SWACH

Semi-Annual Report

Reporting Period:
January 1, 2018 – June 30, 2018

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Attachment: Semi-Annual Report Workbook

Semi-Annual Report Information and Submission Instructions

Purpose and Objectives of ACH Semi-Annual Reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit Semi-Annual Reports for project achievement. ACHs will complete a standardized Semi-Annual Report template developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones and metrics based on approved Project Plans. As needed, ACHs may be requested to provide back-up documentation in support of progress. HCA and the Independent Assessor will review Semi-Annual Report submissions.

Reporting Requirements

The Semi-Annual Report template for the reporting period January 1, 2018 to June 30, 2018 includes two sections as outlined in the table below. Section 1 instructs ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 2 per the Medicaid Transformation Toolkit. Section 2 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Each section in the semi-annual report contains questions regarding the regional Transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional Transformation work completed by either:

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

Please read each prompt carefully for instructions as to how the ACH should respond.

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	**Sub-Section Description**
Section 1. Required Toolkit Milestones (DY 2, Q2)	Milestone 1: Assessment of Current State Capacity
	Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	**Sub-Section Description**
	Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations
	Milestone 4: Identification of Partnering Providers
Section 2. Standard Reporting Requirements	ACH Organizational Updates
	Tribal Engagement and Collaboration
	Project Status Update
	Partnering Provider Engagement
	Community Engagement
	Health Equity Activities
	Budget and Funds Flow

Key Terms

The terms below are used in the Semi-Annual Report and should be referenced by the ACH when developing responses.

1. **Community Engagement**: Outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.
2. **Health Equity**: Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.[1]
3. **Key Staff Position**: Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, Program Management and Strategy Development
4. **Partnering Provider**: Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
5. **Project Areas:** The eight Medicaid Transformation projects that ACHs can implement.
6. **Project Portfolio**: The full set of project areas an ACH is implementing.

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

Semi-Annual Report Submission Instructions

ACHs must submit their completed Semi-Annual Reports to the Independent Assessor **no later than July 31, 2018 at 3:00p.m. PST.**

File Format

ACHs must respond to all items in the Microsoft Word Semi-Annual Report template and the attached Microsoft Excel workbook in narrative or table format, based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word and Microsoft Excel or a searchable PDF format. Below are examples of the file naming conventions that ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR1 Report. 7.31.18
- *Excel Workbook:* ACH Name. SAR1 Workbook. 7.31.18
  - *Attachments:* ACH Name.SAR1 Attachment X. 7.31.18

Note that all submitted materials will be posted publicly; therefore, ACHs must submit versions that can be public facing.

Washington Collaboration, Performance, and Analytics System (WA CPAS)

ACHs must submit their Semi-Annual Reports through the WA CPAS which can be accessed at https://cpaswa.mslc.com/. **ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled "Semi-Annual Report 1 – July 31, 2018**." The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 1 – July 31, 2018.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

Semi-Annual Report Submission and Assessment Timeline

Below is a high-level timeline for assessment of the Semi-Annual Reports for reporting period January 1, 2018 – June 30, 2018.

ACH Semi-Annual Report 1 – Submission and Assessment Timeline			
No.	**Activity**	**Responsible Party**	**Timeframe**
1.	Distribution of Semi-Annual Report Template and Workbook to ACHs	HCA	March 30, 2018
2.	Overview of Semi-Annual Report Template	HCA/IA	Apr 9, 2018
3.	Publish pre-recorded webinar with additional information about the Semi-Annual Report assessment	IA	Apr 2018
4.	Submit Semi-Annual Reports	ACHs	July 31, 2018
5.	Conduct assessment of reports	IA	Aug 1-25, 2018
6.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 25-30, 2018
7.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 26-Sept 14, 2018
8.	If needed, review additional information within 15 calendar days of receipt	IA	Sept 10-29, 2018
9.	Issue findings to HCA for approval	IA	TBD

Contact Information

Questions about the Semi-Annual Report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH Contact Information

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

ACH Name:	Southwest Washington Accountable Community of Health (SWACH)
Primary Contact Name **Phone Number** **E-mail Address**	Daniel Smith 503-459-6495 Daniel.smith@southwestach.org
Secondary Contact Name **Phone Number**	Kachina Inman 541-520-9382 Kachina.Inman@southwestach.org

Section 1: Required Milestones for Demonstration Year (DY) 2, Quarter 2

This section outlines questions specific to the milestones required in the Medicaid Transformation Project Toolkit by DY 2, Q2. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone 1: Assessment of Current State Capacity

1. **Attestation:** The ACH worked with partnering providers to complete a current state assessment that contributes to implementation design decisions in support of each project area in the ACH's project portfolio and Domain I focus areas. Place an "X" in the appropriate box.

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

Yes	No
X	

2. If the ACH checked "No" in item A.1, provide the ACH's rationale for not completing a current state assessment, and the ACH's next steps and estimated completion date. If the ACH checked "Yes" in item A.1, respond "Not Applicable."

   ACH Response: Not Applicable.

3. Describe assessment activities and processes that have occurred, including discussion(s) with partnering providers and other parties from which the ACH requested input. Highlight key findings, as well as critical gaps and mitigation strategies, by topic area for the project portfolio and/or by project.

   ACH Response:

SWACH fielded two assessments with its partners as part of a suite of assessment activities designed to develop an understanding of the current state of partner organization capacity and need in a variety of areas. This will be used to guide project implementation and inform resources and technical assistance offerings SWACH may make available in the region.

<u>Health Information Exchange (HIE) Assessment</u>

The first assessment, launched in February 2018, focused on HIE. An online survey was distributed to 31 physical and behavioral health organizations across the region. SWACH received 28 responses (90%). Since the initial fielding, several additional organizations have engaged more deeply with SWACH and may complete the HIE assessment later this year.

Key findings include:

- Most clinical partner organizations (96%) reported having an Electronic Health Record (EHR). This is somewhat contrary to anecdotal information that suggested behavioral health partners may not have implemented EHRs. However, it is possible that some smaller behavioral health providers not included in the assessment or Medicaid Transformation Project planning have not implemented EHRs.

- Partner organizations across the region use at least 15 different EHRs. Approximately half of respondents have the ability or licensing right to modify their EHR. This has implications for partners' ability to efficiently exchange information or implement technological solutions.

- Most of the region's HIE occurs within the health system (that is, behavioral health and physical health providers are sharing information with each other. Other organizations, such as oral health providers or community-based organizations, exchange much less information). Most information is exchanged manually (i.e. fax or paper based, rather than electronic). No organizations reported any electronic exchange with community paramedicine or law enforcement / criminal justice organizations.

- Just under 40% of organizations participate in any HIE and 50% report using EDIE, PreManage or both. 25% report having an electronic interface with the Washington Prescription Monitoring Program.

- When asked about gaps and barriers, responding organizations highlighted costs to modifying their EHRs and participating in HIE, as well as ongoing challenges with interoperability.

HIE assessment results were discussed with the Regional Health Improvement Plan (RHIP) Council in March and April. SWACH asked members (including some responding organizations) for feedback on the findings and potential next steps. RHIP identified several gaps including information that may be exchanged by local public health departments and school-based providers. Council members noted that exchanging information and using information that has been exchanged are separate challenges.

HIE assessment results were also reviewed and discussed with the Clinical Integration Workgroup. The workgroup identified the need for further collaboration between physical health and behavioral health providers to formulate regional strategies that allow for more efficient means to transfer health information between settings. This review supported the development of tactical options for the region to consider when developing an organizational Clinical Transformation Plan that supports increased use of current technology and resources.

As an example of an ongoing mitigation strategy to address the gaps in information exchange and shared care planning that SWACH was aware of prior to a formal assessment, SWACH has continued to convene a PreManage/EDIE Learning Collaborative to enhance the use and utility of the PreManage platform in the region. The collaborative is supported by SWACH as well as the Qualis HUB and has created a two-year strategic framework. The goals of the collaborative are to:

1) Increase the use of PreManage within behavioral health settings

2) Support workflow designs within behavioral health settings to enhance care coordination and HIE

3) Collaborate with primary care and Managed Care Organizations (MCOs) to develop regional policies and protocols for shared care planning

4) Expand the use of the PreManage in emergency room and non-traditional care settings

SWACH continues reviewing HIE assessment results to understand gaps. SWACH is also working to identify potential grouping of partners with similar strengths and needs. Goals include informing a strategy around collaborative learning, leveraging funding to support partners with prioritized HIE needs, and supporting the overall regional need for improving the exchange of health information to improve integration and care coordination in SWACH communities.

As the HIE assessment confirmed the use of various EHRs, SWACH is approaching this issue as an opportunity for the region to coordinate effective strategies that would increase sharing critical health information for targeted populations. Following the assessments, SWACH arranged strategic meetings with clinical partners to scope regional priorities, outline implementation strategies related to increased care coordination and clinical integration, and further assess the capacities of organizations' EHRs to inform potential investment strategies to meet integration objectives. Additional planning in Q3 and Q4 of 2018 will help formulate a portfolio of potential solutions.

Clinical Partner Assessment

Between March and May of 2018, SWACH fielded a second assessment focused on behavioral health and physical health partners. This assessment aligned with the Domain I and project areas outlined in the Medicaid Transformation Project Toolkit.

The Clinical Partner Assessment was also fielded online. Whereas the HIE Assessment focused only at the organization level, the Clinical Partner Assessment was fielded with behavioral health *organizations* and physical health *practices*. This meant that some organizations submitted multiple assessments (i.e. both behavioral and physical health; multiple physical health assessments representing multiple practice sites; etc.).

As of mid-June 2018, SWACH received 47 total responses representing 24 clinical partner organizations (82.5% response rate). Since the initial fielding, several additional organizations have engaged more deeply with the Transformation work. SWACH anticipates several additional complete responses later this year.

Clinical Partner Assessment results were reported out over June and July. Part 1 focused on the respondent organizations and the Domain I focus areas; Part 2 focused on project specific questions. Results were presented and discussed each month with SWACH's Data Workgroup (formerly Data and Learning Team) and the RHIP Council.

- Part 1 is available here: http://southwestach.org/wp-content/uploads/2018/07/SWACH-Clinical-Partner-Assessment-Summary-Part-1_for-RHIP.pdf

- Part 2 is available here: http://southwestach.org/wp-content/uploads/2018/07/SWACH-Clinical-Partner-Assessment-Summary-Part-2_for-RHIP.pdf

Key findings include:

- Both behavioral health and physical health partners report strong interest in participating in Bi-directional Integration and Community-Based Care Coordination projects. However, only 20% of responding behavioral health organizations are interested in participating in Chronic Disease projects and 40% are interested in the Opioid Project.

- All partnering organizations serve Medicaid members. However, behavioral health organizations reported higher percentages of Medicaid members (case mix) than physical health partners. 66% of responding physical health practices reported that less than 25% of their patients were covered by Medicaid.

- Assessment findings continue to confirm that access to care is a challenge for the region. Only 44% of responding physical health practices say they are currently accepting new Medicaid patients without limitations. 72% do not expect the proportion of Medicaid members served to change in the next 12 months.

- One behavioral health organization and five physical health practices reported that they had more than 50% of payments in Value-Based Payment (VBP) categories that count toward the regional target. Ten behavioral health organizations and nine physical health practices reported 0% of payments in qualifying VBP categories. Furthermore, 53% of behavioral health respondents and 66% of physical health respondents indicated their participation in VBP was expected to change in the next 12 months.

- Most physical health practices (91%) report having organizational / internal support for efforts related to delivering integrated care, including specific strategic or operational plans and completion of various readiness assessments and planning. Only 9% of behavioral health organizations report having these types of support. This difference is also seen in respondents' baseline IPAT scores (i.e. level of integration), where 53% of behavioral health organizations are in pre-coordination or at level one (minimal collaboration) and 63% of physical health practices are at levels five or six. Payment or financing mechanisms were the most commonly reported barriers to integration by both behavioral and physical health respondents.

- Most responding organizations participate in other care coordination programs, including Health Homes, Primary Care Case Management, First Steps and more. Most prioritize various populations for care coordination services. Physical health practices were less prepared to manage care for patients with severe mental health problems

and/or need for social services than they were for patients with substance use related issues.

- While all but one responding physical health practice reported having providers who prescribe opioids, only 33% of behavioral health organizations do. This may explain the limited interest in the Opioid Project described in the first bullet point. 77% of physical health practices with opioid prescribers have adopted the CDC's opioid prescribing guidelines, while few behavioral health organizations with opioid prescribers have adopted any guidelines. Patient resistance was the greatest barrier to implementing opioid prescribing guidelines.
- Most responding organizations provide multiple types of self-management supports, including offering a variety of in-house programs. However, only 20% refer patients to a chronic disease self-management program and no behavioral health organizations report referring to the national diabetes prevention program.

Gaps and Mitigation Strategies

SWACH's clinical assessments highlighted the region's support for increasing clinical integration and care coordination between physical health and behavioral health providers. As noted above, the assessment also indicated the need for regional strategies to increase integration across care settings and mitigate existing barriers to integration. SWACH created a framework and roadmap that structurally supports a portfolio approach to incentivize cross-setting partnerships, implement change process for increased integration, and establish a framework for collective impact and shared learning across projects (see attachment A).

Another component to this mitigation strategy is SWACH's developing plan to fold non-clinical partners into the clinical partner Transformation planning process, rather than creating a separate and parallel assessment process. One of SWACH's goals is to remove barriers for clinical partners to work with non-clinical partners in developing and implementing their Clinical Transformation Plans. SWACH will identify several categories of non-clinical partners (e.g. housing, transportation, community paramedicine) with clearly defined roles for how each category of partner could work with the clinical partners to support efforts under community-clinical linkages (i.e. have clear tactics). SWACH will issue a Request for Qualifications (RFQ) in Q3 of 2018 to identify non-clinical partners that meet defined roles and are willing to participate in community-clinical linkage efforts.

4. Describe how the ACH has used the assessment(s) to inform continued project planning and implementation. Specifically provide information as to whether the ACH has adjusted projects originally proposed in project Plans, based on assessment findings.

ACH Response:

SWACH's assessment portfolio (HIE, Clinical Partner) provided information on the current state of partnering providers. SWACH used information collected through the assessments to help develop the Clinical Transformation plan template (see attachment B), which included a menu of tactics for clinical partners to choose for overall project implementation. For example,

the assessments identified partnering providers' desire to potentially integrate peers and/or Community Health Workers (CHWs) into their care teams. This information confirmed SWACH's workforce development strategies related to CHWs and peers. SWACH also used the assessment findings to solicit guidance from the RHIP Council related to workforce needs and barriers, future capacity needs of stakeholders and how to break down silos of care.

Additional review of the assessment data continues with the Clinical Integration Workgroup. To date, review has focused on current organizational practices, approaches to managing chronic health conditions and exploring how funding and payer mix may impact capacity for integration and participation in Transformation activities. The assessment also identified that planning for integration is much farther along in primary care relative to behavioral health. This data point will help inform future resource allocations as it identified that behavioral health providers may have further to travel along the integration continuum.

Information gathered through SWACH's assessments did not result in any major changes to SWACH's original approach outlined in the November project plans.

5. Provide examples of community assets identified by the ACH and partnering providers that directly support the health equity goals of the region.

ACH Response:

During the reporting period, SWACH identified several community assets to support health equity in the Southwest region:

The Southwest Washington Equity Coalition is a group of leaders representing community and culturally specific groups and organizational partners from housing, education and health. They gather together to support equity in the community. The group started by convening a few community conversations. A need to build collective action around equity emerged from those meetings.

The Community Foundation of Southwest Washington offered to support the coalition through training and leadership training with the Center for Equity and Inclusion (CEI), which supports the equity movement nationally. The Healthy Living Collaborative (HLC), a program of SWACH and part of the Southwest Washington Equity Coalition, leveraged additional resources through a United Way grant to further support the work through CEI. The group completed an initial three-day training and will continue meeting monthly over the next five months to continue the trainings. This training has already provided a common language and shared understanding for equity advocates, which will help in moving collective work forward in the community. Additionally, the group shared tools including the equity lens tool that HLC is implementing across workgroups and committees (see attachment C). SWACH plans to bring these tools to its other work groups and committees. Furthermore, the equity coalition has helped advance development of partnerships among its members.

Community Health Advocates and Peer Support Specialists (CHAPS) is a regional peer network that works to build momentum and support for practicing peers. Peers and CHWs have a unique ability to support some of the region's most underserved communities and are often able to provide support for communities experiencing greater levels of stigma and trauma. CHAPS

convene peers every other month to share learnings, network, provide support and advocate for greater workforce development opportunities in the community.

SWACH's Clinical Partner Assessment found that 20% of behavioral health organizations and 19% of physical health practices in the region employ or contract with CHWs and 67% of behavioral health organizations employ peer support workers. Additionally, 40% of behavioral health organizations and 34% of physical health practices report having some sort of agreement with Medicaid MCOs to pay for community health workers or peer services. SWACH plans to support and expand the use of this workforce and provide shared learning collaboration to promote the asset of peers and CHWs in Medicaid Transformation Projects.

6. Provide a brief description of the steps the ACH has taken to address health equity knowledge/skill gaps identified by partnering providers, and how those steps connect to ACH Transformation objectives.

ACH Response:

Healthy equity, trauma-informed care and stigma reduction are core components of SWACH's strategic framework. To address these complex issues, SWACH has taken a multi-faceted approach to further health equity in the region. This includes:

1) Offer training
2) Infuse equity objectives throughout SWACH's strategic framework and Clinical Transformation Plans
3) Commit to advance SWACH's policies and procedures to support furthering equity

Through HLC's past work and SWACH's 2018 assessments, training emerged as a critical first step in understanding the complexity of equity. Many of HLC's partners are providers who are embarking on Transformation efforts. Through the HLC, over the reporting period SWACH successfully leveraged funding to offer four, eight-hour trainings on leading social justice and equity, including one advanced course on implicit bias. Over the past three years, more than 200 individuals received training through HLC. More than 80 individuals completed training during the reporting period. SWACH plans to continue offering these trainings to further advance regional understanding of equity issues. That includes a new series of trainings offered this fall.

Rural communities identified the need to slightly modify the current training to better meet their needs and advance skill development. SWACH will work with the trainer to build this feedback into the curriculum. The focus on health equity training will ensure partnering providers are more prepared to provide quality, value-based services to all. It will also set them up for success to meet the equity objectives they will define in their Clinical Transformation Plans.

SWACH also convened a group of partnering providers and community partners to embed equity in the Clinical Transformation Plan. The partners identified a need for formal equity

assessments to evaluate a variety of areas. For example, organizational governance, policies and opportunities for improvement around racial equity, trauma informed care and stigma. Assessment findings will be reported to SWACH and help shape improvement plans for each organization that chooses to participate. SWACH consulted with equity experts throughout this process for guidance on best practices. Based on the recommendations from partnering providers and equity experts, the following tactics were embedded in the Clinical Transformation Plan:

a) Provide equity, stigma reduction or trauma-informed care training

b) Complete an equity assessment

c) Develop an equity plan

Partnering providers interested in embarking on an equity assessment or plan will be required to participate in a shared learning cohort. SWACH will also require ongoing reporting to ensure partners are making milestone improvements over time. The cohort provides an opportunity to share tools and resources as well as discuss barriers and successes, so the entire region can benefit.

SWACH has identified a need to strengthen its own approach to equity and will complete an equity assessment and plan in 2019. SWACH will actively participate in the shared learning cohort and complete this work alongside partnering providers. SWACH is committed to ensuring that equity is woven throughout the Transformation work and is embedded in the foundation which supports all goals and objectives, so that the Southwest region can attain the vision of all people having equitable access to quality whole-person care and living in connected and thriving communities without barriers to wellness.

B. Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)

1. **Attestation:** During the reporting period, the ACH has identified common gaps, opportunities, and strategies for statewide health system capacity building, including HIT/HIE, workforce/practice Transformation, and value-based payment. Place an "X" in the appropriate box.

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

Yes	No
X	

2. If the ACH checked "No" in item B.1, provide the ACH's rationale for not identifying common gaps, opportunities, and strategies for statewide health system capacity building. Describe the steps the ACH will take to complete this milestone. If the ACH checked "Yes," respond "Not Applicable."

ACH Response: Not Applicable

3. Describe progress the ACH has made during the reporting period to identify potential strategies for each Domain I focus area that will support the ACH's project portfolio and specific projects, where applicable.

ACH Response:

The Domain I focus areas remain a priority for SWACH. During the reporting period, several potential strategies emerged to further develop SWACH's capacity to address Domain I.

The most significant development during the reporting period is the statewide focus on partnership and collaboration to develop statewide strategies related to Domain I. HCA, Association of Washington Public Health District (AWPHD), University of Washington, State Agencies and all nine ACHs have committed to identifying common opportunities. This led to the development of a Health Systems Capacity Building Partnership (HSCBP) process for collective action related to Domain I focus areas.

The HSCBP is a strategic partnership of statewide entities and communities identifying common gaps and common opportunities statewide for health system capacity building. Convened by HCA with the facilitation support of the AWPHD, the group's purpose is to address challenges and realize opportunities in health system Transformation that are best met with coordinated regional or statewide approaches. Health system capacity building, including HIE, workforce/practice Transformation and VBP, is an opportunity to work collaboratively to catalyze Transformation as one system.

