk of not meeting agreed-upon milestones in a timely fashion, develop technical assistance or training needs in response to partner needs, and curate emerging promising practices that can be spread across the region.

Some project specific content from these partner reports will be summarized for workgroup or cohort use cases (i.e. the Opioid Taskforce may wish to monitor the frequency and spread of guideline training across the region) or on an ad hoc basis. SWACH will also use other data sources to supplement project monitoring (e.g. the Department of Health's quarterly opioid dashboard, programmatic data from Pathways HUB, etc.).

Among our wide range of providers and multiple initiatives, SWACH expects that delays and setbacks will occur during each stage of change. Through coordination, active involvement in learning collaboratives and regular reporting mechanisms, SWACH will rely on processes to inform our collective support strategies when an organization is not able to meet required milestones. Moreover, SWACH is committed to identifying technical assistance needs early and establishing a regional and organizational culture of continuous quality improvement and rapid cycle Plan-Do-Study-Act (PDSA) methodology. SWACH is working with partners to actively plan for these contingencies through developing capacity within the organization, leveraging third-party relationships and developing our funds flow model that accounts for expected adjustments.

Alignment with Other Programs

Explain how the ACH ensures partnering providers avoid duplication while promoting synergy with existing state resources from DY 2, Q3 through DY 3, Q4.

ACH Response

Responses must cover the following:

Project 2A

15. What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

Project 3A

16. What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

For ACHs implementing Project 2B

17. How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?
18. What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?
19. How is the ACH's approach aligned with MCO care coordination contract requirements?

For ACHs implementing Project 2C

20. How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?
21. What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?

For ACHs implementing Project 2D

22. What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)

For ACHs implementing Project 3B

23. How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?
24. What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

For ACHs implementing Project 3C

25. What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?

For ACHs implementing Project 3D

26. What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

SWACH Response

For ACHs implementing Project 2A

- Q #15 - What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

Throughout the state, there are a variety of initiatives centered on expanding opportunities to provide whole-person care and many variations of clinical integration models. SWACH plays a pivotal role in coordinating with both the organization/agency that is facilitating corresponding initiatives and the partnering providers that are participating. This requires constant communication, collaboration and participation from SWACH on several advisory panels, meetings and joint strategy sessions with many different interested parties.

For example, SWACH coordinates very closely with the Department of Health's Pediatric Transforming Clinical Practice Initiative (P-TCPI). SWACH participates in a monthly CCS strategy meeting with key behavioral health and primary care champions, DOH and MCOs. SWACH coordinates closely and on a regular basis with MCOs in the region to ensure that initiatives are aligned.

SWACH participates in monthly DOH Practice Transformation meetings to stay up to date on developments, help support coordination of initiatives and provide local insight and guidance for our DOH partners. SWACH is also aligned with the DOH Practice Transformation Hub in support of providers' transformation initiatives. SWACH leadership meets regularly with DOH leadership and practice transformation coaches to mutually support each organization's initiatives.

SWACH is also actively involved with the Washington Chapter of the American Academy of Pediatrics, participating on a plenary panel and advisory committee to support shared learning with providers developing integrated primary care practices. SWACH has also been collaborating with the UW AIMS Center, Washington State Hospital Association, DOH PreManage Pediatrics Pilot Program and the University of Washington PALS Plus initiative.

Through SWACH's active participation with the above organizations, we are better able to identify alignment opportunities, leverage expertise and shared learning opportunities, and support providers where they are at in relation to their participation with the same organizations. For example, one provider is participating in a PreManage for Pediatrics pilot program. This investment from DOH allows SWACH to align with the pilot program and reallocate potential investments elsewhere.

For ACHs implementing Project 2B

- Q #17 - How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?

  SWACH intends to begin with a target population defined as adults with multiple conditions (behavioral health and chronic disease), a population that may overlap with those currently served by Health Homes and is less likely to overlap with the First Steps Maternity Support Services program.

  SWACH selected two CCAs to implement the Pathways HUB: Community Voices Are Born (CVAB) and Sea Mar (the only FQHC in our region, with an active Health Homes program). The primary premise of the Pathways HUB model is find, treat and measure.

  CVAB referrals will initially come from the population this organization already serves. When a person is identified as having a care manager with Health Homes, the CVAB care coordinator will record this, ask the person's preference and coordinate care or refer to the Health Homes care manager. The care coordination is tracked and measured to prevent duplication and ensure there is appropriate support.

  Because Sea Mar is an organization with both programs, its internal data will more readily identify whether a person is currently served by Health Homes or whether to refer to the Pathways HUB. Referrals and care coordination are all tracked and measured to ensure outcomes achieved are those desired by the person being served and to prevent duplication.