This group met several times during the reporting period, organized a matrix of ACH strategies related to specific projects and determined additional correlated statewide initiatives as well as corresponding potential HSCBP activities. While HSCBP has continued to develop and results from the work have materialized, future strategic alignments are forthcoming during Q3 and Q4.

Each month, all nine ACH executive directors participate in peer-to-peer learning and review strategies from across the state. During the reporting period, this strategic shift in peer-to-peer learning and collaboration has been facilitated and supported by a contract with Applied Insight, LLC, in partnership with HCA. Structurally, this provides ACHs an opportunity to facilitate strategic meetings with all five MCOs, allied statewide health related associations (Washington State Hospital Associations, Washington State Medical Association), state agencies, key stakeholders, constituents and a variety of large philanthropic organizations.

Through this process of shared learning, potential strategies have emerged. For example, there is a need to address workforce development as well as the regulations and policy needs related to developing and exchanging health information. The process of shared learning also helped identify opportunities to develop statewide training and development related to value-based care delivery and payment reform across the state and in our region. Much of the work during this reporting period has been foundational and critical to establishing the structure and

framework to collectively develop partnerships and address Domain I areas across regions. Specifically, a strategic matrix related to workforce was developed through this process and SWACH is in the process of prioritizing potential regional ACH activities that align across the state. As noted above, the collaborative efforts during this reporting period are foundational. SWACH is in the process of reviewing potential new strategic options and working across the state and region to prioritize strategies.

SWACH has coordinated with HCA, VBP Action Team, MCOs, health systems, providers, ACHs, consultants and other stakeholders to advance SWACH's VBP strategies that will develop increased capacities for providers to be successful in a VBP arrangement. Through these partnerships and processes, SWACH has supported partnering providers' ability to elevate barriers to VBP. Partnering providers will need additional training and technical assistance to achieve VBP goals. SWACH will leverage ACH resources to help partner organizations address their training and technical assistance needs. At the statewide level, ACHs established a monthly meeting with all MCOs to collectively strategize and operationalize the needed capacities within ACHs and organizations to support a successful and sustainable transition to VBP. At the regional level, through the assessment and clinical Transformation plan processes, SWACH is gaining a better understanding of the current state of VBP and the potential needs for investment in infrastructure, workforce and technical assistance. Moreover, SWACH's assessment of partnering providers' HIT/HIE use has been a key part of the progress made by SWACH during this reporting period. For example, this information has led to further review of strategies related to advancing PreManage use to support care coordination, transitional care and shared care planning. This is also an example of how the recent statewide collaborative approaches to support Domain I initiatives will be leveraged at the regional level.

4. Provide information as to whether the ACH has adjusted Domain I strategies as originally proposed in its Project Plan based on ongoing assessment.

ACH Response:

A key component of SWACH's approach to developing Domain I strategies was to conduct assessments related to this domain. As mentioned in the response to Milestone 1, SWACH conducted two formal assessments during the reporting period that gathered inputs related to Domain I (HIE Assessment and Clinical Provider Assessment).

<u>HIT/HIE (Population Health Management)</u>

Assessment findings led SWACH to make two strategic changes to the overall HIT/HIE approach. Prior to the assessment, SWACH's initial strategic approach outlined the establishment of a HIT/HIE Task Force comprised of chief information officer/chief technology officer level participants and staffed internally by SWACH's chief information and technology officer. This task force was intended to analyze the assessments and provide recommendations to allocate regional resources from a Systems Capacity Building Fund (SCBF).

While SWACH still intends to develop recommendations for allocating regional resources, assessment findings led SWACH to make two strategic changes to the overall HIT/HIE approach:

First, existing workgroups are best positioned to synthesize assessment data and a separate HIT/HIE task force is not necessary. The Data Workgroup conducted an initial review of assessment findings, revised and presented those findings to the RHIP Council for further input and analysis. The findings were also distributed to the clinical workgroups, which helped inform tactical considerations for participating partners as they developed a framework for clinical Transformation.

Second, it was determined that SCBF was redundant and that funding category was eliminated. During the reporting period, the SWACH Board of Trustees approved a 2018 funding allocation and process for regional capacity investment as well as Transformation plan and implementation. This rendered the SCBF strategy unnecessary since elements of the SCBF, including HIT/HIE investments, would be folded into the regional capacity investment.

Workforce

SWACH is strategically aligned with a variety of statewide and regional initiatives to support workforce development necessary to provide team-based coordinated care across settings. As another example of how assessment results influenced strategies, SWACH developed a deeper understanding of the potential role of peers and CHWs across care settings. The results indicated a stronger than anticipated desire from clinical providers to develop new opportunities to integrate peers and CHWs into the care team. SWACH will continue to work with partners, CHWs and peers to further evaluate interest and determine how SWACH can best support the growth and development of the opportunities for CHWs and peers in regional workforce development.

VBP

During the reporting period, SWACH did not adjust the originally proposed VBP strategies. Due to the collaborations and shared learning opportunities in Q2 between HCA, MCOs and ACHs, SWACH anticipates potential refinements or reprioritization during the next reporting period because more information is now being shared related to MCO strategies and priorities. SWACH remains a neutral convener, willing and able to provide technical assistance. SWACH is also committed to investing resources to increase provider capacity, as well as help identify regional gaps and barriers.

5. Describe the ACH's need for additional support or resources, if any, from state agencies and/or state entities to be successful regarding health system capacity building in the Transformation.

ACH Response:

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:

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE.	Approving general behavioral health integration codes would significantly impact 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.
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole-person care and VBP.	Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs	ACH's would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. This will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH 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.	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.
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	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.
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	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	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.

	Team or other technical assistance from the state.	
Systems for Population Health Management support for: •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries	Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists)	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers and other positions not reimbursed by Medicaid
Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing and licensed social workers	Training and TA for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, trauma-informed practices, cultural sensitivity	Establishing a career path for rural nursing and workforce needs, from high school, through four-year programs
Support for dental health aide therapists and other dental professions that expand scope of practice will improve dental access	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	Improved coordination with DOH to ensure coordinated opioid prevention efforts
	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 be prepared	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.
	Resources tailored to behavioral health providers who are 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	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.

	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)	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.

C. Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

For this milestone, the ACH should either:

- *Respond to items C.1-C.3 in the table following the questions, providing responses by project. (For projects the ACH is not implementing, respond "Not Applicable.")*

  Or,

- *Provide an alternative table that clearly identifies responses to the required items, C.1-C.3. The ACH may use this flexible approach as long as required items below are addressed.*

1. **Medicaid Transformation Approaches and Strategies**

   Through the Project Planning process, ACHs have committed to a set of projects and associated strategies/approaches. For each project, please identify the approach and targeted strategies the ACH is implementing. The state recognizes that ACHs may be approaching project implementation in a variety of ways.

   For each project area the ACH is implementing, the ACH should provide:

   a. A description of the ACH's evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals, and requirements.

   b. A list of Transformation activities ACH partnering providers will implement in support of project objectives. Transformation activities may include entire evidence-based approaches or promising practices, sub-components of evidence-based approaches or promising practices, or other activities and/or approaches derived from the goals and requirements of a project area.

   c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area, and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether

the ACH has sufficiently satisfied the equivalency requirement.

2. **Target Populations**

   Provide a detailed description of population(s) that Transformation strategies and approaches are intended to impact. Identify all target populations by project area, including the following:

   a. Define the relevant criteria used to identify the target population(s). These criteria may include, but are not limited to: age, gender, race, geographic/regional distribution, setting(s) of care, provider groups, diagnosis, or other characteristics. Provide sufficient detail to clarify the scope of the target population.

      Note: ACHs may identify multiple target populations for a given project area or targeted strategy. Indicate which Transformation strategies/approaches identified under the project are expected to reach which identified target populations.

3. **Expansion or Scaling of Transformation Strategies and Approaches**

   a. Successful Transformation strategies and approaches may be expanded in later years of Medicaid Transformation. Describe the ACH's current thinking about how expanding Transformation strategies and approaches may expand the scope of target population and/or activities later in DSRIP years.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
Project 2A: Bi-directional Integration of Physical and Behavioral Health	
1. Transformation Strategies and Approaches	Project 2A (Bi-directional Integration) is built upon five core concepts of integration that have been identified by the Clinical Integration Workgroup and that are fundamental evidence-based practices and strategies of the Collaborative Care Model and the Bree Collaborative. The core concepts go beyond a single project and provide a foundational path for sustainable integration beyond the project timeline. The committee selected five core concepts as the core concepts that SWACH will use to develop the implementation plans and direct resources toward. They include: 1) Offering enhanced development of integrated care teams 2) Ensuring that behavioral health and primary care become routine services, including health screenings, regardless of setting 3) Sharing of clinical information across settings 4) Implementing strategies and systems to increase capacity to support population health management 5) Utilizing data to provide accountable care Crucial to SWACH's strategy of five core concepts of integration, rather than a specific clinical model, is the implementation of a flexible approach toward integration allowing providers to build upon their integration efforts that are currently underway. This approach will offer all Medicaid providers, regardless of size or scope, the ability to incrementally increase their capacity to provide integrated clinical services. To align the region with a common language around state of readiness and organizational goals, SWACH will utilize the SAMSHA Six Levels of Integration to conceptualize readiness, strategic goals and progress. The SAMSHA model provides a systemic organizational structure to implement a variety of clinical integration strategies in different clinical settings for different sub-populations and provider types. Because SWACH is taking a flexible approach toward clinical models of integration, having a conceptual tool to organize the region along a continuum of integration will be useful for supporting change across settings. Allowing the implementation of key concepts common to both the Bree Collaborative recommendations and the Collaborative Care Model, based on a provider's readiness and consistent with their strategic plans, enables SWACH to support positive movement along the continuum of integration without dictating which integration model a provider must use. By encouraging providers to choose the integration model best suited to their readiness and strategic plans–whether it be the Bree Collaborative or Collaborative Care Model –the ACH can support movement along the continuum of integration. Through building a strong foundation of core concepts, this approach becomes an architectonical framework.

2. Target Populations

Target Population: all Medicaid beneficiaries (adults and children) across the region. As behavioral health and primary care settings that serve Medicaid further their integration efforts, each practice or collaboration may implement strategies throughout the project that focus on more targeted sub-populations, such as individuals with specific chronic, mental health or substance use conditions.

Scope: The target population includes just under 128,000 individuals, with the majority (93%) residing in Clark County. 62,343 (49%) are children, with a higher percentage of children living in Clark County (49%) than in Klickitat and Skamania (43%).

	Clark	Klickitat	Skamania	SWACH Total
Total Medicaid Lives	118,904	6,632	2,386	127,904

HCA AppleHealth Enrollment Reports, Enrollees in Medical Programs by County, May 2018.

Criteria: Target population selection was informed by the Clinical Integration Workgroup, the suggested target population in the state's Project Toolkit and an understanding that many of the strategies and activities that partners will be implementing are systems changes that have the potential to affect all patients/clients, rather than a more tailored program with more specific enrollment criteria. This broad population is also well aligned with SWACH's focus on sustainable, large scale impact.

3. Expansion or Scaling of Transformation Strategies and Approaches

SWACH supports regional partners through targeted investments and technical assistance for integrated, team-based models of care. SWACH will support regional workforce development and authentic community engagement to enhance equity policies and procedures to include reducing institutional racism, addressing stigma and providing trauma-informed care. Alongside our partners, SWACH will support the development of community-clinical linkages, advancement of population health management systems and will support providers to build capacity to be successful in VBP contracting.

Across the project portfolios, cohorts of providers will develop organizational strategies to integrate physical and behavioral health supports along the six levels of SAMHSA integration framework. (*Substance Abuse and Mental Health Services Administration* https://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf) Additional strategies include:

- Support the development of a Clinical Transformation Plan that includes system change improvements for physical and behavioral health integration models, inclusive of chronic disease prevention/management, substance use disorders and the social determinants of health. (see attachment B)
- Establish continuous quality improvement principles to be applied to all settings.

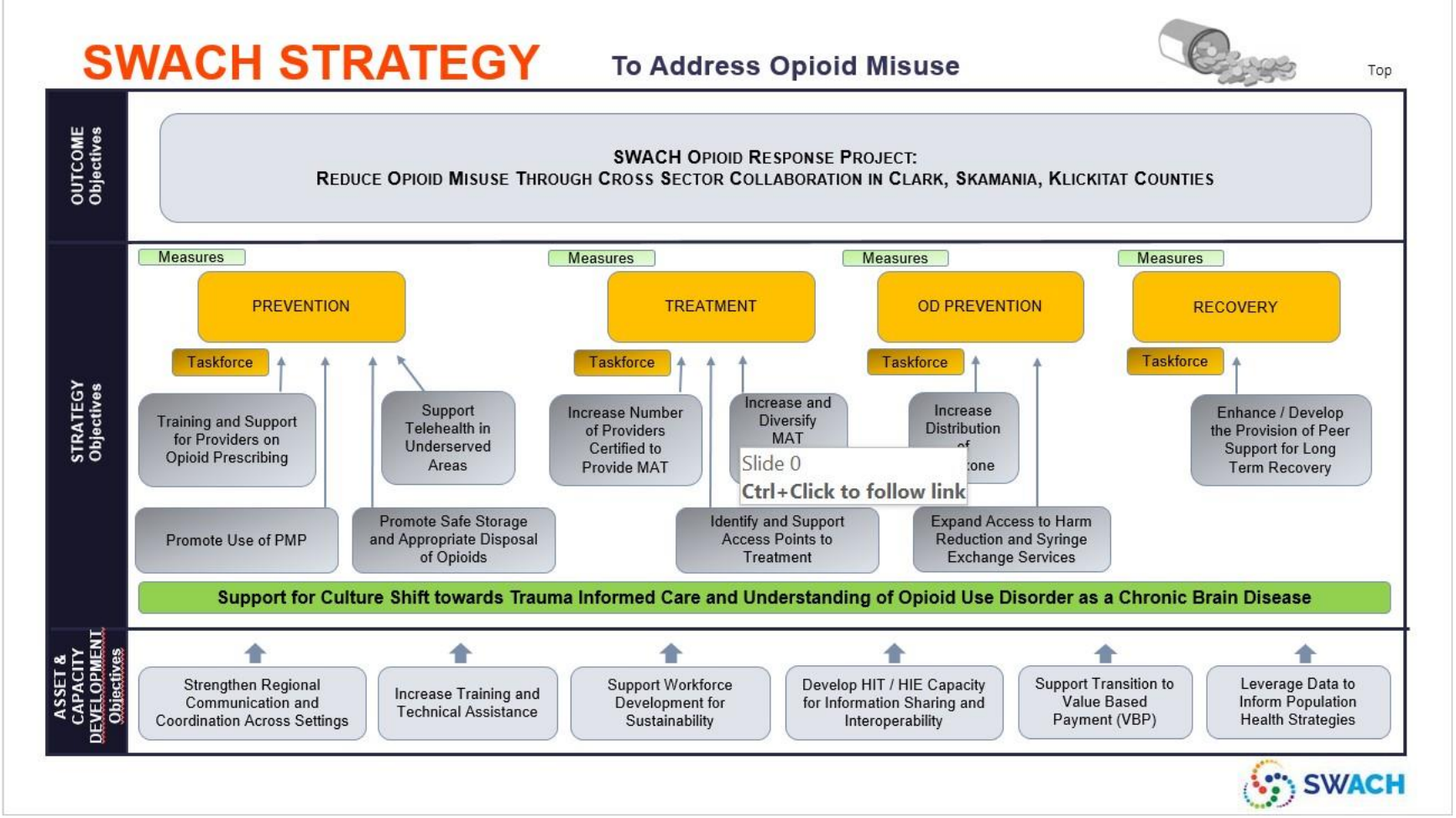
	• Develop and implement a region-wide monitoring plan that incorporates available data from multiple sources and includes regular reporting from partnering providers. • Develop and implement an evaluation plan for key initiatives. • Design and implement a shared learning infrastructure for providers across the region. • Develop clear purposes, objectives and outcomes for each shared learning cohort. • Align cohorts based on commonalities. • Link cohorts to Policy Committee for policy development. • Add regional value by incorporating community voices throughout shared learning infrastructure. • Publish and disseminate learnings, barriers and opportunities. • Support shared learning across data sharing partners and broader SWACH partners where results can inform Medicaid Transformation Project activities and decision making. • Continue to support regional efforts to integrate cross-sector data (health, education, housing), identify populations that are being served by multiple sectors and understand how experiences in one sector influence outcomes in another ("Community Connections" initiative). • Fund Transformations that are scalable and significant system redesigns. • Facilitate technical assistance to providers to help transition to value-based contracting. SWACH's approach regarding shared learning collaborative cohorts, evaluations, regular monitoring, partnerships and relying on data for decision making provides a framework for regional and organizational continuous quality improvement and therefore guides expansion and scaling of clinical integration approaches. SWACH recognizes that organizations are in different stages of change yet all working towards meeting an overall goal of integrated care delivery. Shared learning collaboratives will allow those that are farther along the continuum of integration to can share best practices, approaches to Transformation activities, identification of barriers and opportunities for improvements. Likewise, organizations not as far along will benefit from those that are farther along–creating a continuous learning environment supported by SWACH.
Project 2B: Care Coordination	
1. Transformation Strategies and Approaches	SWACH has selected the Pathways Community HUB project as an evidence-based and nationally endorsed model for the assessment and coordination of services that are critical for improving health outcomes, including medical (e.g., physical, behavioral, substance abuse and oral health), social, environmental and educational services. SWACH's Community Care Coordination Workgroup, formed to support the implementation of the Pathways HUB, has endorsed the model. In recognizing the Pathways HUB will take time to scale and sustain, the workgroup recommended several additional elements to the care coordination strategy (to compliment Pathways HUB implementation). The Pathways HUB will serve as a core SWACH program, creating cohesion and linkages across Medicaid, including the region's other MTPs. Ultimately, the Pathways HUB will be available for use with all payers in the region to further support the sustainability of system Transformation.

	As part of the strategic framework and in response to the recommendation of the Community Care Coordination Workgroup, SWACH has added the following care coordination strategies to support community-clinical linkages: • Support increased efficiency and access to information on real-time social services • Support development of care coordination in rural areas as appropriate and informed by rural community voice • Provide training and collaborative learning opportunities to create or strengthen community-clinical partnerships These additional strategies ensure support of care coordination activities throughout MTP and the Pathways HUB project implementation and SWACH will work with partners to determine how best to support these strategies in parallel to the Pathways HUB implementation and beyond. Within the Clinical Transformation Plan, there is one required care coordination tactic and partners may choose additional tactics under care coordination as well. Through assessment, providers have expressed much interest in participating in the Pathways HUB. Many will choose to have a participatory role within the HUB either as a Referral Partner or as a contracted Care Coordinating Agency (CCA) as the model is scaled. As some partners may not immediately have an active role in the HUB, and as the HUB will take time to implement and scale, SWACH included additional tactics to support and enhance Transformation in care coordination, particularly in support of community-clinical linkages. Partners are required to choose the tactic*: Increase/enhance partnerships with community partners through policy, protocol or formal agreement* to ensure clinical providers think beyond clinical walls in Clinical Transformation Plans. Requiring Clinical Transformation Plans to include interdependent community-clinical linkages is necessary and it will not be simple. The work ahead is new and SWACH will provide technical assistance and support in the design and implementation of a regional shared learning infrastructure for community-clinical partnerships for exchange of best practices, barriers and solutions. For the full list of care coordination tactics in the Clinical Transformation Plan, please see the attachment B. Community-clinical linkages and support of the three care coordination strategies listed above are critical to the Transformation of healthcare; improving health outcomes, decreasing health inequities and providing system savings which will support value-based contracting. SWACH plans to engage non-clinical partners to participate in the Clinical Transformation Plans through an RFQ process, which will serve to incentivize innovative cross-sector relationships, focus on specific populations not initially targeted by the HUB and tie back to the expanded care coordination strategy listed above. The Pathways HUB will further support the sustainability of the health system Transformation by serving as the community's driving force for breaking down silos, coordinating needed supports beyond the walls of health care and advancing improvements in overall health and disparities.
2. Target Populations	**Target Population:** Adult Medicaid beneficiaries with co-occurring physical health and behavioral health (mental health and/or substance use) conditions. SWACH has defined a broad target population for Pathways HUB implementation to leave space to continue conversations with MCOs and local partners leading up to alignment with existing care coordination efforts (e.g. Health Homes, etc.). During Pathways HUB implementation, refinement of the target population is expected.

	Scope: Approximately 5.7% of the SWACH Medicaid population have co-occurring conditions, or 6,272 individuals, defined as one or more chronic condition, a mental health condition and substance use disorder. If only looking at the Medicaid population with one or more chronic conditions and a mental health condition, this expands to 15.3%. *Data from HCA: Behavioral Health and Chronic Disease Co-Occurring Conditions, 2016.* **Criteria:** The Community Care Coordination Workgroup recommended the initial target population, with information and support provided by the Data Workgroup. The workgroup reviewed populations used in Ohio HUB implementation (high risk pregnancies), however, there was concern the population was not large enough in the Southwest region and the population characteristics were different from the high risk pregnancy populations in larger urban regions (higher education attainment of mothers, predominantly white, etc.). The workgroup preferred to focus on a broader population with high morbidity/mortality (as adult Medicaid beneficiaries with co-occurring physical health and behavioral health (mental health and/or substance abuse) conditions experience a higher rate of morbidity/mortality. The National Association of State Mental Health Program Directors found in 2006 that individuals with serious mental illness were dying 25 years earlier than the general population and frequently the causes of death were treatable health concerns such as metabolic disorders, cardiovascular disease and diabetes. SWACH anticipates that this project will have broad impact as increased regional focus on coordination, collaboration, efficiency and practice alignment will extend beyond the Medicaid population. The Community Voices Council, regional partners, as well as payors, will help inform the expansion of the project beyond the Medicaid population as the model expands.
3. Expansion or Scaling of Transformation Strategies and Approaches	SWACH is committed to implementation of a Community-Based Pathways HUB to support a network of Care Coordination Agencies (CCAs), helping to eliminate organizational silos and avoid duplication of services. The SWACH board has approved the contract with the Coordinated Care Solutions software consultants, Providence CORE evaluation components; and the contracts and training with two CCAs are expected to be complete by end of Q4 2018. Once the initial training, implementation of software and workflows are completed during implementation, SWACH expects to expand the number of CCAs. and with the help of a Community Voices Council and the Data Workgroup, populations will be further refined, and additional populations will be identified to continue expansion and scaling of the Pathways HUB across the region and to populations beyond Medicaid. SWACH will also serve as a support for community-clinical linkages by incentivizing innovative cross-sector relationships and projects through the Clinical Transformation Plans; and provide opportunities for learning, action and care traffic control. SWACH will foster authentic community informed improvements to our healthcare system through investment in community-based partnerships with clinical settings. Investments will target workforce development, population health management systems and quality improvement support, as well as incorporation of equity policies and procedures to address institutional racism, stigma and trauma.
Project 2C: Transitional Care	

1. Transformation Strategies and Approaches	*Not Applicable*
2. Target Populations	
3. Expansion or Scaling of Transformation Strategies and Approaches	
Project 2D: Diversion Interventions	
1. Transformation Strategies and Approaches	*Not Applicable*
2. Target Populations	
3. Expansion or Scaling of Transformation Strategies and Approaches	
Project 3A: Addressing the Opioid Use Public Health Crisis	
1. Transformation Strategies and Approaches	SWACH aims to reduce opioid-related morbidity and mortality through programs and services that form an integrated net of prevention for people at risk of opioid abuse and a blanket of support for people struggling with opioid use. To accomplish this aim, SWACH supports a multi-sector, multipronged approach to address the epidemic with a focus on prevention, treatment, overdose prevention and recovery. SWACH evidence-based strategies and approaches are informed by a diverse and robust regional opioid collaborative as well as strategy specific taskforces and workgroups. Opioid strategies integrate across SWACH's concurrent projects

of Bi-directional Integration, Community-Based Care Coordination and Chronic Disease Prevention and Control. For an illustration of how opioid strategies integrate across the SWACH project portfolio, please see Question 4 – the section titled: **Outcomes by the End of the Transformation - From a Medicaid Beneficiary's Perspective (**See page 40).



	To address the opioid public health epidemic, SWACH intends to work with partnering providers to implement the following Transformation activities OVERALL • **Promote culture shift to understand and treat Opioid Use Disorder (OUD) as a chronic disease affecting the brain** PREVENTION ***Training and Support for Providers*** • Implement Washington State Medical Director Group Interagency Guidelines on Prescribing Opioids for Pain • For Emergency Department: Implement Washington Emergency Department Opioid Prescribing Guidelines • Integrate decision support tools for opioid prescribing in the EHR • Participate in the WSMA/WSHA Washington Opioid Reports Program • Provide trainings on trauma-informed care • Provide trainings on pain management ***Promote Use of Prescription Monitoring Program*** • Register providers with the PMP • Establish guidelines and protocols for checking PMP • Plan for / integrate PMP into EHR ***Promote Safe Storage and Appropriate Disposal of Medications*** • Promote public awareness campaign and distribute educational materials about safe storage and disposal of medications • Promote and utilize "Start with One" campaign and resources • Develop partnerships between community and clinical agencies to support return / disposal of medication • Secure medication disposal within clinical settings • Secure medication disposal in the community (in partnership with pharmacy, law enforcement, fire and rescue, etc.) ***Support Telehealth in Opioid Response*** • Utilize telehealth to support partnerships between physical health, behavioral health and community agencies for integrated care approaches to management and treatment of pain and opioid patients TREATMENT ***Identify and Support Access Points to Treatment*** • Engage across settings for communication / collaboration and/or integration of services to support greater engagement of people with OUD and access to treatment • Develop care coordinating mechanism to support treatment initiation and continuing support/management of treatment

	• Utilize peer support services • Implement validated screening and provide training for identification of OUD • Provide training for stigma reduction, support and management of people with substance use disorders • Develop policies and protocol for referring/connecting to treatment • Increase number of treatment access points in clinical settings • Apply the Collaborative Care Model in Office Based Opioid Treatment (OBOT) settings • Apply the Nurse Care Management OBOT model in clinical settings ***Increase Number of Providers Certified to Provide Medication Assisted Treatment (MAT)*** • Provide Training for Providers to receive MAT waivers • Increase number of MAT providers in care settings outside of substance use disorder treatment settings (e.g. primary care, hospitalists, ED's, specialists) ***Diversify MAT Initiation Sites*** • Develop cross-setting partnerships and policies to increase MAT initiations coupled with care coordination and transition to treatment • Create policies that lower barriers to treatment initiation • Initiate MAT in ER alongside development of cross-setting partnerships and policies to ensure care coordination and transition to treatment OD PREVENTION ***Increase Access to Naloxone*** • Provide overdose and naloxone training for care team and/or patients and/or community members • Increase access to Naloxone through prescription and/or distribution • Expand settings for access and distribution of naloxone • Develop cross setting partnerships to support naloxone distribution • For Emergency Department: Provide overdose education and take-home naloxone for individuals seen of opioid overdose • Expand access to Harm Reduction and Syringe Exchange services RECOVERY ***Enhance Peer Support Services to Support Persons with OUD*** • Support engagement and develop partnerships across settings utilizing peers in outreach, engagement and ongoing support efforts for persons with OUD • Provide training in recovery coaching for peers • Provide trauma-informed care training for peers

2. Target Populations	**Target Population:** All Medicaid beneficiaries without a cancer diagnosis who use opioids, including a subpopulation of those with Opioid Use Disorder (OUD) who are *not* receiving medically assisted treatment (MAT). **Scope:** In FY 2016, there were approximately 12, 234 Medicaid beneficiaries in the SWACH region who used opioids and did not have a cancer diagnosis. 2,288 had a diagnosis of opioid abuse and of those, 81.8% (1,872 individuals) were not receiving MAT. *Data from HCA. Regional Health Needs Inventory Data Packet, Phase 3, Opioid Tab. April 2017.* We anticipate that this project will have broad impact as increased regional focus on coordination, collaboration, efficiency and practice alignment will extend beyond the Medicaid population to benefit all persons who use opioids. According to data from the Washington Prescription Monitoring Program, in Q4 2016 there were approximately 46,939 individuals with any opioid prescription, with a higher rate of prescriptions in Clark and Skamania Counties (90.5 per 1,000 and 83.8 per 1,000 respectively) compared to Klickitat (50.3 per 1,000). *Data from DOH. Prescription Monitoring Program Indicators 2012-2016. Nov 2017.* **Criteria:** The Opioid Workgroup used several key criteria to inform project development, including target population selection. These included: • True Need - is there a high magnitude of documented need? • Current Efforts - what populations are currently being targeted by regional efforts? How can work currently taking place best be supported without duplication? • Impact/Scale - does it affect many Medicaid covered lives; will it provide a return on investment within two-three years? • Spread – does it engage across the region? • Actionable - is it ready to be implemented immediately? SWACH was also informed by conversations with local providers that indicated OUD is underdiagnosed and actual treatment penetration rates (including MAT) are likely lower than the data suggest.

3. Expansion or Scaling of Transformation Strategies and Approaches	SWACH has successfully supported the development of collaboratives to inform the Medicaid Transformation Project. The work has brought together regional clinical and community stakeholders. It's created opportunities for alignment and collaboration across settings resulting in communication and collaboration with the aim of increased access to treatment, improved transition of care and continuity of OUD treatment, as well as connection to social supports. SWACH proposes to leverage this funding to further support regional coalition building. For patients to get the greatest benefit in connecting to a range of treatment and wrap around services, the service providers themselves need to be connected, engaged and collaborating. This funding would be used to build on the work so far and enhance regional and local opportunities to develop new policies and system change approaches to address the opioid crisis. Continued and enhanced coalition building supports the aim of new policies and system changes to make sustainable the cross-setting collaboration and community-clinical linkages necessary in service of people with OUD. SWACH would leverage partnerships with public health agencies in each of the counties in the SWACH region (Clark, Skamania and Klickitat) to staff and coordinate this push towards greater collective impact through coalition building. As the Medicaid Transformation progresses, SWACH will expand the scope of our region's opioid response strategies. Expanded participation and impact will be achieved through the following strategies: • SWACH and its partners will review regional data to identify non-participating providers and community partners whose involvement would support a scale up of the regional response to the opioid epidemic, develop a communication and outreach strategy and engage potential partners in involvement. SWACH and its partners will refine our recruitment schedule based on interim progress. • SWACH will identify community partners who can champion expansion and mobilize increased participation. • SWACH will form committees and workgroup structures for discussion, collaboration and implementation of innovative strategies and system changes to address the opioid crisis. • SWACH's Data Workgroup will review available data to inform scale and sustain strategies. • SWACH will develop virtual platforms and social media portals, community information sharing, partner sharing and sharing across ACH projects. • SWACH will work with local public health agencies in Clark, Skamania and Klickitat to develop / expand county specific coalitions addressing locally specific circumstances related to the opioid epidemic. Coalitions will maximize collective impact locally while remaining connected to and informed by regional work. County specific coalitions will support sustainability of cross-setting collaboration and community-clinical linkages, new policies and system changes that develop through the MTP work. • SWACH will engage partners, workgroups and committees to consider and plan for regional opioid conferences. • SWACH management team will monitor implementation progress and provide support to troubleshoot issues. Each site will share learning needs with this team which will evaluate needs and deploy support. • SWACH will work to develop and regularly report on VBP models for the region. • SWACH will collaboratively work with MCO partners to develop payment structures supporting evidence-based best practices that sustainably address the opioid crisis. • SWACH will work with MCO partners to establish VBP models for participating providers. • SWACH will work with partners to establish regular needs assessments for ongoing supports.

	• SWACH will establish cross-site and cross-setting shared learning collaboratives to facilitate best practice sharing, support ongoing training and assist efforts to scale up selected strategies/approaches.
Project 3B: Reproductive and Maternal/Child Health	
1. Transformation Strategies and Approaches	*Not Applicable*
2. Target Populations	
3. Expansion or Scaling of Transformation Strategies and Approaches	
Project 3C: Access to Oral Health Services	
1. Transformation Strategies and Approaches	*Not Applicable*
2. Target Populations	
3. Expansion or Scaling of Transformation Strategies and Approaches	

Project 3D: Chronic Disease Prevention and Control	
1. **Transformation Strategies and Approaches**	As participants in the Chronic Disease Prevention and Control project, prospective Transformation Partners must decide on 1) the target population(s) they will focus upon, as well as 2) the change strategy they will implement from a list of the Chronic Care Model elements, including: • Systems of care: promote effective improvement of strategies aimed at comprehensive system change, encourage open and systematic handling of errors, provide incentives based on quality of care, develop agreements that facilitate coordination of care across organizations • Self-management support: train providers and staff on helping patients with self-management goals, using evidence-based self-management tools, using group visits to support self-management, set and document self-management goals collaboratively with patients, follow-up and monitor self-management goals; seek to break down barriers to utilization of community health workers as part of a treatment team; actively promote evidence-based self-management education for patients as part of whole person care • Delivery system design: use planned interactions to support evidence-based care, ensure regular follow-up by care team, define roles and tasks of team members, provide clinical case management services for complex patients with coordination • Decision support: embed evidence-based guidelines into daily clinical practice, integrate specialty expertise in primary care, share evidence-based guidelines and information with patients • Clinical information systems: provide timely reminders for providers and patients for recommended care, identify relevant subpopulations for proactive care, facilitate individual patient care planning, share information with patients and providers to coordinate care, monitor performance of practice team • Community-based resources: encourage patients to participate in effective community programs for partnerships with community organizations to support and develop interventions that fill gaps in needed services In addition to these Chronic Care Model elements, each Transformation Partner can choose optional activities such as implementation of the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, CDC National Diabetes Prevention Program and/or partner with Community Paramedicine. SWACH's merge with the Healthy Living Collaborative also serves to help our region (as well as Cowlitz/CPAA ACH) with its mission of policy initiatives, engagement of community health workers as a workforce, its capacity as a convener and commitment to upstream health initiatives—all contribute to addressing regional health priorities and expansion of successful chronic disease prevention efforts.

2. **Target Populations**	**Target Population:** Medicaid beneficiaries with the following chronic conditions: adults with diabetes (particularly Type 2), adults and children with obesity, adults with hypertension and cardiovascular disease, and children with asthma. In addition to these target populations, SWACH is following its provider champions in supporting the emerging cultural shift to view OUD as a chronic disease. As this effort continues throughout the Transformation period, SWACH may seek additional alignment between the Opioid and Chronic Disease Prevention and Control projects by including OUD as an area of focus for chronic disease efforts. Related, SWACH is also exploring pain as a chronic condition. **Scope:** SWACH has constructed the following estimates to understand the potential Medicaid population sizes by condition. Some are presented as ranges, given the variety of data sources and measurement periods. Estimates are likely an undercount, given that chronic conditions may be more prevalent in Medicaid populations than the general population • Adults with diabetes: 4,000 – 6,000. An additional 6,100 adults may also have pre-diabetes. *Data from BRFSS 2012-2014 and 2014-2016, Medicaid enrollment reports (May 2018), Healthier Washington Data Dashboard (July 2016 - June 2017), and HCA: Behavioral Health and Chronic Disease Co-Occurring Conditions, 2016.* • Adults with obesity: 17,700. *Data from BRFSS 2014-2016 and Medicaid enrollment reports (May 2018).* • Children with obesity: Approximately 11% of 10th graders in Clark County and 17% in Klickitat County are obese. *Data from Healthy Youth Survey 2014, 2016* • Adults with hypertension: 18,560 – 19,200. *Data from BRFSS 2013, 2015 (county and state estimates) and Medicaid enrollment reports (May 2018).* • Adults with cardiovascular disease: Approximately 12,180 adults have cardiovascular disease (including hypertension, endocardial disease, myocardial infarction, angina, congestive heart failure, cardiomyopathy and related conditions). *Data from HCA: Behavioral Health and Chronic Disease Co-Occurring Conditions, 2016.* • Children with asthma: Approximately 10% of 10th graders in Clark County have asthma, and 16% of adults in the SWACH region have had asthma at some point in their lives. *Data from Healthy Youth Survey 2014, 2016 and BRFSS 2014-2016.* **Criteria:** The target population selection was informed by a review of available data focusing on both Medicaid and the broader population, to understand disease prevalence and leading causes of morbidity and mortality in the region. Potential target populations were then refined based on RHIP and workgroup/committee feedback, including clinical perspectives and an understanding of which populations likely align with other projects in the portfolio.

3. **Expansion or Scaling of Transformation Strategies and Approaches**	Through Clinical Transformation Plans, regional partners and organizations serving the cultural, linguistic and geographic diversity across the region, SWACH expects to identify cohorts of providers who identify interests in serving chronic disease populations and making significant improvement on performance metrics identified for the Chronic Disease Prevention and Control project area, including a reduction in health disparities. These metrics include: • Emergency department visits per 1,000-member months • Child and adolescents' access to primary care practitioners • Comprehensive diabetes care: eye exam (retinal) performed • Comprehensive diabetes care: HbA1c • Comprehensive diabetes care medical attention to nephropathy • Inpatient hospital utilization • Statin therapy for patients with cardiovascular disease Successful providers will be asked to share learning through shared learning collaboratives and SWACH will support efforts to scale those strategies or approaches that prove to be impactful as well as identify ways to ensure long-term sustainability. SWACH will also prioritize strategies that connect community to clinical efforts to ensure all people have access to chronic disease management and prevention where they live and not just in a clinical setting. SWACH also intends to work with HLC and CPAA ACH to expand the CHW workforce and leverage resources to share and expand successful chronic disease management and prevention efforts.

4. What specific outcomes does the ACH expect to achieve by the end of the Transformation if the ACH and its partnering providers are successful? How do these outcomes support regional Transformation objectives?

ACH Response:

For the SWACH region to succeed, collective action from participating providers and stakeholders is necessary. Achieving a more connected service delivery system, improving access to services, connecting social service agencies with care settings in new ways and transitioning to a VBP system will improve overall wellness in the region. SWACH is working with partners in its region to improve health, increase the quality of care and services, enhance employee satisfaction, increase employee retention and maintain a sustainable workforce. SWACH will invest in prevention, support wellness for its neighbors at every stage of life and help build strong families. SWACH's collective impact strategy is built on three gears that turn together to catalyze and drive long-term Transformation:

1) A strong and diverse set of cross-sector partnerships
2) Authentic community engagement
3) A strong data and shared learning infrastructure

SWACH is working to create healthy communities by bringing diverse organizational partners, funders and community members together to find ways to sustainably finance large-scale social impact innovations. This occurs through convening and providing tools, technical assistance and investments that allow SWACH to bring health, equity and community voice to decision making.

At a high level, the SWACH region has several goals and outcomes that will be indicators of success for the region. SWACH has four **cornerstones** and three broad **focus areas** to benchmark against:

Cornerstones

1) Health equity
2) Reduction of stigma
3) Trauma-informed care
4) Collaborative shared learning

These cornerstones support SWACH's Transformation objectives. They are fundamental to SWACH's vision in which all people have equitable access to quality whole-person care and live in connected and thriving communities without barriers to wellness. Through a partnership framework, SWACH is working with partnering providers, community members, stakeholders and content experts to develop tools and approaches to address health inequities, reduce the role of stigma and approach our collective work through a trauma-informed lens – regardless of setting.

Focus Areas

1) Whole-person integrated care
2) Community-clinical linkages
3) Sustainable large-scale impact

Whole-Person Integrated Care

A primary goal for the region is to provide integrated behavioral health and physical health care for the Medicaid population. Advancing along the continuum of integrated care, SWACH has organized its strategy along the six levels of SAMHSA integration framework. Because partnering provider organizations are in different phases of change and have different organizational goals, the region has organized progress measures for overall integration success in two broad ways (sub measurements are in development). One, partnering providers will solidify the level of integration they are currently in by improving coordination with other care settings. This would include, for example, the development of policies and protocols to share health information, develop new workforce to support integrated care teams, create closed loop referral processes and procedures, and advance population health management systems that create capacity to succeed in VBP contracts. Second, partnering providers have identified movement along the SAMHSA continuum *(i.e. from level two to level four)* within their organizations goals. As the framework would suggest, as partnering providers move farther along the integration continuum they are providing more integrated services in their care settings. SWACH has assessed partnering providers during this reporting period to provide baseline data on the level of integration. As SWACH engages with partnering providers to develop their Clinical Transformation Plans, SWACH has made the movement or solidification along the continuum one of three required tactics to participate with SWACH. Through this process, SWACH will analyze future state goals of providers and monitor regional and organizational progress toward achieving clinical integration.

Community-Clinical Linkages

SWACH will serve as a support for community-clinical linkages by incentivizing innovative cross-sector relationships and projects; and providing opportunities for learning, action and care traffic control. SWACH will foster authentic community-informed improvements to our healthcare system through investment in community-based partnerships with clinical settings. Investments will target workforce development, population health management systems and quality improvement support, as well as incorporation of equity policies and procedures to address institutional racism, stigma and trauma. SWACH will also develop a Community-Based Pathways HUB to support a network of CCAs, helping eliminate organizational silos and avoid duplication of services. A key measurement of the SWACH region's success is developing the Pathways Community HUB infrastructure, developing the CHW and peer workforce through Community Care Agencies (CCA) within organizations and enhancing care coordination efforts across the region.

Sustainable Large-Scale Impact

SWACH believes that to achieve sustainable large-scale impact, we must effectively allocate resources which align with the overall strategy and goals of the region. Embedded in SWACH's strategic framework is the ideal that SWACH will work to create healthy communities by bringing diverse organizational partners, funders and community members together to find ways to sustainably finance large-scale social impact innovations. We do this by convening, providing tools, technical assistance and investments that allow us to bring health, equity and community voice to decision making. Partnering providers expect SWACH investments to be successful over the long term and during the Transformation timeline. Supporting providers to have the infrastructure, workforce and technology needed to be successful in a VBP arrangement and effectively provide integrated and connected care will be critical. Another

important component of large-scale impact it the intent to fund Transformations that address inequities, stigma, trauma and institutional racism.