  SWACH has ongoing communication and engages many partners, including MCO Health Homes and others, to learn about potential workflows, how CCS software enhancements will help interoperability and potential referral sources. SWACH also engages in statewide and cross-ACH learnings to inform the design and tracking of referrals in/out of the Pathways HUB. Regular meetings of the workgroup and the upcoming SWACH HUB Advisory Committee will include MCO representatives and partnering providers to discuss alignment and avoid overburdening partners with administrative requests.

- Q #18 - What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?

  SWACH participates in statewide collaboratives with partners, including Health Homes and other ACHs, to learn about efforts and initiatives that involve care coordination and understand how to best align efforts and avoid duplication.

  SWACH staff also regularly attend regional collaboratives to identify areas for potential alignment or duplication. Examples include the regional Transforming Clinical Practice Initiative (TCPI) Care Coordination workgroup, the regional ACEs meeting, and the Aging and Disability Resource Network.

SWACH has also established collaborative relationships with neighboring Pathway HUBs operating in Oregon, just south across the Columbia River, and has established a close relationship with the CPAA and Pierce ACH Pathways HUBs.

- Q #19 - How is the ACH's approach aligned with MCO care coordination contract requirements?

  SWACH has engaged with Amerigroup, Community Health Plan of Washington and Molina Healthcare (the three MCOs in our region) to understand how best to align care coordination efforts and contract requirements. Several MCO partners will attend SWACH's two-day strategic implementation planning meetings to proactively begin discussions between payors, SWACH and partnering providers. SWACH intends to design Pathways Community HUB policies and procedures with significant input from the HUB Advisory Committee, which will include members representing various perspectives, including Medicaid enrollees, community-serving agencies, CCAs and payors, to name a few. With such diverse input, SWACH hopes to improve quality of overall care coordination while avoiding duplication and overburdening of partners.

For ACHs implementing Project 3A

- Q #16 - What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

  SWACH has identified the following programs or services to facilitate alignment with state efforts to reduce opioid-related morbidity and mortality through that target prevention, treatment and recovery supports:
  - Washington State Interagency Opioid Working Plan
  - Washington State Opioid Response Plan
  - DOH Administered CDC Special Projects - 2018 Opioid-DSLR Crisis CoAg - Cooperative Agreement for Emergency Response: Public Health Crisis Response
  - Washington Hub and Spoke model
  - Medication Take Back Programs through Regional Prevention Coalitions
  - WSMA/WSHA Washington Opioid Reports Program
  - Six Building Blocks - Team-Based Approach to Improving Opioid Management in Primary Care
  - UW AIMS program - Technical Assistance for Collaboratives Care and OBOT Nurse Case Management Model
  - Qualis Technical Assistance program
  - DOH technical assistance program to help new practices start office-based buprenorphine services
  - Starts With One Campaign

For ACHs implementing Project 3D

- Q #26 - What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

  SWACH has been closely aligned with statewide efforts to improve and manage chronic disease. Our close alignment with the Department of Health and our local health department has increased our ability to understand how to augment existing programs in our region. This has resulted in supporting the development of our Community HUB. Through the analysis of understanding this wide array of current services, we will be able to increase access to the appropriate chronic disease management and prevention programs and referring agencies to support the closing of specific pathways. Another example is our partnership with the EMS sector to develop a Community Paramedicine model to support more community-based care for chronic disease prevention. We have also been able to analyze how to support the MCOs in further development of the Chronic Care Model inside of each clinical transformation initiative. We will align our transformation plans with partners to align with the chronic disease quality metrics of each plan and further support transformation versus creating duplication.

Regional Readiness for Transition to Value-based Care

Explain how the region is advancing Value-based Care objectives.

ACH Response
Responses must cover the following: 27. What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples. 28. What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?

SWACH Response
Each provider's position along the VBP continuum will determine their actionable steps: • Some providers, especially larger health systems and primary care organizations, have been and are currently under a VBP contract. They are actively working with SWACH to help facilitate partnerships and enhanced relationships between their organizations and behavioral health and community-serving organizations. This

partnership development is intended to support clinical integration and community-clinical linkages while reducing value-based contract risk. Moreover, providers are actively involved with SWACH in further developing their population health capacities and identifying sub-populations they are targeting for interventions.

- In other instances, providers are working with SWACH and our MCO partners to "clean up" their empaneled population so MCOs can effectively develop strategies for patients assigned to their providers. As an example, a rural primary care provider under a VBP contract has been working with SWACH and our MCO partner to identify a cohort of patients empaneled with one provider, yet living much closer to and having been seen by another provider, who would prefer ongoing services provided by the provider they are not assigned to.