Outcomes by the End of the Transformation - From a Medicaid Beneficiary's Perspective

From the perspective of a Medicaid beneficiary, how do SWACH cornerstones and focus areas translate to a future state of whole person care? Consider a hypothetical "Jane Doe", a mother with an unmanaged chronic disease and behavioral health conditions. She accesses services from a non-clinical community-based organization but is not actively engaged in physical or behavioral health care services for her conditions.

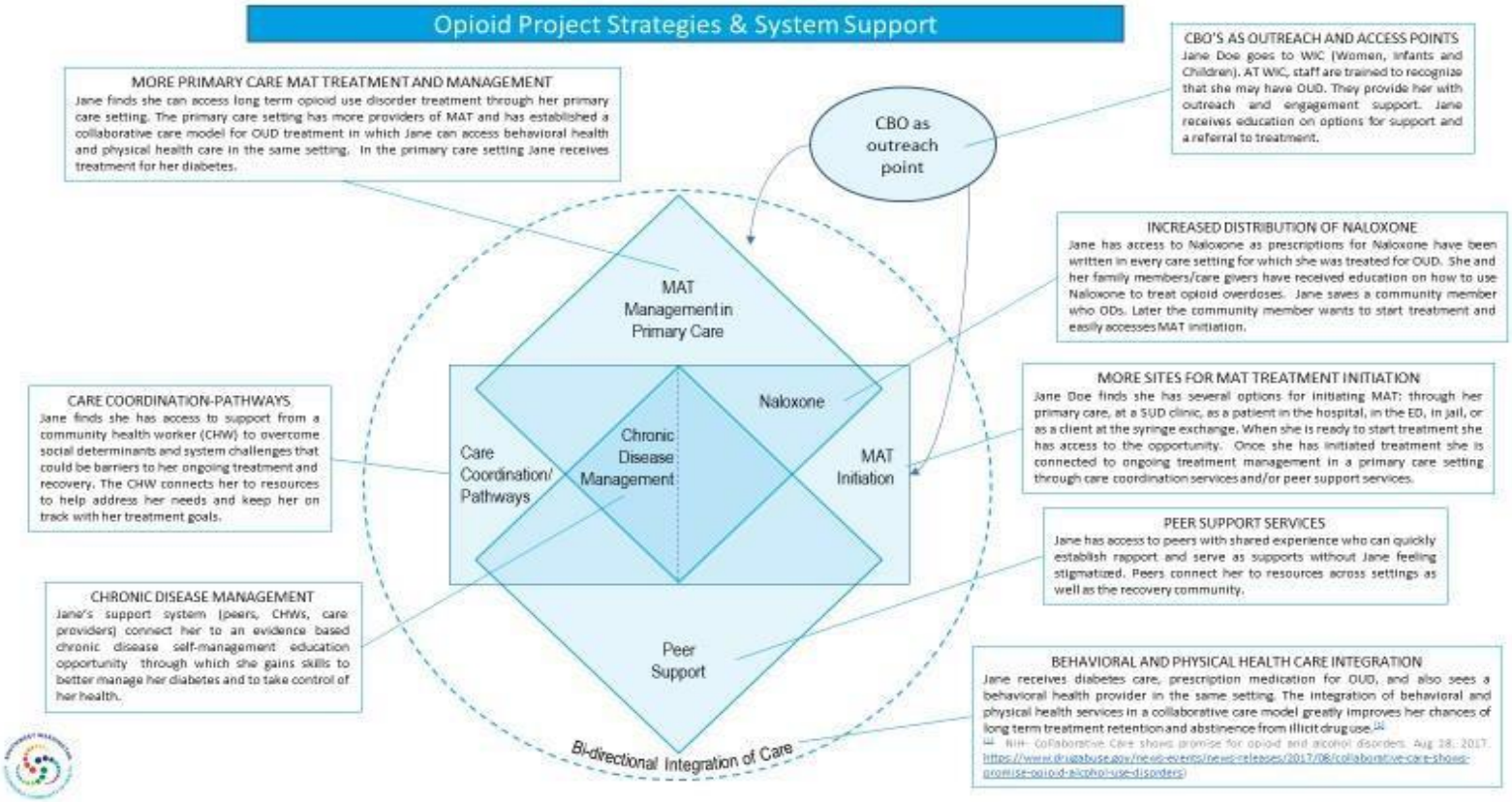
Jane has undiagnosed Opiate Use Disorder (OUD) and uncontrolled diabetes. She accesses services for her child through Women, Infants and Children (WIC). In the following example of the SWACH future state vision, SWACH opioid response strategies synergistically weave together in support of Jane Doe and integrate across SWACH's concurrent projects of Bi-directional Integration, Community-Based Care Coordination and Chronic Disease Prevention and Control.

When Jane Doe accesses WIC, her encounter initiates a cascade of support and access to services beyond WIC's scope. Community-clinical linkages and cross-setting collaboration serve to lower barriers for Jane to engage in treatment for her physical and behavioral health issues. The WIC encounter becomes the access point for Jane's engagement with treatment services for her diabetes and OUD as well as a spectrum of biopsychosocial resources for whole person health. As illustrated in the diagram below, the following overlapping conditions are in place by the end of the Transformation Project, reinforcing one another in delivery of whole-person integrated care for Jane Doe.

- CBOs as Outreach and Access Points
    - Jane goes to WIC where staff are trained to recognize that she may have OUD and provide her with outreach and engagement support. Jane receives education on options for support and a referral to treatment and Pathways care coordination.
- Care Coordination - Pathways
    - Jane finds she has access to support from a CHW to overcome social determinants and system challenges that could be barriers to her engagement and treatment. The CHW connects her to resources to help address her needs and supports her in keeping on track with her treatment goals. The HUB is also able to track Jane's care coordination needs, ensuring the CCA is appropriately meeting her needs and identifying any partially met or unmet pathways.
- More Sites and Providers for Medically Assisted Treatment (MAT) initiation
    - Jane finds she has multiple options for accessing and initiating MAT: through primary care, at a substance use disorder treatment facility, as a patient in the hospital, in the ED, in jail or as a client at the syringe exchange. When she is ready to start treatment, she has access to the opportunity. Once she has initiated treatment and has stabilized she is connected to ongoing MAT management in a primary care setting through care coordination and/or peer support services.
- Peer Support Services
    - Jane has access to peers with shared experience who can quickly establish rapport and serve as supports without Jane feeling stigmatized. Peers connect her to resources across settings as well as to the recovery community. They are

trained as recovery coaches and trauma-informed.

- More Primary Care MAT Management
  - Jane finds she can access long-term OUD treatment through her primary care setting. Primary care settings have more providers of MAT who are trained in trauma informed care. The primary care settings have established a collaborative care model for OUD treatment in which Jane can access behavioral health and physical health care in the same setting. Through engagement with primary care, Jane receives treatment for her diabetes.
- Chronic Disease Management
  - Jane's support system (CHW's, peers, providers) connect her to an evidence-based chronic disease self-management education opportunity through which Jane gains skills to better manage her diabetes and take control of her health.
- Behavioral and Physical Care Integration
  - Jane receives diabetes care, prescription medication for OUD, and sees a behavioral health provider in the same setting. The integration of behavioral and physical health care services in a collaborative care model greatly improves her chances of long-term treatment retention and abstinence from illicit drug use.
- Increased Access to Naloxone
  - Jane has low barrier access to naloxone through dispensation or prescription across every care setting in which she received treatment related to OUD. She and family members have received education as to how to use naloxone to treat opioid overdoses. Jane saves a community member who overdoses. Later the community member is ready to engage in treatment and easily able to access service.



D. Milestone 4: Identification of Partnering Providers

This milestone is completed by executing Master Services Agreements (formally referred to as Standard Partnership Agreements) with partnering providers that are registered in the Financial Executor Portal. For submission of this Semi-Annual Report, HCA will export the list of partnering providers registered in the Portal as of June 30, 2018.

1. The state understands that not all ACH partnering providers participating in Transformation activities will be listed in the Financial Executor portal export. In the attached Excel file, under the tab D.1, "Additional Partnering Providers," list additional partnering providers that the ACH has identified as participating in Transformation activities, but are not registered in the Financial Executor Portal as of June 30, 2018.

Complete item D.1 in the Semi-Annual Report Workbook.

Section 2: Standard Reporting Requirements

This section outlines requests for information that will be included as standard reporting requirements for each Semi-Annual Report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-Level Reporting Requirements

A. ACH Organizational Updates

1. **Attestations:** In accordance with the Transformation's STCs and ACH certification requirements, the ACH attests to being in compliance with the items listed below during the reporting period.

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

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

   ACH Response: Not Applicable

3. **Key Staff Position Changes**: Provide a current organizational chart for the ACH. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period. Place an "X" in the appropriate box below.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

See Attachment D for current Organizational Chart.

Insert or Include as an Attachment: Organizational Chart

B. Tribal Engagement and Collaboration

1. In the table below, provide a list of tribal engagement and collaboration activities that the ACH conducted during the reporting period. These activities may include relationship building between the ACH and tribal governments, IHS facilities, and UIHPs, or further engagement and collaboration on project planning and/or implementation. Add rows as needed.

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
ACH, HCA and Tribes Collaboration	4/11	Vicki Lowe, ED American Indian Health Commission for WA and ACH EDs	Vicki Lowe, ED American Indian Health Commission for WA and ACH EDs	Update on Indian Health Care ACH/Project Planning/Engagement and alignment strategies	ACHs and tribal partners meeting to coordinate efforts. Developed ongoing facilitated check ins with ACH EDs. Coordinated points of contact and liaisons for each region
ACH Tribal Liaison Meeting Standing Meeting (every two weeks)	5/4	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice	Lena Nachand; Jessie Dean Vicki Lowe Rene Hilderbrand	Coordinate with HCA and other ACHs to learn about establishing relationship with tribes	ACHs obtained education about history of tribes and level set of relationship expectations and communication

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		Wilson; Susan McLaughlin; Marya Gingrey; Adam Aaseby; Rene Hilderbrand; Wes Luckey; Ruben Peralta; Jenny Slagle; Devon Wilson; Linda Parlette, Daniel Smith	Wes Luckey; Ruben Peralta; Jenny Slagle; Louise Nieto		
ACH Tribal Liaison Meeting	5/18	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice Wilson; Susan McLaughlin; Marya Gingrey; Adam Aaseby; Rene Hilderbrand; Wes Luckey; Ruben Peralta; Jenny Slagle; Devon Wilson; Linda Parlette	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice Wilson; Susan McLaughlin; Marya Gingrey; Rene Hilderbrand; Ruben Peralta; Jenny Slagle; Louise Nieto	Collaborate with tribes and other ACHs about Transformation strategies	Education and slides about tribes and treaty history; Specifics around Indian Healthcare system; BH survey results from each tribe – and seek to align strategies of tribal BH Integration Project with ACH projects as much as possible
ACH Tribal Liaisons in-person Meeting	5/24	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice Wilson; Susan	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice Wilson;	Update on Indian Health Care ACH/Project Planning/Engagement and Alignment strategies	HCA to develop a tracking spreadsheet on how ACHs are funding IHCPs and funding around projects in partnering with tribes

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		McLaughlin; Marya Gingrey; Adam Aaseby; Rene Hilderbrand; Wes Luckey; Ruben Peralta; Jenny Slagle; Devon Wilson; Linda Parlette	Susan McLaughlin; Marya Gingrey; Rene Hilderbrand; Ruben Peralta; Jenny Slagle; Louise Nieto		
Conversation with Steve Kutz (Cowlitz tribe and board member) about next steps on engaging with Yakama	5/15	Steve Kutz Kachina Inman	Steve Kutz Kachina Inman	Build relationships with both Cowlitz and Yakama tribes	Set up meeting with Cowlitz Tribe staff to discuss engagement with MTP work Steve will reach out to Yakama tribal members at upcoming cross state tribal meeting and ask for a meeting with SWACH partners
Meeting with Cowlitz Tribe clinical partners	5/30	Daniel Smith Emily Gardner, MD Kay Culbertson	Daniel Smith Emily Gardner, MD Kay Culbertson	Learn more about opportunities for partnership	Cowlitz Tribe requested completing a clinical assessment Cowlitz Tribe is interested in partnership with MTP work Learned more about Cowlitz Tribe Clinical services
Meeting with CPAA to discuss opportunities to	6/1	Rene Hilderbrand	Rene Hilderbrand	To discuss CPAA and SWACH overlap	CPAA will share process for partnering and

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
streamline work for tribes across ACHs		Kachina Inman	Kachina Inman	in work and discuss opportunities for partnership	supporting tribal work to see if it may also meet the needs of SWACH Will set up a second meeting with King County to see if we can streamline work and processes for Cowlitz Tribe CPAA will present at upcoming Healthy Living Collaborative quarterly meeting
Follow Up Call with Steve Kutz	6/15	Steve Kutz Kachina Inman	Steve Kutz Kachina Inman	Follow up conversation to discuss engagement with Yakama Nation	SWACH will draft a letter to tribal council members inviting them to participate in SWACH work, offering to set up an in-person meeting wherever is best for them, and letting them know a board seat is reserved if they want to participate Steve will review letter prior to sending
ACH Tribal Liaison Meeting	6/15	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice	Jessie Dean; Chase Napier; Lena Nachand; Vicki Lowe; Lisa Rey Thomas; Candice	Discuss opportunities for IHCPs to earn additional funds (such as equity accelerator or "high performer	Continue to discuss and consider how to continue relationships with tribes beyond Medicaid Transformation Vicki Lowe provided technical assistance

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		Wilson; Susan McLaughlin; Marya Gingrey; Adam Aaseby; Rene Hilderbrand; Wes Luckey; Ruben Peralta; Jenny Slagle; Devon Wilson; Linda Parlette	Wilson; Susan McLaughlin; Marya Gingrey; Rene Hilderbrand; Ruben Peralta; Jenny Slagle; Louise Nieto	pool"); and establish alignment around project reporting; HCA suggests simplification and alignment	and suggested ACHs obtain review/assistance from tribal members (herself, Steve Kutz) in drafting correspondence to tribes about MTP projects or funding
Call with Lena at HCA	6/20	Lena Nachand Kachina Inman	Lena Nachand Kachina Inman	Discuss engagement with the Yakama Nation and learn from other ACHS on future engagement and process for allocating funds	Lena will share letter to Yakama Nation with her team at HCA for feedback Kachina will do further outreach with Cowlitz Tribe to talk next steps Kachina will work with SWACH leadership to get letter sent to the Yakama Nation
Communication with Steve Kutz on Cowlitz Tribe	6/20	Steve Kutz Kachina Inman	Steve Kutz Kachina Inman	Steve reviewed and provided input to letter to Yakama Nation	Steve reviewed letter and made recommendations on content of letter and next steps in the process of engaging.
Connected Steve Kutz to Pathways work	6/21	Steve Kutz Kathy Burgoyne Kachina Inman	Steve Kutz Kathy Burgoyne Kachina Inman	Kachina Inman connected Kathy Burgoyne to Steve Kutz per Steve's request to get more information about Pathways after SWACH board meeting	SWACH to provide more information about Pathways HUB model and work with Cowlitz tribe and CPAA for follow-up

Project Reporting Requirements

C. Project Status Update

1. Provide a status update that highlights Transformation planning progress by listing activities that have occurred during the reporting period in the table below. Indicate the project(s) for which the activity applies. If the activity applies to all projects, indicate as such. Are project activities progressing as expected? What are the next steps? Add rows as needed.

   Examples of activities may include, but are not limited to the following:

   - *The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.*
   - *Partnering providers have completed training on project interventions.*
   - *Partnering providers have adopted and/or are using project tools/protocols.*
   - *The ACH has invested in and/or provided technical assistance for partnering providers.*
   - *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
   - *New services are being offered/provided to Medicaid beneficiaries.*

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
SWACH finalized its strategic framework and roadmap.	Across all project areas	Yes	Continue forward with implementation planning to achieve this strategy and roadmap
SWACH defined required and optional Medicaid Transformation tactics for clinical partners to consider.	Across all project areas	Yes	Clinical partner selection of specific tactics to pursue Medicaid Transformation

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
SWACH defined its funds flow model for DY2.	Across all project areas	Yes	Reach binding agreements with partners for specific funds distribution
SWACH worked with partners to register on the partner portal.	Across all project areas	Yes	Partners complete Clinical Transformation Plans and form binding agreements
SWACH defined its overall communications strategy with partners, the community and other stakeholders.	Across all project areas	Yes	Complete communications activities in support of this overall strategy
SWACH created content and relaunched its website.	Across all project areas	Yes	Regular website updates
SWACH launched a new monthly newsletter.	Across all project areas	Yes	Continue regular newsletter publication
SWACH updated its Public Relations materials.	Across all project areas	Yes	Use standard PR materials for press releases and events
SWACH reactivated its social media outreach (Facebook / Twitter).	Across all project areas	Yes	Continue regular activity on social media platforms
SWACH completed its current state assessment.	Across all project areas	Yes	Use assessment results to inform Medicaid Transformation approach and planning
SWACH summarized assessment results and shared with key stakeholders, e.g. the Regional Health Improvement Council.	Across all project areas	Yes	Use assessment results to inform Medicaid Transformation approach and planning

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
SWACH finalized the target populations for each of the selected projects.	Across all project areas	Yes	Focus on these target populations in Transformation and implementation planning
SWACH distributed and collected feedback from partners on the draft Clinical Transformation Plan template.	Across all project areas	Yes	Feedback incorporate into final Clinical Transformation Plan template
SWACH distributed the final Clinical Transformation Plan template.	Across all project areas	Yes	Partners complete and submit their Clinical Transformation Plans by 8/17/18
SWACH established a Technical Assistance support structure for partners completing their Clinical Transformation Plans.	Across all project areas	Yes	Provide Technical Assistance support to clinical partners
SWACH developed PreManage/EDIE Learning Collaborative	Across all project area	Yes	Expand collaborative to more partners
SWACH met monthly with the Clinical Integration Workgroup.	Across all project areas	Yes	Continue monthly meetings
SWACH invested in trauma-informed care training for Klickitat County	Across all project areas	Yes	Scale training
SWACH met monthly with the Regional Health Improvement Council.	Across all project areas	Yes	Continue monthly meetings
SWACH jointly led Integrated Managed Care (IMC) Readiness meetings with HCA, County officials, Providers and stakeholders	Across all project areas	Yes	Continue meeting to refine Early Warning system, communications and coordination activities amongst stakeholders.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
SWACH meets monthly with Healthy Skamania-a local group representing all Medicaid providers and non-clinical partners- developed to improve the overall health of Skamania County and facilitate Medicaid Transformation projects in the region.	Across all project areas	Yes	Continue as chartered and create more shared learning opportunities and partnership development
SWACH working with Klickitat and Skamania to identify and leverage funding for a position within the rural community to connect with SWACH to establish more authentic connection to community	Across all project areas	Yes	Collaborate with Klickitat and Skamania Counties to determine details, position description and funding level
SWACH board finalized the decision to move forward with CCS Pathways model.	Community-Based Care Coordination	Yes	Finalize CCS vendor contract and move forward with planning
SWACH board approved funding for Pathways evaluation through Providence Center for Outcomes Research and Education (CORE)	Community-Based Care Coordination	Yes	Work with other ACHs to determine evaluation needs
SWACH engaged Community Care Coordination workgroup to inform SWACH's regional Care Coordination strategy	Community-Based Care Coordination	Yes	Support community-clinical linkages through clinical Transformation project plans and provide opportunities for learning, in parallel to Pathways HUB implementation
SWACH met regularly with opioid workgroups including taskforces focused on treatment and recovery.	Opioid Response	Yes	Develop and/or expand county-specific opioid coalitions to maximize collective impact locally while remaining connected to and

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
			informed by regional efforts
SWACH, with PeaceHealth, initiated a PeaceHealth Community Opioid Collaborative - supporting a lead role for the region's largest Medicaid provider in innovative cross setting collaborations and responses to the opioid epidemic.	Opioid Response	Yes	Continue regular meetings
SWACH, with Klickitat Valley Hospital (KVH), initiated a KVH Opioid Taskforce - supporting a lead role for the county's largest Medicaid provider in innovative cross setting collaborations and responses to the opioid epidemic.	Opioid Response	Yes	Continue regular meetings
SWACH delivered three community opioid conventions featuring state and regional subject matter experts. • Opioids, Feedback Reports, and Supporting Change in Provider Behavior • Team Based Approaches to Medically Assisted Treatment for OUD • Changing the Conversation about Opioid Treatment	Opioid Response	Yes	Continue engaging with community stakeholders to serve as a hub for collective impact, shared learning, innovation and information
SWACH facilitated cross-setting collaboration project to integrate peer provider services into clinical workflows in a FQHC setting. Collaborating partners:	Opioid Response	Yes	Continue providing leadership and quality improvement technical assistance

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
Community Voices Are Born (CVAB) and SeaMar CHC.			
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.	Opioid Response	Yes	Continue engaging with community stakeholders to serve as a hub for collective impact, shared learning, innovation and information
SWACH facilitated MAT waiver training opportunity for regional providers.	Opioid Response	Yes	Coordinate and sponsor another MAT waiver training opportunity in August
SWACH facilitated partnership discussion between Clark County Public Health and Sharehouse CBO to expand syringe exchange.	Opioid Response	Yes	Continue to support opportunities for partnership and expanding access to syringe exchange
SWACH facilitated collaboration between Lifeline and PeaceHealth MAT champion to develop rapid response MAT program with low barrier access.	Opioid Response	Yes	Continue support for increased access to low barrier MAT
SWACH facilitated collaboration between Lifeline, Public Health and PeaceHealth pharmacy to develop naloxone awareness project using informational posters and targeting people who inject drugs.	Opioid Response	Yes	Continue support for increasing access to naloxone

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
SWACH facilitated discussion between Lifeline and SeaMar CHC to explore enhancement of hub and spoke model to include regional FQHC as a spoke to regional hub.	Opioid Response	Yes	Continue support for enhancement of regional hub and spoke model
SWACH facilitated agreement between Lifeline and PeaceHealth to integrate CDP patient care navigator full time into PeaceHealth clinical settings.	Opioid Response	Yes	Continue supporting increased access to MAT and diversification of MAT initiation sites through integration of physical and behavioral health services and community-clinical linkages
SWACH facilitated discussion between Klickitat Valley Hospital, Comprehensive Behavioral Health, and Lifeline Connections to develop and provide MAT services in Klickitat.	Opioid Response	Yes	Identify MAT providers and formalize partnership agreements

Portfolio-Level Reporting Requirements

D. Partnering Provider Engagement

1. During the reporting period, how has the ACH coordinated with other ACHs to engage partnering providers that are participating in projects in more than one ACH?

ACH Response:

SWACH has actively participated in the following:

- Weekly ACH Executive Director (ED) meetings to coordinate efforts, review initiatives and foster collaborations

- Monthly ACH ED peer-to-peer learning sessions. ACHs EDs coordinate engagement strategies, identify cross-ACH partners and align strategic initiatives
- ACH EDs coordinate strategic meetings with cross-ACH health systems partners, providers, statewide organizations and other stakeholders
- Liaison with DOH and cross-ACH partners related to the implementation and development of Pathways HUB model. Several half day strategy sessions with participating organizations
- Shared learning with other ACHs related to partnering provider reporting and cross-ACH learning opportunities
- Structured regular meetings with CPAA ACH (shared border and provider) to review initiatives, align strategies and review cross-region provider goals
- Participate in regular project lead peer-to-peer learning calls that focus on cross-ACH partners and project portfolios involving participating providers
- Coordinate with Greater Columbia ACH regarding Mid Adopter Integrated Managed Care (IMC) readiness reviews, assessments and potential shared investments related to providers who operate in both regions
- Participate with Pierce County ACH around alignment of QI strategies through the Institute for Healthcare Improvement IA (Improvement Advisor) Program
- Participate in weekly ACH/Tribal Opioid Project collaboration call

2. Briefly describe the ACH's expectations for partnering provider engagement in support of Transformation activities.

ACH Response:

In collaboration with partnering providers, through workgroups, RHIP Council key partner input and a request for community input, SWACH has developed a Clinical Transformation Plan template for partnering clinical providers to complete and submit in August 2018. SWACH is asking clinical organizations in the areas of physical and behavioral health to create Clinical Transformation Plans to capture their initiatives for achieving SWACH goals related to Medicaid Transformation. In return, SWACH will provide technical assistance and compensation for submitting a successful plan. This will accomplish the following:

- Identify gaps and opportunities related to the goals of Medicaid Transformation
- Shape a regional plan for technical assistance, partnership and funding
- Establish measures of success for the region
- Serve as the foundation for clinical initiatives to support Medicaid Transformation

- Participate in SWACH training events and shared learning collaboratives

In the submission instructions of the Clinical Transformation Plan, SWACH asks each clinical partner to attach a letter of support signed by the organization's leadership to demonstrate commitment to achieving the vision of Medicaid Transformation (required attestation). SWACH asks that the letter include:

1. Confirmation of organizational leadership's agreement with the responses and Clinical Transformation Plan details, as well as continued support for Medicaid Transformation
2. Organization's willingness to participate in SWACH training events, shared learning collaboratives and governance committees as needed
3. Confirmation of understanding the Clinical Transformation Plan will: 1) serve as a starting point for a binding agreement with SWACH, and 2) inform the development of the regional Implementation Plan developed by SWACH for HCA

SWACH also believes that non-clinical partners are essential to achieving the goals of Medicaid Transformation. Engagement and inclusion of non-clinical community partners is critical to the design and implementation of Clinical Transformation Plans. SWACH is working with regional partners and community voices to develop the framework, approaches and strategies for system changes that realize a desired future state as a region with optimized community-clinical linkages. SWACH intends to help facilitate and incentivize community-clinical linkages by deploying funding in a manner that encourages new partnerships, approaches and systemic changes—rather than one-off projects. Shared learning collaboration is also an important planned strategy to ensure lessons are learned from linkages which currently exist and to inform SWACH of gaps and potential needs to either support new or sustain existing partnerships.

3. Describe the ACH's efforts during the reporting period to engage partnering providers that are critical to success in Transformation activities. What barriers to their participation have been identified, and what steps has the ACH taken to address those barriers? Include the steps the ACH has taken to reach partnering providers with limited engagement capacity.

   ACH Response:

Throughout planning and assessment, SWACH has engaged partners to participate in and inform Transformation activities. SWACH's RHIP Council represents various sectors and key partners. The RHIP Council has been instrumental in connecting SWACH to additional partners identified as critical to SWACH efforts. SWACH has engaged partners through the Clinical Integration Workgroup, Community Care Coordination Workgroup and Opioid Workgroup and taskforce, as well as one-on-one meetings. SWACH has developed relationships with key partners and inquired specifically about the barriers they experience or may anticipate in participation of Medicaid Transformation. Examples of barriers identified by SWACH include:

Barriers identified by partners	SWACH steps to address barrier
Lack of capacity and infrastructure	SWACH meets regularly with partnering providers to review Clinical Transformation Plans, provide technical assistance and understand their specific needs or barriers to capacity building and infrastructure. Once Clinical Transformation Plans are submitted, SWACH intends to bring cohorts of partners together to determine efficient and sustainable solutions.
Shifting Marketplace	There are many uncertainties, given the current policy climate at the federal level, which impacts decision making processes. Market consolidation has also impacted decision making. SWACH intends to demonstrate project effectiveness by funding third-party evaluations to enhance the knowledge base of transformation initiatives. SWACH has also utilized consultants with a national footprint to support providers who are experiencing policy uncertainty and consolidated markets.
Difficulty engaging non-clinical partners, as measures are very clinically-based	SWACH plans to engage non-clinical partners through an RFQ process, which will serve to incentive innovative cross-sector relationships. To maximize whole-person health, SWACH believes the community and social service sectors are essential partners in our regional efforts to transform healthcare systems.
MCO rates and requirements	SWACH collaborates with other ACHs to work with MCOs and align projects, reporting requirements and ensure the continuation of strategies around long-term sustainability.

For partners with limited engagement capacity, SWACH reached out in various ways to ensure accommodations can be made if necessary or to leave the door open for providers who may want to engage later. For example, SWACH may have experienced limited success in response from a clinical provider after several methods of outreach (email, telephone call, engagement through known partner/person to make an introduction). However, if the partner indicated they were not interested in participating in Medicaid Transformation Projects at this time, SWACH ensured the provider was aware of updates, continued an open invitation and responded or reengaged in conversations with the partner when the partner expressed interest. SWACH also launched a new website to

provide information and routinely encourages all providers interested in more information to connect by email, phone or in-person.

4. For 2019 mid-adopter regions, describe the ACH's process to assess current capacity and readiness of Medicaid behavioral health providers to transition to fully integrated managed care. How has the ACH identified, or plan to identify, the needs of Medicaid behavioral health providers?

ACH Response:

Two of the three counties in the SWACH region are early adopters (Clark and Skamania). The third county in the region, Klickitat, is a mid-adopter. SWACH and Greater Columbia ACH have collaborated closely to assess readiness for Klickitat County providers. The only behavioral health provider in Klickitat County provides a significant number of services in the Greater Columbia ACH region. SWACH and Greater Columbia shared readiness assessments between our two agencies. SWACH followed the readiness assessments with a series of meetings in the region to identify and prioritize the needs of the providers to transition to IMC. SWACH coordinates with the region's providers, the County government, MCOs, community stakeholders and HCA through the Implementation CORE team, which was established in Q1 to prepare for IMC as a collaborative effort. These efforts, and additional one-on-one meetings with the behavioral health provider, helped SWACH identify the needs of the region and how to potentially allocate available resources, in conjunction with Greater Columbia ACH.

E. Community Engagement

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

1. In the table below, list the ACH's community engagement activities that occurred during the reporting period. Add rows as needed.

Community Engagement Activities for the Reporting Period						
Activity Description	**Date**	**Objective**	**Target Audience**	**Associated Project Areas**	**Brief Description of Outcome**	**Attendance Incentives Offered? (Y/N)**
Behavioral Health Advisory Board	Monthly meeting	Bring the consumer voice and other experts together to	Community members and partners	All project areas	Updating community members of work connected to MCOs and providing opportunities to	Yes- Mileage reimbursement offered

		advise key organizations on behavioral health and holistic care concerns	with interest or focus on behavioral health		receive feedback from community on behavioral health barriers	and food is provided
HLC Executive and HLC Committee	Monthly	Continue to support HLC efforts and ensure that community engagement, equity and policy remain a focus at SWACH	Community partners and community members	Focus on community engagement, equity and policy	Continue to provide community perspective on strengthening efforts related to community engagement, equity and policy.	No
Meetings with Vancouver Public Schools	1/16 6/7 6/25 6/27	Continue to strengthen relationship with Vancouver Public Schools through programming, planning, and partnership	VPS and SWACH staff	Community-clinical linkages and integration of whole-person care	Strengthen programming of Education Community Health Advocates program, discussed opportunities for school-based health centers, partners at Strengthening Neighborhoods meetings	No
Policy Committee hosted a luncheon in Olympia with legislators to share policy agenda	1/28 2/28	Policy Committee members and partners shared and advocated for policy agenda	Education, housing, social services providers, community members and advocacy groups	Across all project areas	Shared stories, further developed relationship with legislators and legislative staff. Built relationship with WA Chapter of American Pediatrics, which wants to connect more with SWACH partners.	No
Community Health Advocates and Peer	2/15 4/19 6/21	SWACH provided presentation	Practicing peers, CHW,	Opioid	Brought practicing peers together to	Yes-Coord. committee

Supports (CHAPS)		on opioid prevention efforts	CHAs, recovery coaches, and organizational partners	Workforce development	learn, network and advocate.	is paid $15 an hour for their support of convening CHAPS
P-TCPi Regional Care Coordination monthly meetings	3/29, 5/17 and 6/20	SWACH provided presentation on Medicaid Transformation Projects	Regional Pediatric Care Coordinators	All project areas, with focus on Community-Based Care Coordination	Work with state, public health and other partners to align strategies	No
Six County Transitional Care Collaborative Steering Committee Meeting and Convening	4/3 and 5/4	SWACH provided updates on Medicaid Transformation Projects and also facilitated discussion on behavioral health care coordination	Organizational partners connected to transitional care, including long term care facilities	All project areas, with focus on Community-Based Care Coordination	Work with key hospital and care coordination partners to align resources and inform strategy	No
Collaboration with Way Enough Decision Coaching	5/8, 5/18, 5/21, 6/8	Develop collaboration with SWACH Opioid Project to support trauma informed care strategies	Trauma affected community members, particularly those with OUD, and their providers	Opioids	Continuing collaboration around trauma informed care education and training	No
Conference call with WA Pharmacy Association	5/23 6/27	SWACH learned of activities across state and shared MTP plans to identify	Organizational partners, pharmacy	All Project areas	Connect through training opportunities, provide linkage to clinical providers and facilitate innovative thinking around community	No

		potential collaboration			pharmacies and potential partnerships	
Policy Committee	1/8	Finalized statewide legislative agenda and discussed next steps for outreach and advocacy efforts	Policy committee members	Across all project areas	Finalized statewide policy agenda, discussed local issues needing advocacy, planned legislative lunch in Olympia	No
Skamania County Human Services Advisory Board	1/10	Provide ACH updates	Consumers, organizational partners, county partners	All project areas	Provided ACH updates	No
Community dialogue with Attorney General Bob Ferguson	1/30	SWACH was one of a handful or partners to support Attorney General Bob Ferguson to visit SW WA and share how undocumented communities are being impacted	Community members and partners	Equity and community engagement	Provided an opportunity to hear state and federal updates. Community members were able to voice questions and concerns and dialogue about important issues in the community	No
Skamania County Human Services Advisory Board	2/14	Discuss Skamania community conversations opportunity	Consumers, organizational partners, county partners	All project areas	Advisory Board committed to assisting with community conversations	No
Policy Committee	2/21	Reviewed state session and	Policy Committe	Across all project	Finalized plan for legislative session and	No

		planned for HLC quarterly meeting with legislative panel	e members		received updates on legislative agenda	
Skamania County Human Services Advisory Board lunch to plan for community conversations	3/14	Develop outreach plan	Consumers, organizational partners, county partners	All project areas	Developed outreach plan	No
Policy Committee	3/21	Vote on leadership positions, prioritize local policy agenda, review strategic plan	Policy Committee members	Across all project	Debriefed state session and begin brainstorming and getting updates on local policy agenda	No
Community Conversations– Skamania County	3/28	Provide an opportunity to get feedback from Skamania residents on community needs	Over 45 community members, more than half on Medicaid, some providers	All project areas	Received feedback from Skamania county residents about barriers, needs and projects areas	Yes- Dinner and childcare provided, with activities for children
HLC Funders Meeting	4/7	Continue to leverage funds for the ACH to support community engagement efforts, policy and systems change, health	Funders (state, local, foundations, health systems) HLC leadership members and	Community engagement, equity and systems change	Received updates on SWACH leadership changes and HLC work. Provided feedback to strategic planning for HLC and learned about opportunities for partnership and	No

		equity and collaboration	SWACH staff		collaboration on elements of ACH work	
Clark College	4/12	Discuss opportunities for partnership and collaboration	SWACH and Clark College staff	Workforce developme nt and equity	Learned more about each other's scope of work and discussed opportunities for collaboration and support on workforce development and equity related work	No
Policy Committee	4/18	Discuss local policy issues, discuss membership	Policy Committe e members	All project areas	Received updates on local policy issues and prioritized where to focus energy	No
Meeting with Educational Service District (ESD) 112 specifically around early learning services	4/24	Discuss ACH and HLC work and how early learning could fit into current and future work	Staff at ESD 112 and connectio n to other early learning supports	Across all project areas	Shared more information about RHIP and Policy Committee. Connected ESD 112 to Providence CORE to further explore data sharing opportunities and evaluation	No
Center for Equity and Inclusion training with local leaders	5/1-5/3	Three-day equity training to develop common language, introduce equity lens, learn about how history contributes to inequities	Partners representi ng housing, healthcare , social services, higher education, k-12, culturally specific advocacy groups	Equity and community engagemen t support to project areas	Developed common language, learned how to use equity tool, strengthened partnerships, developed new partnerships, built new skills and abilities	No
Community engagement	5/8	Strengthen community	Communi ty members,	All – We developed a plan to	Developed a three-pronged approach for community	Yes-Gift cards offered to

strategy session		engagement strategy	peers, CHWs, culturally specific groups, organizational partners.	ensure deep community engagement strategies and imbed them in all SWACH work	engagement: Community Voices Council, Community discussions, attending meetings throughout the region	community members and peers/CHWs
Equity workgroup	5/9	Discuss plan for embedding equity into Transformation efforts	Community groups, community-based organizations, clinical partners	Equity	Reviewed equity framework developed by Uncommon Solutions. Provided feedback on opportunities and strengths	No
Meeting with Partners in Careers (PIC)	5/14	Learned more about workforce development partnership and opportunities	PIC and SWACH staff	Across all project areas – specifically around workforce development	Received information about programs at PIC that could support Transformation efforts. Shared information about SWACH and HLC current and future work	No
Meeting with Healthy Columbia Willamette	5/14	Town hall meeting to learn more about potential areas of focus for the community needs assessments	Community partners	All project areas	Reviewed data and provided feedback and community perspective. Provided ideas to get more voices to related discussions. Discussed ways to connect work to SWACH.	No
Policy Committee	5/16	Discuss equity lens, focus on local policy agenda	Policy Committee members	All project areas	Started planning for HLC quarterly meeting. Decided to try to do policy training, CPAA and SWACH updates, opioid prevention and voter registration. Received updates on local policy agenda	No

Community Convention: Why We Must Change the Conversation About Opioid Treatment	5/25	Reduce stigma related to OUD – through understanding of OUD as chronic disease of the brain, trauma-informed care, importance of peer providers	Community members, elected representatives, community based organizations, public health, CHW's, peer providers, BH and PH providers, health system leaders.	Opioids	100+ attendees. Supported a shift in understanding, approach and culture around opioid treatment	No
Equity workgroup	6/6	Discuss how to bring equity into Transformation plan	Community groups, community-based organizations, clinical partners	Equity	Decided to imbed equity into the Clinical Transformation Plan through participation in assessment and plan	No
Meeting with Share House Housing and Homeless Shelter	6/14	Plan expansion of syringe exchange and naloxone distribution	People who inject drugs	Opioids	Follow up meeting to explore collaboration with Clark County Public Health	No
Equity workgroup	6/26	Review Clinical Transformation Plan	Community groups Community Based Organizations, clinical partners	Equity	Finalized equity section of Clinical Transformation Plan and discussed shared learning opportunities	No
Meeting with DSHS	6/28	Share Pathways Hub model and Discuss Care Coordination Strategies	People in need of social services support and Care Coord.	Care Coordination	Share learning and potential ways to collaborate in the support of Medicaid members, particularly those in acute need of social service support	No

2. Describe how the ACH and its partnering providers have reached out to populations with limited proficiency in English.

ACH Response:

There have been several specific attempts by SWACH and partnering providers to reach out to populations with limited proficiency in English. These efforts include:

- Sponsored translation at the Statewide CHW conference
- Outreached to the deaf and hard of hearing community for large opioid learning forum by providing ASL interpretation and video-taping the conference
- Provided Spanish translator for the Skamania community conversations
- Maintain strong connection to culturally specific groups in the community (League of United Latin American Citizens, Urban League, Latino Resource Group, etc.)
- Ensure all public facing materials and information recognize health literacy guidelines

SWACH recognizes that much more work is necessary to improve in this area and to focus more attention on these populations. SWACH plans to build this capacity through the Community Voices Council and planned community conversations.

3. Focusing on community groups that may be underrepresented in Transformation efforts, identify challenges to engagement that have occurred; describe the strategies the ACH and its partnering providers have undertaken to address these challenges.

ACH Response:

The RHIP Council decided to strengthen the existing community engagement strategy to ensure SWACH brings community voice to decision-making across all Transformation work. A focus group of RHIP Council members, peers, community health workers, culturally specific advocacy groups and organizational partners met in May to build on past community engagement work and strengthen future work. The focus group made recommendations that were taken back to RHIP for approval. The result was implementation of a three-pronged community engagement approach. The three-pronged approach includes:

1) Forming local and regional Community Voices Councils (CVCs)
2) Continuing community conversations
3) Ensuring that SWACH is well represented at local and regional meetings and events

1) **Forming local and regional Community Voices Councils:** SWACH will support the development of a regional CVC. Community members who are deeply connected to their community will be selected to serve on the council. Priority will be given to those who are on Medicaid or closely support friends or family members on Medicaid. Klickitat and Skamania counties will each select a minimum of five members to sit on the CVC. Clark County will select a minimum of ten. SWACH staff will work closely with the

community to identify CVC members that represent diverse geographic areas, ages, races, ethnicities and cultural groups. The number of members per county is based on population size. Each county CVC will meet with people in their own county every other month. On alternate months, they will meet with all SWACH CVCs to form the regional CVC. SWACH has received feedback, particularly from our Skamania and Klickitat partners, that their needs look very different compared to those in Clark. Therefore, it is important to have the county specific CVCs, so they can coalesce locally and bring their perspectives to the regional CVC. CVC members will sit on committees and workgroups of SWACH to ensure information is shared and that the CVC has an opportunity to provide recommendations and be part of decision-making processes. CVC members will be paid for their time. SWACH will use learnings from HLC's CHW work on payment models to inform appropriate compensation. SWACH will work closely with the Behavioral Health Advisory Board (BHAB) and the Community Health Advocates and Peer Supports (CHAPS) peer network to ensure consumer and peer groups that are helped by and connected to SWACH are also connected to the CVC. Both BHAB and CHAPS bring incredible perspective and expertise that will be critical to SWACH. For a visual representation of this proposed structure, please see Attachment E.

2) **Ensuring that SWACH is well represented at local and regional meetings and events:** SWACH staff will develop a plan to actively engage in existing and upcoming community meetings and events. This means attending formal meetings and events as well as finding less formal ways to engage with the community and show up where people are already coming together. SWACH is exploring ways to engage local liaisons in each county. SWACH recognizes it takes significant time to develop trust. Having a local liaison who connects back to SWACH will help strengthen the connection and ensure local voices and perspectives are continually shared.