- Many of our behavioral health providers are focused on developing capacities to be successful in a VBP arrangement, being held accountable for outcomes and potentially taking on more risk in their contracts. For example, SWACH supported a pilot program for three behavioral health providers to integrate PreManage into their organizations. PreManage is an interoperable health information sharing platform that provides an opportunity to access and share clinical information for patients who are likely receiving services in a primary care setting, a hospital setting and a behavioral health setting. This increased capacity allows behavioral health providers a valuable new window into patient care. It also allows them to manage a subpopulation of shared patients, develop shared care planning and track clinical outcomes over time. These new capacities are critical developments necessary to succeed in any category of VBP. We anticipate that by TY 3, Q4, a significant regional cohort of behavioral health providers, as well as most primary care providers, will have implemented PreManage into their workflows.

Emerging provider champions in the SWACH region are appropriately focused on supporting whole-person care through team-based care, partnerships with community-based organizations and partnerships with behavioral health providers and other allied stakeholders. These champions take on leadership roles in SWACH workgroups. For example, they contribute to the workgroups, share lessons learned, present at regional and state conferences, contribute to and publish articles, publicly elevate the need to address social determinants of health, sit on local boards, and advocate for policies that support whole person care, paying for outcomes and allocating the needed resources to make the transition from fee for service to pay for value.

Regional Readiness for Health Information Technology (HIT) / Health Information Exchange (HIE)

Explain how the region is advancing HIT/HIE objectives.

ACH Response
Responses must cover the following: 29. What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples. 30. How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?

SWACH Response

Examples of SWACH taking actionable steps to facilitate information exchange at different points of care started in TY 1, Q3.

- SWACH has partnered with DOH, Qualis Health, Collective Medical Technologies, Molina Healthcare, Community Health Plans of Washington and the three largest behavioral health agencies (BHA) in the region to develop a pilot program and learning collaborative. The TY 2 goal of the pilot and learning collaborative is to implement PreManage/EDIE, a health information exchange platform, into the workflows of the three BHAs. The platform allows different care providers an opportunity to share clinical information, develop shared care recommendations and shared care plans, receive notifications of emergency room visits and intakes, and develop population health interventions for targeted populations.
- SWACH has supported the learning collaboratives by partnering with Qualis Health to produce a Behavioral Health PreManage Implementation Guide, a tool that is now available statewide.
- SWACH has also coordinated with Qualis Health practice transformation coaches to refine workflows, promote coordination among organizations and implement rapid PDSA cycles within the partner organizations.
- SWACH utilized a portion of transformation incentives between TY 1, Q3 and TY 2, Q2 to support BHAs' implementation needs, ongoing technical assistance and continuous quality improvement strategies.

Another way SWACH will leverage transformation resources to support statewide information exchange systems is through implementation of the Pathways Hub CCS IT platform. SWACH is one of six ACHs using CCS for Pathways. This alignment allows for multiple information exchange opportunities: testing of CCS interoperability across ACHs; collection of disaggregated demographic data across regions to address equity issues; potential for integration of CCS with 211 resource data; and integration of CCS with electronic health record systems and OneHealthPort.

Technical Assistance Resources and Support

Describe the technical assistance resources and support the ACH requires from HCA and other state agencies to successfully implement selected projects.

ACH Response

Response should cover the following:

31. What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?
32. What technical assistance or resources does the ACH require from HCA and other state agencies?
33. What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?

SWACH Response

An example of technical assistance SWACH has found successful is our partnership with Qualis Health and practice transformation coaches that support several of our partnering providers. Specifically, SWACH coordinates with Qualis and a partnering provider to develop an integrated primary care family medicine clinic. SWACH and Qualis have been involved with the provider in each phase of the development. Qualis deployed a practice coach to facilitate each stage of implementation, from the initial exploration of the model to facilitating ongoing Patient-Centered Medical Home tools and processes.

Another helpful resource has been leveraging the technological expertise of Collective Medical Technologies (CMT). CMT has provided several partnering providers with expertise in developing secure data files that are transferred between providers and CMT, population health management and stratification tools, technical connections between CMT and a partner's electronic health record, and creating use cases for potential clinical interventions.

SWACH has identified *Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care* as a technical assistance resource for prevention and treatment-focused strategies in the opioid response. To explore the program, SWACH met with UW's Dr. Laura-Mae Baldwin, who helped lead development of Six Building Blocks, and partnering providers Sea Mar CHC and PeaceHealth, whose primary care and clinical services reach the majority of the region's Medicaid population.

Another helpful resource for prevention strategies is the WSMA/WSHA Opioid Feedback program. SWACH has coordinated with program representatives to deliver a presentation on participation in the program for partnering providers. SWACH has facilitated registration with this program for partnering providers, including hospital and primary care settings. Participation in the program was included as a change tactic in the SWACH CTP template.

Regarding treatment strategies, SWACH is exploring collaboration with UW TelePain to support a cohort of MAT providers around shared learning for management of pain and

medication assisted treatment. SWACH has also utilized technical assistance from DOH, specifically Mary Catlin, through the CDC funded grant to help communities increase access to agonist treatment for Opioid Use Disorder. Additionally, UW-AIMS has provided technical assistance and training for partnering providers interested in collaborative care and particularly the nurse case management model of office-based opioid treatment.

SWACH has identified the Institute for Healthcare Improvement (IHI) as resource for the MTP quality improvement work. The IHI's science of improvement methodologies form the framework for SWACH's work with partnering providers to support a culture of improvement. SWACH has a staff member enrolled in IHI's Improvement Advisor certification program and has provided IHI-framed QI support for various projects. These projects include: a hepatitis c treatment project that supports cross-setting partnerships between a peer provider organization and a primary care FQHC, as well as a collaborative project between treatment settings and hospital settings to develop a low-barrier rapid response MAT clinic to support continuity of care and access to resources for newly MAT indicted patients.

SWACH recognizes that with limited resources across the state, prioritizing additional support is often difficult. SWACH believes that collaboration across the state is a key element in achieving the desired outcomes for Transformation and has collaborated with ACHs to develop the chart below. While the following is not an exhaustive list, SWACH recommends the following additional supports:

Technical assistance and resources needs from HCA and state agency partners

- Stronger collaboration between HCA and MCOs
- ACH and HCA continued collaboration to find interoperability solutions
- In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes.
- TA for population health management support for:
    - Data governance
    - Interoperability
    - HIE
    - Disease registries
    - Telehealth
    - PreManage/EDIE
    - Centralized registries
- Support for dental health aide therapists and other dental professions that expand scope of practice will improve dental access

- Support from HCA for guidance on the ACHs' role in moving towards whole-person care and VBP
- ACH's would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs and provider organizations.
- SWACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPI Practice Transformation Network and its vision for continuity after January 2019.
- Support from the state on VBP, specifically, understanding how we can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other TA from the state.
- Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators, BH specialists)
- Training and TA for common training needs: MAT, PMP, Six Building Blocks, transitional care models, trauma-informed practices, cultural sensitivity
- Increased capacity for practice transformation support directly to participating providers - i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions
- Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models, how it will impact them and what steps they should take to prepare
- Resources tailored to behavioral health providers having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity
- Best practices and strategies specific to billing/coding for healthcare providers that align payments with the intent behind bi-directional integration (i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes)
- Approving general behavioral health integration codes would significantly affect long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings.
- Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring

- Streamline informational requests from our partners. This will enhance continued assessment and planning.
- Regular communication and access to results from state-level health system capacity surveys such as the VBP survey, the Washington State Health Workforce Sentinel Network and the Medicaid EHR Incentive Program.
- Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes
- ACHs want to ensure that information held in these data repositories (All-Payers Claims Database and Clinical Data Repository) is accurate, accessible, timely and useful to our transformation work and to our partners.
- MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers and other positions not reimbursed by Medicaid
- Establishing a career path for rural nursing and workforce needs, from high school through four-year programs
- Improved coordination with DOH to ensure coordinated opioid prevention efforts
- Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care
- Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
- Taking leadership role around regulations that are a barrier to MTP goals. Specifically, behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.

SWACH is particularly interested in learning as much as possible from our ACH partners. SWACH actively participates in a wide variety of topical learning opportunities throughout the state. SWACH is particularly interested in:

- Lessons learned and best practices related to the four projects our region has selected through each stage of the process.
- Learning from other regions how to best support behavioral health providers' transition to VBP arrangements.
- Continued shared learning with the five other ACHs implementing the Pathways care coordination model.
- Continued shared learning around opioid response strategies, including programs such as Six Building Blocks and implementation of models such as the nurse case management model for Office-Based Opioid Treatment (OBOT), paramedicine models

such as the Tacoma Fire and Rescue Naloxone leave-behind program, as well as paramedicine models across the state to support chronic disease management and diversion.

Moreover, SWACH is dedicated to addressing stigma, health equity and increasing awareness of trauma-informed care best practices and considers our partners across the state as valuable contributors to cross-ACH learning opportunities that address these topics.