3) **Continuing community conversations:** This element will continue to build on SWACH's past strategy of community listening sessions. Because five to ten community members will never fully represent each of our counties' unique needs, assets or experiences, SWACH plans to convene community conversations in partnership with our local CVCs to bring the community together to provide feedback on Transformation efforts. These community conversations will provide a venue for SWACH to glean community wisdom that helps break down potential barriers faced by providers. It may also help identify opportunities for SWACH to build on existing strengths of regional communities and work toward better health outcomes for all people.

SWACH is committed to serving and strengthening its communities. Focusing on under-represented groups ensures SWACH's success in this important work. The enhanced development of SWACH's community engagement strategy is an example of how SWACH continues to leverage past learnings to prioritize community voice and equity in decision-making processes and overall Transformation work.

F. Health Equity Activities

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

1. Provide an example of a decision the ACH and its partnering providers have made about project planning or implementation based on equity considerations.

   ACH Response:

SWACH and partners have identified equity as a critical part of the region's overall vision, strategy and work. To embed equity into Transformation efforts, an equity workgroup was formed to support planning and development of a regional strategy. The workgroup is made up of two RHIP members, staff from partnering providers and community organizations working to support equity efforts in their respective organizations, and two SWACH staff. The workgroup has met three times. SWACH staff have met with several equity experts to glean lessons learned and obtain recommendations on how to imbed equity into Transformation efforts in the most meaningful way. Based on the collective feedback from these efforts, four recommendations were provided and approved by the RHIP Council. The Clinical Transformation Plan identifies training, assessment and equity plan as optional tactics. If a partner chooses to participate in an assessment or plan, participation of the shared learning cohort will be required.

- **Training**: Provide training on health equity, stigma and/or trauma-informed care
- **Assessment**: Complete health equity, stigma and/or trauma-informed care assessment (An examination of an organization's governance, policies and programs to identify strengths and opportunities for improvement regarding racial equity, stigma reduction and trauma-informed care)
- **Plan:** Complete a plan to address health equity, stigma and/or trauma-informed care (A plan to improve an organization's racial equity, stigma reduction and trauma-informed care work across the organization's governance, policies and programs.)
- **Shared Learning**: Any partnering provider that plans to embark on an assessment or plan will be required to participate in a shared learning cohort. We have learned from our partnering providers that staff working to further equity work within their own organizations need more support. The shared learning cohorts will provide an environment to learn about tools, resources and approaches, as well as to discuss barriers and share successes. Dedicated staff and consultants will support the shared learning cohorts.

In addition, all partnering providers are required to complete the following open-ended question: *"SWACH views health equity, trauma-informed care and stigma reduction as cornerstones of Medicaid Transformation. As such, SWACH will provide support for this work. Please describe your organization's current approach to this work and your interest in furthering it."* This question will allow SWACH to better understand how equity, stigma reduction and trauma-informed care are currently being approached so we can learn from our partners and build on existing work.

2. How will the ACH and its partnering providers assess and prioritize community health equity issues in the region during the Medicaid Transformation?

ACH Response:

SWACH is committed to and has prioritized regional equity work as part of the Transformation effort. To fully prioritize this effort, SWACH identified a need to have dedicated staff with an expertise in furthering equity work. SWACH is currently working on creating a job description for a director of equity position, with plans to open the position in the next few weeks. The director of equity will be charged with supporting internal and external equity efforts. SWACH realizes that one person will not be able to support all efforts. We are also working to identify consultants who have supported similar work. Furthermore, in the coming year SWACH plans to embark on an organizational equity assessment and plan. We will do this with our partnering providers and fully participate in the shared learning cohorts.

Currently SWACH staff are in the process of developing guiding principles that will help in prioritizing the level of funding for each of the partnering providers. Equity has already been identified of one of the guiding principles.

SWACH plans to continue building relationships with culturally specific groups and communities. Staff currently attend culturally specific community meetings such as League of United Latin American Citizens and the Latino Resource Group. Listening sessions and community conversations continually highlight the need for culturally-specific services. SWACH will continue to partner, learn and work with culturally specific groups to help inform our work and bring additional support to regional Transformation efforts. An example of this is the Urban League, which has a long history of serving the African American community in the Portland area. The Urban League joined the HLC Committee in January and is working toward bringing services to Southwest Washington. SWACH has offered to provide office space and connect the Urban League to funders and partners in Southwest Washington communities.

3. What steps has the ACH taken to provide the ACH board/staff/partnering providers with tools to address health equity? How will the ACH monitor the use of health equity tools by partnering providers?

ACH Response:

The Healthy Living Collaborative (HLC), a SWACH program, has been focusing on the region's health equity efforts for more than five years. HLC has leveraged funding, momentum and experience for this body of work. Activity over the reporting period has included bringing training and capacity building to partners, increasing staff's skills and abilities, and bringing new tools to help ensure that equity is considered in all decision-making, with a particular focus on reducing health disparities.

Increase training and capacity building to partners: For the past three years, HLC has continued to offer an eight-hour *Leading Social Justice and Equity* training. The training focuses on increasing awareness of historical impacts of structural racism; deepening

understanding of the dynamics of oppression, power and privilege; and recognizing and learning strategies to manage bias. Four of these trainings were offered over the reporting period and SWACH encouraged its partnering providers, workgroups, RHIP and board members to participate. Three board members attended the eight-hour training and SWACH will work with the remaining board members to attend one of the fall trainings. To date, more than 200 people have completed this training. SWACH and HLC continue to receive extremely positive feedback and have seen organizational partners bring the training to staff within their own organizations. Strong positive feedback led HLC to offer our first advanced course in implicit bias. The four-hour advanced course is taught by the same instructor, Maria Lisa Johnson, who teaches the leading social justice and equity training. We hope to continue to offer educational opportunities for our partners to do personal exploration and think about how their own organizations may be unintentionally perpetuating inequities. SWACH will continue to track all partners participating in the equity trainings.

Increase staff skills and abilities: All SWACH staff completed the eight-hour *Leading Social Justice and Equity* training. Two members of SWACH staff along with 20 other partners were selected to participate in an equity leadership training with the Southwest Washington Equity Coalition. The training, facilitated through the Center for Equity and Inclusion, occurs over six months and provides preparation, skill building and a variety of tools that can be taken back to individual organizations. HLC has leveraged dollars through United Way to help support the training in Southwest Washington.

Furthermore, SWACH is working to enhance staff understanding of health literacy and plain language principles and to integrate those learnings in future communications materials. For example, in March of 2018, a SWACH staff member participated in trainings at the Legacy Health Literacy Conference and in May of 2018, SWACH engaged a communications consultant with plain language and health literacy training to support a website redesign and other communications needs. SWACH will track all equity related trainings that staff participate in.

Ensuring equity is considered in decision making: The training with the Center for Equity and Inclusion provided tools that can be taken back to individual organizations. One of these tools is an equity lens. SWACH plans to use the equity lens throughout committees, workgroups and with staff. HLC has focused on health equity for many years. Therefore HLC committees are trialing the equity lens tool with a plan to scale the use of the tool across all SWACH work, including the SWACH board. SWACH plans to implement the tool across the organization within six months. SWACH will track decisions made using the equity tool to monitor how frequent the tool is used in different groups and committees across the ACH.

SWACH website redesign to reduce health literacy barriers: SWACH recognizes that most Americans find it difficult to understand information related to healthcare. Even those with strong literacy skills find that understanding health information a challenge. To make SWACH's public facing website more accessible to a wide variety of audiences, including those with low literacy, SWACH engaged a communications specialist to rewrite the site's content and manage a web redesign project aimed at improving user experience and enhancing use of plain language throughout the site.

To give a sense of what was accomplished in this effort, the primary public-facing pages of SWACH's previous website included more than 4100 words and tested at approximately a 15th grade reading level. The equivalent pages on the new site include approximately 2000 words and test at a 9th grade reading level. Additional improvements include streamlined navigation, a

responsive design optimized for mobile devices and tablets, increased white space, an overall reduction in clutter and improved search functionality.

SWACH released a soft launch of the new site in late June of 2018 and is in the process of collecting feedback from stakeholders and community members that will drive additional improvements to the site over time.

Going forward, SWACH will continue to incorporate plain language practices and other health literacy considerations when creating public facing communications. Materials will be tested and reviewed with stakeholders through SWACH's community-based RHIP Council and other workgroups and committees that represent diverse community voices.

Equity imbedded in Clinical Transformation Plans

As mentioned above, partnering providers can select tactics in the Clinical Transformation Plan related to furthering equity, including conducting an assessment and creating an organizational plan. SWACH will work with partnering providers on regular reporting which will allow for continued monitoring of these activities to ensure progress is made in meeting plan goals. Additionally, the equity shared learning cohort will create a more informal and qualitative way for SWACH to monitor improvements in this work.

G. Budget and Funds Flow

Note: HCA will provide ACHs with a Semi-Annual Report Workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of June 30, 2018.

1. ***Attestation:*** *The ACH organization or its equivalent fiscal sponsor has received a financial audit in the past year. Place an "X" in the appropriate box.*

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

Yes	No
	X

a. *If the ACH checked "Yes" in item G.1, have all audit findings and questions been appropriately resolved? If not, please briefly elaborate as to the plan to resolve. If the ACH checked "No" in item G.1, respond "Not Applicable."*

ACH Response:

b. *If the ACH checked "No" in item G.1, describe the ACH's process and timeline for financial audits. If the ACH checked "Yes" in item G.1, respond "Not Applicable."*

SWACH's process and timeline for financial audits moving forward will be to engage a third-party auditor and complete an audit within four months of our fiscal year ending. The reason

that an audit has not been completed to date is that we are in the process of reorganizing our financial statements to align with the HCA's use categories and changing our accounting software. When this process is complete, we will engage a third-party auditor to audit the financial years ending June 30, 2017 and June 30, 2018.

ACH Response:

2. **Design Funds**

   Complete items outlined in tab G.2 of the Semi-Annual Report Workbook.

3. **DY 1 Earned Incentives**

   Complete items outlined in tab G.3 of the Semi-Annual Report Workbook.

4. **Integration Incentives**

   For early- and mid-adopter regions only, complete the items outlined tab G.4 of the Semi-Annual Report Workbook and respond to the following:

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

      ACH Response:

As noted above in Section G, question 4, SWACH has relied on several inputs to develop priorities for integration incentive allocations for the Mid-Adopter county (Klickitat). Primarily, our prioritization has developed from our HIE/HIT assessment, clinical assessment and Greater Columbia IMC readiness assessment. To avoid redundancy, and with the cooperation of the region's behavioral health provider, SWACH partnered with Greater Columbia ACH to assess readiness for IMC. This assessment led to joint meetings between ACHs to review possible investment strategies and alignment of potential investments. SWACH has also met monthly with elected officials, providers and stakeholders to further advance the priorities of the region. SWACH also participates on a multi-agency CORE IMC implementation team that will continue to meet and further develop investment strategies. To date, the primary focus for the Mid-Adopter region has been on infrastructure investments to enhance billing capabilities, reporting, population health management and miscellaneous back office functions. Future considerations are more likely to focus on workforce development, recruitment and retention strategies and team-based care training and workflow development.

Two counties in the SWACH region are Early Adopters (EA): Clark and Skamania. Because the EA region completed financial integration more than two years ago, the EA provider's priorities are different than in Klickitat. To date, SWACH has met monthly with the Behavioral Health

Provider Alliance to accomplish three objectives related to the allocation of integration incentives:

1) Jointly develop a priority list related to clinical integration (different than, but related to, financial integration). This has been the highest priority for the region.

2) Identify gaps related to clinical integration service delivery and develop strategies to close the gaps. For example, shared care planning was an identified gap that is necessary for clinical integration. SWACH brought this gap to the Clinical Integration Workgroup to develop strategies that would support solutions for this issue. Before SWACH became an ACH, the region invested significant resources in behavioral health providers to better position these organizations for IMC. The work of the southwest region during this time led to HCA guidance document for use of integration incentive dollars and included funding for billing, workforce, technical assistance and IMC readiness reviews.

3) The third objective for integration incentives is to provide needed resources for IMC readiness that have materialized since our region became an EA in 2016.

In 2017, the SWACH region created a Regional Health Care Advisory Committee, chaired by the county commissioners with representation from community members, public health officials, county departments related to behavioral health, elected state representatives and senators, and the behavioral health advisory board. The committee convenes every four months to receive updates related to early adopter, Medicaid Transformation and MCOs. Through this process, multiple stakeholders can provide input into prioritizations and participate in regional investment decisions.

Furthermore, SWACH is in the process of developing a Waiver and Investments Committee that would report directly to the SWACH board. While this development is taking place, SWACH has supported an ad-hoc Waiver and Investments Committee made up of stakeholders and community partners. This committee developed recommendations on funds flow allocations, guiding principles and regional investments related to integration incentives, as well as MTP incentives already earned. SWACH anticipates that the ad-hoc committee will sunset in Q4 once the Waiver and Investments Committee is formally established.

b. Describe the decision-making process the ACH will use to determine the distribution of integration incentives. Include how the ACH will verify that providers receiving assistance or funding through the integration incentive funds will serve the Medicaid population at the time of implementation.

ACH Response:

SWACH staff and the ad-hoc Waiver and Investments Committee (described in the response to the previous question) develop spending principles, guidelines and targets for the integration incentives. This process is informed by various sectors of the community, including the Behavioral Health Providers Alliance and the RHIP Council. These principles, guidelines and targets are then approved by the SWACH board. Most of the integration incentives will be distributed as part of SWACH's binding agreements with clinical partners. These agreements

will include statements of work that detail how the integration incentives will be used to further integration. SWACH staff will negotiate these agreements using the approved principles, guidelines and targets. SWACH's governance structure will ultimately approve these agreements. A portion of the integration incentives may be distributed as part of regional investments that support multiple partners working on integration. These investments will be informed by the HIE/HIT and clinical assessments that SWACH completed with clinical partners, as well as the information SWACH receives from Clinical Transformation Plans. These investments will also be informed by the RHIP Council and approved by the SWACH board.

There are numerous ways in which SWACH is verifying that integration providers receiving assistance through the integration incentives will serve the Medicaid population. First, through assessments and other data collection SWACH knows where the region's Medicaid population receives service and is using this data in selecting partners and funding levels. Second, SWACH will require partners to attest to this in their binding agreements. Third, SWACH will require partners to report on this as part of their ongoing reporting requirements in their binding agreements.

5. Total Medicaid Transformation Incentives

The items outlined in tab G.5 of the Semi-Annual Report Workbook is informational only. ACHs are not required to complete any items in this tab of the Workbook.

SWACH Framework and Roadmap

Our Vision

SWACH believes all people should have equitable access to quality whole-person care and live in connected and thriving communities without barriers to wellness. SWACH is working with partners in our region to **improve health,** increase the **quality of care and services**, enhance **employee satisfaction,** increase **employee retention** and maintain a sustainable workforce. We will invest in **prevention,** support **wellness for our neighbors at every stage of life and help build strong families.**

Our Strategy

Our collective impact strategy is built on three gears that turn together to catalyze and drive long-term transformation: a strong and diverse set of cross-sector **partnerships**, authentic **community engagement**, and a strong **data and shared learning infrastructure.**

Our Focus Areas

1. Use improvement methods to work in and across settings to implement key change ideas and standards of care for: **I. Whole-Person Integrated Clinical Care**
   - **II. Community-Clinical Linkages**
   - **III. Sustainable Large Scale Impact**

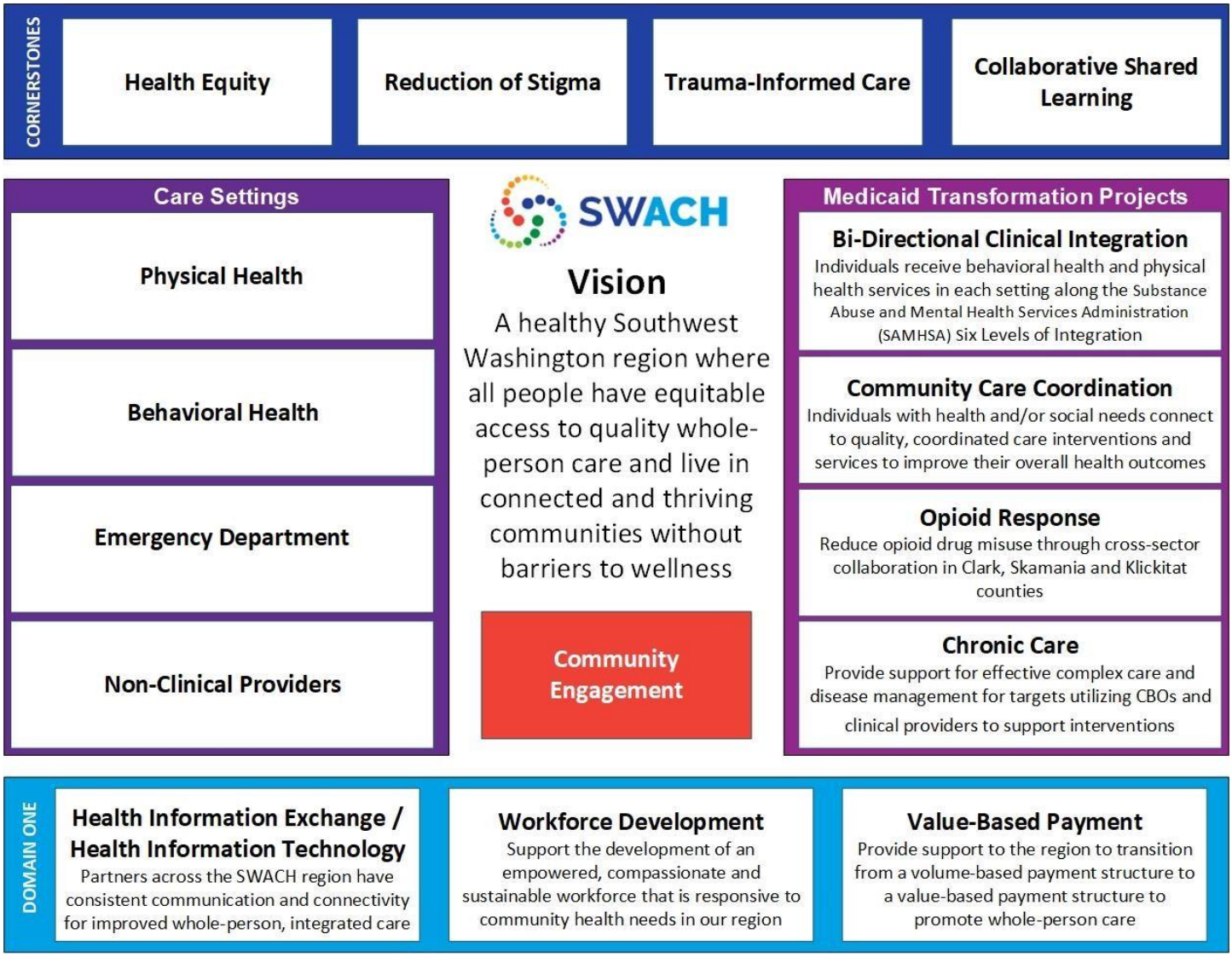
2. Use authentic community voices, provider inputs and data to identify priority populations and communities with the greatest needs and disparities.

3. Identify the settings of care and providers people rely most heavily upon for care, and infuse resources and supports to transform those settings.
   - **Quality Improvement Technical Assistance**
   - **Value-Based Payment Support**
   - **Workforce Development**
   - **Assistance Incorporating Authentic Community Voice**
   - **Tools and Technology for Population Health Management**
   - **Address Inequities, Stigma, Trauma and Institutional racism**
   - **Community-Clinical Linkages/Partnership Development**

4. Use data to optimize efforts and conduct robust evaluations on our priority initiatives. Spread effective approaches to other populations, settings, and providers throughout the region through a community-driven shared learning and action infrastructure.

- **Shared Learning:** Robust Monitoring and Evaluation
- **Collective Systemic Change & Action:** Scale, Spread, Innovate
- **Sustainability**

Our Framework



Document Purpose

The following roadmap is intended to give a deeper look into the three primary goals SWACH intends to support. These strategies and tactics are a mix of work that has been completed, is currently in motion and will be done in the future.

GOAL 1. WHOLE-PERSON INTEGRATED CARE

Problem Statement: We currently do not have a comprehensive and integrated approach to delivering healthcare in our region. Our current system of siloed care and fragmented data and health information sharing does not adequately support individuals and families. Integrating behavioral and physical health across the care continuum helps create a system of care that offers individuals the services they need when they need them.

AIM Statement: SWACH supports regional partners through targeted investments and technical assistance for integrated, team-based models of care. SWACH will support regional workforce development and authentic community engagement to enhance equity policies and procedures to include reducing institutional racism, stigma and traumainformed care. Alongside our partners, SWACH will support the development of community clinical linkages, advancement of population health management systems and will support providers to build capacity to be successful in value-based payment contracting.

STRATEGY #1: Understand the current state of clinical partners in the region through an assessment portfolio
(Health Information Exchange (HIE), Health Information Technology (HIT), Clinical Assessments)

- Develop and deploy a two-part assessment. First, a HIT/HIE assessment for clinical providers. Second, a comprehensive clinical assessment for behavioral health organizations and physical healthcare practices.
- Analyze assessment results to inform potential regional investments.

STRATEGY #2: Co-design with partners, ensuring community voice, the framework for system changes and desired future state transformation.

- Establish Bi-Directional Clinical Integration Workgroup to develop system change framework, priorities, strategies and tactics to enhance clinical integration in the region.
- Develop bi-directional future state requirements in collaboration with providers.
- Ensure authentic community voice is embedded throughout the system.
- Develop opioid future state requirements in the areas of prevention, overdose, treatment and recovery.
- Develop chronic disease targeted populations and corresponding interventions across care settings.

STRATEGY #3: Cohorts of providers develop organizational strategies to integrate physical and behavioral health supports along the six levels of SAMHSA integration framework.

(*Substance Abuse and Mental Health Services Administration* https://www.integration.samhsa.gov/integrated-caremodels/CIHS_Framework_Final_charts.pdf)

- Support the development of a transformation plan (TP) that includes system change improvements for physical and behavioral health integration models, inclusive of chronic disease prevention/management, substance use disorders and the social determinants of health.
- Complete guidance documents for TP and provide regional and organizational technical assistance for completing TP.
- Establish continuous quality improvement principles to be applied to all settings.
- Develop and implement a region-wide monitoring plan that incorporates available data from multiple sources and includes regular reporting from partnering providers.
- Develop and implement an evaluation plan for key initiatives.

STRATEGY #4: Design and implement a shared learning infrastructure for providers across the region.

- Develop clear purposes, objectives and outcomes for each shared learning cohort.
- Align cohorts based on commonalities.
- Link cohorts to Policy Committee for policy development.
- Add regional value by incorporating community voices throughout shared learning infrastructure.
- Publish and disseminate learnings, barriers and opportunities.
- Support shared learning across data sharing partners and broader SWACH partners where results can inform Medicaid Transformation Project activities and decision making.

GOAL 2. COMMUNITY-CLINICAL LINKAGES

Problem Statement: Whole-person health and wellbeing is impacted by many factors beyond clinical walls.
Integration is not a cure for inadequate access to resources. More must be done to ensure our approach to whole health addresses the social determinants of health, which impact everyone's health outcomes, healthcare costs and our overall community wellness. To maximize whole-person health, we must include the community and social service sectors as essential partners in regional efforts to transform healthcare systems.

AIM Statement: SWACH will serve as a support for community-clinical linkages by incentivizing innovative cross-sector relationships and projects and providing opportunities for learning, action and care traffic control. SWACH will foster authentic community informed improvements to our healthcare system through investment in community-based partnerships with clinical settings. Investments will target workforce development, population health management systems and quality improvement support, as well as incorporation of equity policies and procedures to address institutional racism, stigma, and trauma. SWACH will also develop a Community-Based Pathways HUB to support a network of care coordination agencies, helping eliminate organizational silos and avoid duplication of services.

STRATEGY #1: SWACH believes that non-clinical partners are essential to achieving the goals of Medicaid Transformation. Co-design, with regional partners and community voice, the framework, approaches and strategies for system changes that realize a desired future state as a region with optimized community-clinical linkages.

- Understand the regional current state of community-clinical linkages through: ○ Review of the HIE/HIT and provider assessments
    - Reviewing data, including regional community health needs assessments
    - Identify current partnerships between physical health and behavioral health providers and nonclinical provider organizations
- Develop strategy and future state goals along a continuum of change for strengthening engagement between community and clinical settings.
- Implement three-pronged approach to elevate community voice, including creating a Community Voice Council, attending community meetings and holding regularly scheduled SWACH dialogues in different communities within our region.
- Ensure that community health workers, peers and people who use Medicaid services are represented in all parts of SWACH's governance structure.

STRATEGY #2: Design and implement a regional shared learning infrastructure for community-clinical partnerships for exchange of best practices, barriers and solutions.

- Transformation to include interdependent community-clinical partnerships is necessary and it will not be simple. The work ahead is new and SWACH will provide technical assistance and support for movement along the continuum of the partnership engagement framework to enhance communityclinical partnerships and projects.
- Create learning cohorts of providers that are in similar stages of transformation and provide technical assistance.
- Incorporate authentic community voice and other community input in the learning process.
- Work with partners, community health workers, community health advocates, peers and community members to identify innovative ideas, system/program gaps and barriers.
- Support development of Southwest Washington Community Health Advocate and Peer Support (CHAPS) shared learning network

STRATEGY #3: Enhance and support capacity development and outreach in existing care coordination efforts in the region.

- Implement a community-based care traffic control system utilizing the Pathways HUB model.
- Support expansion and integration of community health worker and peer providers as essential to whole-person care.
- Support increased efficiency and access to information on real-time social services.
- Support development of care coordination in rural areas as appropriate and informed by rural community voice.
- Provide training and collaborative learning opportunities.

GOAL 3. SUSTAINABLE LARGE-SCALE IMPACT

Problem Statement: Complex issues in our community are causing increasing health inequities, rising healthcare costs and unaffordable housing. Multiple funding streams that often have conflicting requirements and regulations drive our healthcare system. Systemic barriers are preventing needed health improvements, but diverse communities have limited voice and opportunity to participate in decision-making.

AIM Statement: SWACH works to create healthy communities by bringing diverse organizational partners, funders and community members together to find ways to sustainably finance large-scale social impact innovations. We do this by convening, providing tools, technical assistance and investments that allow us to bring health, equity and community voice to decision making.

STRATEGY #1: Fund transformations that are scalable and significant system redesigns that address inequities, stigma, trauma and institutional racism.

- Utilize the transformation plan template and binding agreements between SWACH and partners to fund scalable, significant system redesigns
- Transformation plans that are system redesigns and inclusive of changes that address health inequities, stigma, trauma and institutional racism will be incentivized through funding and technical support.
- Develop equity framework with stakeholders, including community voice.
- Facilitate technical assistance to providers to help transition to value-based contracting.

STRATEGY #2: Develop a policy agenda that facilitates action for Southwest Washington at the local, regional, state and federal levels.

- Expand the reach of the HLC Policy Committee to cover all policy issues related to SWACH's work.
- Hire a dedicated position to manage the policy portfolio.
- Create direct communication between all parts of the governance structure, workgroups, etc. and the policy staff and committee.

STRATEGY #3: Create braided funding for large-scale social impact by partnering with funders around the Community Resiliency Fund and other investments.

- Convene funders who are interested in this work to pool funding and create a shared governance model for decision-making.
- Deploy funding in a manner that encourages new partnerships, approaches and systemic changes, rather than one-off projects.
- Convene partners regarding shared savings and pay-for-performance models that promote large-scale social impact.

STRATEGY #4: Identify regional investments that will support the goal of whole-person integrated clinical care.

- Develop a transparent collective action process for decisions.
- Establish coordinating structure to align with, whenever possible, other ACHs' regional investments.
- Coordinate with statewide health system capacity building partnerships.
- Continue to support regional efforts to integrate cross-sector data (health, education, housing), identify populations that are being served by multiple sectors and understand how experiences in one sector influence outcomes in another ("Community Connections" initiative).

Clinical Transformation Plan Template

Southwest Washington Accountable Community of Health (SWACH)
2404 E. Mill Plain Blvd. Ste B
Vancouver, WA 98661

(360) 828-7319
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SouthwestACH.org

Introduction:

SWACH is the Southwest Washington Accountable Community of Health (ACH). We are the ACH for the counties of Skamania, Klickitat and Clark. Our vision is a healthy Southwest Washington where all people have equitable access to quality whole-person care and live in connected, thriving communities, without barriers to wellness. In plain talk, that means a healthier Southwest Washington – for everyone.

SWACH is one of nine ACHs in the state. Each ACH is accountable for improving health and health equity in its region. This involves collaborating with community members and other experts such as healthcare providers, social determinant organizations, public health and local agencies to address our biggest health challenges. Many of you are already involved in this work and our partnerships continue to grow.

The ACHs are chartered and funded through Healthier Washington Medicaid Transformation, a five-year agreement between Washington State and the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid Transformation agreement with the federal government allows Washington to test new and innovative approaches to providing health coverage and care.

About SWACH

SWACH believes all people should have equitable access to quality whole person care and live in connected and thriving communities without barriers to wellness. SWACH is working with partners in our region to **improve health,** increase the **quality of care and services**, enhance **employee satisfaction,** increase **employee retention** and maintain a sustainable workforce. We will invest in **prevention, help build strong families and** support **wellness for our neighbors at every stage of life.**

Our collective impact strategy is built on three gears that turn together to catalyze and drive long-term transformation: a strong and diverse set of cross-sector **partnerships**, authentic **community engagement** and a strong **data and shared learning infrastructure.**

SWACH Goals for Change

SWACH has three specific goals for change. We will use improvement methods to work in and across settings to implement key change ideas and standards of care to meet regional goals:

I. Whole-Person Integrated Clinical Care

The U.S. healthcare system often treats different types of health services as if they are unrelated. For example, behavioral health and physical health. However, good health is about the whole person – from head to toe. A focus on whole-person integrated clinical care looks at how different types of providers can work together as one team to improve community members' whole health.

II. Community-Clinical Linkages

Washingtonians often face barriers to health. Many experience discrimination or lack of access to food, housing and other essentials. Enhancing community-clinical linkages means making it easier to connect community members with the various types of support they need to be healthy. Because good health almost always starts outside of the doctor's office.

III. Sustainable Large-Scale Impact

Nobody knows Southwest Washington's needs better than the people who live here. Making large-scale improvements in community health requires community input and a lasting commitment to change. A focus on sustainability and large-scale impact helps identify ways organizations are fundamentally shifting the way we address health – for the long term and for everyone.

These goals will be implemented by driving change in four specific project areas identified by the Washington State Healthcare Authority (HCA) and selected by SWACH.

1) **Bi-directional Integration of Physical and Behavioral Health**
2) **Community-Based Care Coordination**
3) **Addressing the Opioid Use Public Health Crisis**
4) **Chronic Disease Prevention and Control**

To accomplish these goals, SWACH will use data and input from the community and providers to identify priority populations and geographies with the greatest needs.

What is a Clinical Transformation Plan?

The Clinical Transformation Plan (CTP) is the tool used by clinical organizations in Clark, Klickitat and Skamania counties to capture their high-level plans for Medicaid Transformation. It allows clinical organizations to document initiatives within and across care settings, including behavioral health, physical health (primary care practices including pediatrics and dental, as well as hospitals), and emergency departments, as well as community settings. Each organization's Clinical Transformation Plan will document initiative details regarding tactics, timelines, measures and needs for resources and support.

Clinical Transformation Plans will also capture clinical organizations' activity through the Medicaid Transformation timeline (2019-2022), which has three stages:

- Planning
- Implementation (includes all building and testing of changes through roll-out)
- Scale and sustain

These stages are generally broken down into a timeline defined by the HCA in the ACH toolkit. However, SWACH understands that some or many of your initiatives may not progress through these stages in the exact timeframe defined by the HCA.

What am I being asked to do?

We are asking clinical organizations in the areas of physical and behavioral health to create a Clinical Transformation Plan to capture their initiatives for achieving SWACH goals related to Medicaid Transformation. In return, SWACH will provide compensation for submitting a successful plan. This will accomplish the following:

- Identify gaps and opportunities related to the goals of Medicaid Transformation
- Shape a regional plan for technical assistance, partnership and funding
- Establish measures of success for the region
- Serve as the foundation for clinical initiatives to support Medicaid Transformation
- Participate in SWACH training events and shared learning collaboratives

How do I create a Clinical Transformation Plan?

Create your organization's Clinical Transformation Plan by completing the template included in this document. Specific instructions are included in each section.

The template includes the following primary sections:

- Organizational Information
- General Questions
- SWACH Tactical Framework
- Initiative Details
- Attestation

What will SWACH look for in the Clinical Transformation Plan?

SWACH wants to understand enough about your planned initiatives to develop a region-wide picture of all transformation efforts. This will help us to understand your needs for resources or support to help facilitate problem solving, funding and solutions.

At a tactical level, we are seeking your help to drive Medicaid Transformation through the following:

- Initiatives that align with SWACH Goals for the region
- Initiatives that address the communities of the greatest need
- Initiatives that drive system change and lead to sustainable large-scale impact
    - A blend of initiatives that can begin showing progress quickly balanced with larger initiatives where implementation would not occur in 2019.

Updates to the Transformation Plans will be required on an annual basis throughout the duration of Medicaid Transformation.

How will Clinical Transformation Plans be used?

Clinical Transformation Plans will prepare us for the remaining years of Medicaid Transformation by capturing the level of detail necessary to build, scale and sustain change.

The plans are a critical input for building SWACH's regional Implementation Plan, which is due to the HCA by October 1, 2018. The Implementation Plan enables the flow of Medicaid Transformation funds to the Southwest Washington region.

Input from your Clinical Transformation Plan will also help shape a binding agreement with SWACH. The Clinical Transformation Plan itself is a starting point for this agreement and is not a binding agreement.

Finally, the plans will help realize the region's vision for transformation and potential opportunities for technical assistance, infrastructure improvements, funding and community discussions.

What if I have questions and how do I submit a Clinical Transformation Plan?

The Clinical Transformation Plan template was designed to balance the level of detail required to make a cohesive regional implementation plan with ease of use for SWACH's clinical partners. We hope the template facilitates the documentation of your organization's initiatives.

SWACH looks forward to assisting you to successfully submit a Transformation Plan. We welcome any questions you may have regarding the plan and how best to complete it. Details regarding submission are as follow:

- Clinical Transformation Plans are due to SWACH by 5:00 PM on August 17, 2018.
- You may also use this email address for questions or to seek guidance regarding the Transformation Plan process.
- SWACH has developed an FAQ based on questions we received. It is available to all partners on our website.
- We are committed to supporting our partners through this process. A variety of resources are available to help, including partner checkpoints and technical assistance. More details are available on the Clinical Transformation Plan page of our website.

- Upon request, SWACH will provide technical assistance to assist organizations with their Clinical Transformation Plans.
- You may use our email address transformation@southwestach.org to submit your completed CTP or to request technical assistance.
    - SWACH will confirm receipt of your plan or any inquiry to this email address within one business day of receipt.

Availability of funds

It is important to understand that the Medicaid Transformation Project is not a grant program. Clinical partners can earn funding for completing work related to the planning, implementation and scaling/sustainment of transformations that help achieve whole-person Integrated Clinical Care and Community-Clinical Linkages. Funds available to clinical partners through Medicaid Transformation are intended to provide short term funding for implementing health systems transformation aligned with SWACH goals. These funds are meant to supplement existing resources, are not renewable after Demonstration Year 5 (2022) and thus are not sustainable funds.

Also, please note that SWACH is not guaranteed to receive any Medicaid Transformation Project funding from HCA. Therefore, SWACH cannot guarantee availability of funds for transformation initiatives. In addition, SWACH is responsible for determining which transformation initiatives are 1) best aligned with SWACH goals and 2) hold the most promise to transform Medicaid for critical populations in Southwest Washington and providing funding accordingly.

Clinical Transformation Plan Template

Organizational Information

Instructions: To ensure that SWACH understands your organization's service, size and mission, as well as who the focal points will be for transformation, please answer the questions below.

1) Please provide your organization's name and address.

   Provider Organization Name: Click or tap here to enter text.

   Street Address: Click or tap here to enter text.

   City: Click or tap here to enter text.

   Zip code: Click or tap here to enter text.

2) Please provide the name and contact information for the point person responsible for developing your organization's Transformation Plan.

   Transformation Plan Point Person Name: Click or tap here to enter text.

   Phone: Click or tap here to enter text.

   Email: Click or tap here to enter text.

3) Please provide the name and contact information for the Executive Sponsor for your organization's Transformation Plan

   Transformation Plan Executive Sponsor Name: Click or tap here to enter text.

   Phone: Click or tap here to enter text.

   Email: Click or tap here to enter text.

4) Please provide a brief description (no more than 2-3 paragraphs) of your organization. Click or tap here to enter text.

5) How many employees does your organization have in the Southwest Washington region? Choose an item.

6) What is your organization's mission or vision statement? Click or tap here to enter text.

Medicaid Transformation Questions

This section will help SWACH understand how your organization approaches to topics that are fundamental to Medicaid Transformation. Please note that there are no *right* or *wrong* answers in this section. We just want to hear from you "in your own words" on these topics. The information captured here will help us prepare for conversations regarding the types of support that would help partners across the region.

Instructions:

a) Read and answer each question below by clicking on the words "Click or tap here to enter text."
b) Please try to limit your text entry to approximately 150 words. Brief, high level answers are encouraged.

7) How does Medicaid Transformation fit within your organization's existing vision, mission and/or strategic plans? Click or tap here to enter text.

8) Please describe how SWACH's three strategies of whole person integrated clinical care, community-clinical linkages and sustainability and large-scale impact can integrate into what your organization's future practice looks like. Click or tap here to enter text.

9) SWACH views health equity, trauma-informed care, and stigma reduction as cornerstones of Medicaid Transformation. As such, SWACH will provide support for this work. Please describe your organization's current approach to this work and your interest in furthering it. Click or tap here to enter text.

10) SWACH considers Community Clinical Linkages critical to supporting whole person health. Please describe your organization's clinical linkages with non-clinical partners (NCPs), or any potential linkages that you would consider developing. What barriers do you have or envision related to building linkages? Click or tap here to enter text.

11) Do you utilize a Quality Improvement approach such as the IHI model? If so, which model? Describe how you measure the effectiveness of your QI program and how you determine plans for improvement. What resources or support do you anticipate needing to drive QI activities related to Medicaid Transformation? Click or tap here to enter text.

12) HCA has approved SWACH's selection of four projects for the region. For your organization, please describe which specific sites of care will be focused on certain initiatives or projects and why. Do you foresee scaling successful initiatives to all sites? Why or why not? Click or tap here to enter text.

SWACH Tactic Framework

To assist with developing initiatives, SWACH has created a Tactic Framework, which is a broad set of tactics for each of the four project areas, as well as for overall system change. The purpose of this framework is to suggest possible interventions that clinical partners could choose for transformation. However, SWACH encourages clinical partners to think creatively and develop their own initiatives beyond these suggested tactics.

Instructions:

a) Please review the SWACH Tactical Framework.
b) Consider any tactics that you would like to focus on for transformation. In the next part of the template, you will be able to select tactics to become the initiatives for your organization.
c) SWACH encourages you to consider new or innovative tactics that are not listed in the tactical framework. We look forward to how you can apply examples of your organization's creativity to better meet the needs of our community. You can enter these tactics directly into the next part of the template.
d) We recognize the importance of providing flexibility regarding which tactics you select. However, there are three tactics that SWACH requires all clinical partners to select.

The three **required** tactics are listed immediately below and are highlighted and **bolded** in the Tactic Framework.

i. Bi-directional Integration: **Move along the SAMSHA six levels of integration continuum including solidifying a level)**
ii. Community-Based Care: **Increase/enhance partnerships with community partners through policy, protocol or formal agreement**
iii. Opioid Use: **Promote culture shift to understand and treat Opioid Use Disorder (OUD) as a chronic disease affecting the brain**

LEGEND • **All Care Settings** • **Behavioral Health** • ***PH and ED*** • **Physical Health** • **ED** • **BH and ED**

Bi-directional Integration of Physical and Behavioral Health	**Community-Based Care Coordination**	**Addressing the Opioid Use Public Health Crisis**	**Chronic Disease Prevention and Control**	**System Change**
Tactics which could be deployed for all Medicaid beneficiaries	*Tactics which could be deployed in partnership with community resources*	*Tactics which could be used for Medicaid beneficiaries who use, misuse, or abuse prescription opioids or heroin*	*Tactics which could be used for Medicaid beneficiaries with, or at risk for, chronic disease*	*Tactics which apply broadly across all Medicaid target populations*
☐ **Move along the SAMSHA six levels of integration continuum (including solidifying a level)** ☐ Utilize key elements of Bree Collaborative Model	☐ **Increase/enhance partnerships with community partners through policy, protocol or formal agreement** ☐ Establish processes for warm handoffs to community partners, for example: sign Business Associate	☐ **Promote culture shift to understand and treat OUD as a chronic disease affecting the brain** PREVENTION *Training and Support for Providers*	☐ Increase resources to support patient engagement in chronic disease self- management education programs	Health Equity, Reduction of Stigma and Trauma Informed Care ☐ Provide training on health equity, stigma and/or

Bi-directional Integration of Physical and Behavioral Health	Community-Based Care Coordination	Addressing the Opioid Use Public Health Crisis	Chronic Disease Prevention and Control	System Change
☐ Utilize data systems to track outcomes ☐ Develop shared care planning protocols ☐ Provide evidence-based treatment ☐ Standardize protocols and procedures for closed loop referrals ☐ Standardize protocols and procedures for shared care plan ☐ Standardize protocols and procedures for sharing clinical information ☐ Establish training programs for new and existing staff on integrated care models ☐ Universal Screening for behavioral health (BH) ☐ BH specialist as part of clinical team ☐ Use of the Collaborative ☐ Care Model ☐ Integrate a screening tool for social determinants of health (SDOH) into assessment or workflow	Agreements with community partner to support referrals ☐ Integration of CHW's, peers and paraprofessionals across a variety of care settings ☐ Integration of peer mental health/ ☐ substance use providers across a variety of care settings ☐ Partner with local community resources to address rural care coordination needs ☐ Participate in Pathways Community Hub model ☐ Participate in shared learning clinical community collaboratives identifying SDOH gaps and opportunities for partnership/collaboration ☐ Develop/Implement or Improve follow-up after care transition (ED, Urgent Care, Hospital, other) ☐ Utilization of CHW for care coordination/engagement/support across settings ☐ Close the loop for referrals ☐ Systematically integrate information ☐ from referrals into care plan by documenting follow-up and disposition of referral ☐ Track patient/client status over time with standardized workflows to ensure they are treated to target for	☐ Implement Washington State Medical Director ☐ Group Interagency Guidelines on Prescribing Opioids for Pain ☐ *Integrate decision support tools for opioid prescribing in the Electronic Health Records (EHR)* ☐ *Register providers with PMP* ☐ *Participate in the WSMA/WSHA Washington Opioid Reports Program.* ☐ *Establish guidelines and protocols for checking PMP* ☐ *Plan for / integrate PMP into EHR* ☐ *Plan for / integrate PMP usage into clinical workflow* ☐ For Emergency Department: Implement Washington Emergency Department Opioid Prescribing Guidelines *Promote Safe Storage and Appropriate Disposal of Medications* ☐ Promote public awareness campaign and distribute educational materials about safe storage and disposal of medications ☐ Promote and Utilize "Start with One" Campaign and Resources ☐ Develop partnerships between community and clinical agencies to support return / disposal of medication ☐ Secure medication disposal within clinical settings ☐ Secure medication disposal in the community (in partnership with pharmacy, law enforcement, fire and rescue, etc.) TREATMENT *Identify and Support Access Points to Treatment*	☐ Utilize best practices for participant retention in chronic disease self-management education programs ☐ Standardize process for closed loop referrals ☐ Systematically integrate information from referrals into care plan ☐ Increase linkages to chronic disease self-management education programs in the community ☐ Promote ED/ Hospital diversion through community education programs ☐ Increase coordination with community paramedicine programs ☐ Improve transitions through coordination with community resources for follow up after acute episodes ☐ Promote best and highest use of EMS resources	trauma informed care ☐ Complete health equity, stigma and/or trauma informed care assessment ☐ Complete a plan to Address health equity, stigma and/or trauma informed care Value Based Payment Models ☐ Increase use of ☐ Value-Based Payment (VBP) reimbursement model, in partnership with payers ☐ VBP contracts incentivize integrated, whole person care Health Information Technology / Health Information Exchange

Bi-directional Integration of Physical and Behavioral Health	Community-Based Care Coordination	Addressing the Opioid Use Public Health Crisis	Chronic Disease Prevention and Control	System Change
☐ Refer those who screen positive for SDOH to internal staff for care coordination and follow-up ☐ Universal Screening for physical health ☐ Medical services onsite or enhanced care link and shared care planning with primary care ☐ Use of the Milbank Model of Care	both physical and behavioral health treatment goals ☐ Co-manage patients with positive behavioral health and physical health screens until they achieve their treatment outcomes or are connected to appropriate services ☐ Survey shared patients/clients regularly regarding access, outcomes and experience ☐ Implement protocol with community partners to coordinate care for individuals/tribal members who have been recently incarcerated to reduce recidivism to the jail and reduce calls to 9-1-1 ☐ Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers) ☐ Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted ☐ Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to	☐ Engage across settings for communication / collaboration and/or integration of services to support greater engagement of people with OUD and access to treatment. ☐ Develop care coordinating mechanism to support treatment initiation and continuing support/management of treatment. ☐ Utilize peer support services ☐ *Implement validated screening and provide training for identification of OUD* ☐ *Provide training for support and management of people with substance use disorders (Example)* ☐ *Develop policies and protocol for referring/connecting to treatment* ☐ Increase number of treatment access points in clinical settings ☐ Apply the Collaborative Care Model in Office Based Opioid Treatment (OBOT) settings. ☐ Apply the Nurse Care Management OBOT model to your clinical setting. ☐ Increase number of MAT providers in care settings outside of SUD (e.g. primary care, hospitalists, ED's, specialists) ☐ *Provide trainings for providers to receive MAT Waivers* ☐ *Provide trainings on pain management* ☐ *Provide trainings on SUD management and stigma reduction (Example)* *Diversify MAT Initiation Sites*	☐ Engage local health coalitions to advocate for policies to improve patient care and to develop programs to address SDOH within community ☐ Link individuals, particularly from vulnerable sub-populations, with risky health behaviors (alcohol use, tobacco use, illicit drug use, disordered eating, etc.) to evidence based community support programs and specialty care ☐ Partner with public health and community partners to develop social marketing campaigns to promote healthy choices ☐ Train providers on screening for oral health and perform oral health screening when appropriate	☐ Utilize Data ☐ systems to track outcomes and population health ☐ Support robust EHR systems ☐ Support ☐ implementation of Health Information Exchange (HIE) solutions and protocols (e.g. OneHealthPort, EDIE®, PreManage) ☐ Support the ☐ integration of EHR and HIE ☐ EHR supports registry functionality ☐ EHR collects SDOH data ☐ Utilize telehealth to support partnerships between physical health, behavioral health and community agencies for

Bi-directional Integration of Physical and Behavioral Health	Community-Based Care Coordination	Addressing the Opioid Use Public Health Crisis	Chronic Disease Prevention and Control	System Change
	promote child and adolescent care coordination ☐ High-risk sub-populations are linked to timely interventions for identified risk ☐ Team members are trained in ☐ preconception health and have access to evidence-based guidelines and promising practices ☐ Develop contracts, policies and protocols for integration of non- clinical support within the patient centered medical neighborhood	☐ Develop cross-setting partnerships and policies to ☐ increase MAT initiations coupled with care coordination and transition to treatment. ☐ Create policies that lower barriers to treatment initiation ☐ Initiate MAT in ER alongside development of cross-setting partnerships and policies to ensure care coordination and transition to treatment. ☐ Increase number of MAT providers in ED <u>OD PREVENTION</u> ☐ *Increase Access to Naloxone* ☐ Provide overdose and naloxone training for care team and/or patients and/or community members ☐ Increase access to Naloxone through prescription and/or distribution ☐ Expand settings for access and distribution of naloxone ☐ Develop cross setting partnerships to support naloxone distribution ☐ For Emergency Department: Provide overdose education and take-home naloxone for individuals seen for opioid overdose RECOVERY *~~Enhance Peer~~ Support services to support persons with OUD* ☐ Develop partnerships across settings utilizing peers in outreach, engagement and ongoing support efforts for persons with OUD ☐ Provide training in recovery coaching for peers	☐ Identify relevant sub-populations by creating disease-specific registry/module/report in EHR and develop protocols ☐ All levels of staff participate in Chronic Care Model training ☐ Identify relevant sub-population by creating disease-specific registry/module/report in EHR ☐ Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers) ☐ Increase support for Chronic disease management in behavioral health settings	integrated care approaches <u>Workforce</u> ☐ Support increased capacity for community based preceptor sites ☐ Align recruitment and retention strategies to meet new models of integrated care ☐ Share workforce with another organization ☐ Ease capacity with use of Telehealth or Telepsychiatry

Bi-directional Integration of Physical and Behavioral Health	Community-Based Care Coordination	Addressing the Opioid Use Public Health Crisis	Chronic Disease Prevention and Control	System Change
		☐ Provide trauma informed care training for peers ☐ Integrate peer services into physical health/BH/ED settings	☐ Develop capacity to counsel patients on tobacco use ☐ Integrate the coaching of patients through tobacco cessation attempts into treatment plan ☐ Acquire Certified Tobacco Treatment Specialist	

Initiative Details

Please use this section to identify which *Tactics* you plan to pursue and capture details describing how you will accomplish each *tactic*.

SWACH believes the level of detail for *Key Tasks* should a) be commensurate with the detail of the requested *Target Dates*, which is by quarter and b) less specific for tasks taking place beyond December 31st 2019. We encourage you to contact us at transformation@southwestach.org if you would like to discuss the level of detail for *Key Tasks*.

Instructions:

a) Decide which *Tactics* you plan to pursue.
b) For each *Tactic*, please enter up to two *Measures*. Please use the *Measures* to show how you will determine the effectiveness of the tactic for Medicaid members in SWACH populations.
c) For each *Tactic*, please enter the *Key Tasks* needed to accomplish this *Tactic*. You may enter as many high-level *Key Tasks* as needed.
i. SWACH anticipates that many *Tactics* will require around four to five *Key Tasks*. However, there is no requirement for a certain number of tasks. The goal is to briefly describe the work needed to accomplish each *Tactic*.
d) Select which *Phase* of transformation is associated with each *Key Task*:
ii. Planning
iii. Implementation
iv. Scale and sustain
e) Select the *Target Date* for completion of each *Key Task* at a calendar quarter level.
f) If needed, feel free to copy an existing set of rows and insert them to capture any new or innovative *Tactics* you have suggested as well as the related *Measures*, *Key Tasks, Phases,* and *Target Dates*.

Bi-directional Integration of Physical and Behavioral Health						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Move along the SAMSHA six levels of integration continuum (including solidifying a level)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Technical Assistance	**fundinmg**
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Utilize key elements of Bree Collaborative Model	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Utilize data systems to track outcomes	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Develop shared care planning protocols	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Provide evidence-based treatment	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Bi-directional Integration of Physical and Behavioral Health						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
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Standardize protocols and procedures for closed loop referrals	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Establish training programs for new and existing staff on integrated care models	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Universal screening for behavioral health (BH)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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BH specialist as part of clinical team	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Use of the Collaborative Care Model	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Bi-directional Integration of Physical and Behavioral Health						
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Integrate a screening tool for SDOH into assessment or workflow	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Refer those who screen positive for SDOH to internal staff for care coordination and follow-up	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Medical services onsite or enhanced care link and shared care planning with primary care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Use of the Milbank Model of Care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Bi-directional Integration of Physical and Behavioral Health						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
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Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Increase/enhance partnerships with community partners through policy, protocol or formal agreement	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Establish processes for warm handoffs to community partners, for example: sign Business Associate Agreements with community partner to support referrals	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Integration of CHW's, peers and paraprofessionals across a variety of care settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Integration of peer Mental Health / SUD providers across a variety of care settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
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Partner with local community resources to address rural care coordination needs	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Participate in Pathways Community Hub model	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Participate in shared learning clinical community collaboratives identifying SDOH gaps and opportunities for partnership/collaboration	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Develop/Implement or Improve follow-up after care transition (ED, Urgent Care, Hospital, other)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Utilization of CHW for care coordination/engagement/support across settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Close the loop for referrals	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Systematically integrate information from referrals into care plan by documenting follow-up and disposition of referral	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Track patient/client status over time with standardized workflows to ensure they are treated to target for both physical and behavioral health treatment goals	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Co-manage patients with positive physical health screens until they	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
achieve their treatment outcomes or are connected to appropriate services						
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Survey shared patients/clients regularly regarding access, outcomes and experience	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Implement protocol with community partners to coordinate care for individuals/tribal members who have been recently incarcerated in order to reduce recidivism to the jail and reduce 9-1-1 calls	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote child and adolescent care coordination	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
High-risk sub-populations are linked to timely interventions for identified risk	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Team members are trained in preconception health and have	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Community-Based Care Coordination						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
access to evidence-based guidelines and promising practices						
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop contracts, policies and protocols for integration of non-clinical support within the patient centered medical neighborhood	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
<<enter your own tactic here>>	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Promote culture shift to understand and treat OUD as a chronic disease affecting the brain	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Implement Washington State Medical Director Group Interagency Guidelines on Prescribing Opioids for Pain	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Integrate decision support tools for opioid prescribing in Electronic Health Records (EHR)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Register providers with PMP	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Participate in the WSMA/WSHA Washington Opioid Reports Program.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Establish guidelines and protocols for checking PMP	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Plan for / integrate PMP into EHR	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Plan for / integrate PMP usage into clinical workflow	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
For Emergency Department: Implement Washington Emergency Department Opioid Prescribing Guidelines	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Promote public awareness campaign and distribute educational materials about safe storage and disposal of medications	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Promote and Utilize "Start with One" Campaign and Resources	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop partnerships between community and clinical agencies to support return / disposal of medication	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Secure medication disposal within clinical settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Secure medication disposal in the community (in partnership with pharmacy, law enforcement, fire and rescue, etc.)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Engage across settings for communication / collaboration and/or integration of services to support greater engagement of people with OUD and access to treatment.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop care-coordinating mechanism to support treatment initiation and continuing support/ management of treatment.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Utilize peer support services	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Implement validated screening and provide training for identification of OUD	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide training for support and management of people with substance use disorders (Example)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop policies and protocol for referring/connecting to treatment	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase number of treatment access points in clinical settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Apply the Collaborative Care Model in Office Based Opioid Treatment (OBOT) settings.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Apply the Nurse Care Management OBOT model to your clinical setting.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase number of MAT providers in care settings outside of SUD (e.g. primary care, hospitalists, ED's, specialists)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide trainings for providers to receive MAT Waivers	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide trainings on pain management	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide trainings on SUD management and stigma reduction (Example)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop cross-setting partnerships and policies to increase MAT initiations coupled with care coordination and transition to treatment.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Create policies that lower barriers to treatment initiation	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Initiate MAT in ER alongside development of cross-setting	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
partnerships and policies to ensure care coordination and transition to treatment.						
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase number of MAT providers in ED	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide overdose and naloxone training for care team and/or patients and/or community members	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase access to naloxone through prescription and/or distribution	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Expand settings for access and distribution of naloxone	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop cross setting partnerships to support naloxone distribution	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
For Emergency Department: Provide overdose education and take-home naloxone for individuals seen for opioid overdose	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Develop partnerships across settings utilizing peers in outreach, engagement and ongoing support efforts for persons with OUD	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Addressing the Opioid Use Public Health Crisis						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Provide training in recovery coaching for peers	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide trauma informed care training for peers	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Integrate peer services into physical health/BH/ED settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
<<enter your own tactic here>>	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Chronic Disease Prevention and Control						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Increase resources to support patient engagement in chronic disease self-management education programs	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Utilize best practices for participant retention in chronic disease self-management education programs	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Standardize process for closed loop referrals	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Systematically integrate information from referrals into care plan	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Chronic Disease Prevention and Control						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Increase linkages to chronic disease self-management education programs in the community	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Promote ED/ Hospital diversion through community education programs	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase coordination with community paramedicine programs	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Improve transitions through coordination with community resources for follow up after acute episodes	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Chronic Disease Prevention and Control						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Promote best and highest use of EMS resources	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Engage local health coalitions, to advocate for policies to improve patient care and to develop programs to address SDOH within community	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Link individuals, particularly from vulnerable sub-populations, with risky health behaviors (alcohol use, tobacco use, illicit drug use, disordered eating, etc.) to evidence based community support programs and specialty care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Partner with public health and community partners to develop social marketing	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Chronic Disease Prevention and Control						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
campaigns to promote healthy choices						
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Train providers on screening for oral health and perform oral health screening when appropriate	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Identify relevant sub-populations by creating disease-specific registry/module/report in EHR and develop protocols	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
All levels of staff participate in Chronic Care Model training	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Identify relevant sub-population by creating	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Chronic Disease Prevention and Control						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
disease-specific registry/module/report in EHR						
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase support for chronic disease management in behavioral health settings	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
<<enter your own tactic here>>	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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System Change Tactics						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Provide training on health equity, stigma and/or trauma informed care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Complete health equity, stigma and/or trauma informed care assessment	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Complete a plan to address health equity, stigma and/or trauma informed care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Increase use of Value-Based Payment (VBP) reimbursement model, in partnership with payers	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

System Change Tactics						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
VBP contracts incentivize integrated, whole-person care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Utilize data systems to track outcomes and population health	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Support robust EHR systems	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Support implementation of Health Information Exchange (HIE) solutions and protocols (e.g. OneHealthPort, EDIE®, PreManage)	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Support the integration of EHR and HIE	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

System Change Tactics						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
EHR supports registry functionality	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
EHR collects SDOH data	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Utilize telehealth to support partnerships between physical health, behavioral health, and community agencies for integrated care approaches	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Support increased capacity for community based preceptor sites	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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System Change Tactics						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Align recruitment and retention strategies to meet new models of integrated care	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Share workforce with another organization	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
Ease capacity with use of Telehealth or Telepsychiatry	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
<<enter your own tactic here>>	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
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Attestation

Instructions:

Please attach a letter of support signed by your organization's leadership demonstrating commitment to achieving this vision (required). The letter should include:

- Confirmation of your organizational leadership's agreement with the responses and transformation plan details as well as continued support for Medicaid Transformation.
- Your organization's willingness to participate in SWACH in training events, shared learning collaboratives and governance committees as needed.
- Confirmation that you understand the Clinical Transformation Plan will:
    I. serve as a starting point for a binding agreement with SWACH and
    II. inform the development of a regional Implementation Plan developed by SWACH for the HCA.
- Name, title and contact information for the signatory

Definitions

- **Clinical Partners** – Behavioral and physical health providers located in the three-county region of Southwest Washington: Clark, Skamania and Klickitat counties.
- **Clinical Transformation Plan** - The Clinical Transformation Plan (CTP) is the tool used by clinical organizations in Clark, Klickitat and Skamania counties to capture their high-level plans for Medicaid Transformation.
- **Community Clinical Linkages** – Connections among community and social service sectors to enable regional efforts to transform healthcare systems.
- **Community Health Worker** – Community Health Workers (CHW) are frontline public health workers who are trusted members of, or have an unusually close understanding of, the community served.
- **Equity** – Policies that promote equity recognize that many groups within society have not had access to opportunity in equal ways. The concept of equity provides a case for different treatment for those who have been disadvantaged over time. Equity is happening when we see even outcomes across communities, including markers like race, gender, ability, sexual orientation, and income.
- **Equity, Stigma reduction and Trauma-informed Assessment** – An examination of an organization's governance, policies, and programs to identify strengths and opportunities for improvement regarding racial equity, stigma reduction and trauma-informed care.
- **Equity Plan** – A plan to improve an organization's racial equity, stigma reduction and trauma-informed care work across the organization's governance, policies, and programs.
- **External Partner** – Any organization or agency that is not affiliated with your organization.
- **Funding** - Incentive payments that are received from the Health Care Authority (HCA) for SWACH region, contingent upon reaching specific milestones and outcomes. Funding is the money that SWACH intends to use to support organizations.
- **Health Care Authority** – Washington state agency overseeing the Medicaid Transformation through the Healthier Washington Initiative.
- **Initiative** – Transformation *tactics* can be referred to as initiatives after they have been selected by a clinical partner and/or included in the binding agreement with SWACH.
- **Key Tasks** – Specific work steps that need to be done to achieve transformation tactics.
- **Medicaid Transformation** - Strategic changes within Washington Medicaid to move toward a healthier Washington. The Healthier Washington Medicaid Transformation is an agreement with the federal government that allows us to test new and innovative approaches to providing health coverage and care.
- **Medicaid Transformation Stages** -
  - *Planning* - This stage includes: assessing current state capacity, selecting target population and evidence based approaches, identifying project leads and partners and developing an implementation plan
  - *Implementation* - This stage includes development and operationalizing of guidelines, policies, procedures and protocols, development of Quality Improvement Plan (QIP), and implementation of projects, including all building and testing of changes through roll-out)
  - *Scale and Sustain* – This stage includes usage of continuous quality improvement methods to update adopted guidelines, policies and procedures, supporting project continuation and expansion, developing pay models and implementing VBP strategies
- **Non-Clinical Partner** – Organizations that assist people with Medicaid insurance in the three-county region of Southwest Washington, but do not provide clinical services.

- **Pathways** – Pathways refers to the Pathways Community HUB, which is an approach to bring together an accountable team of community-based agencies that deploy people to reach out to those at greatest risk, assess their risk factors, and ensure that they connect to care. For more information about the Pathways model, please see the Pathways/Rockville Institute website
- **Referrals** – Sending a client or patient to a provider or program outside your organization.
- **Shared Learning Collaborative** – A group of partners who are willing and able to share approaches, measures and outcomes for continuous quality improvement.
- **Social Determinants of Health** – refers to conditions in the places where people live, learn, work, and play which affect a wide range of health risks and outcomes. Differences or inequity related to SDOH in communities often related to low income, housing instability, food security and unsafe neighborhoods. Commonly abbreviated as "SDOH"
- **Stigma** – is when someone is viewed in a negative way because of distinguishing characteristic or personal trait that is thought to be, or is, a disadvantage.
- **Stigma Reduction** – a set of approaches to address the role and effects of stigma at an individual, organizational, community and regional level.
- **Tactic** – Possible approach available to clinical partners to drive change aligned with HCA projects and SWACH goals
- **Tactic Measure** – Marker for showing progress on a selected tactic. This could include HEDIS measures as well as much simpler things like counts. Example: number of providers receiving trauma-informed care training
- **Technical Assistance** - Assistance that is provided to an organization, such as introductions to resources with specialized knowledge or capabilities for assistance
- **Training** - Instruction provided to an organization, within an organization or the region, to educate them about knowledge relevant to Medicaid Transformation
- **Trauma-informed Care** – An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma that patients may have experienced. A trauma-informed approach to care can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

For additional terminology, please also refer to the Medicaid Transformation Glossary on the HCA website.

Sample Clinical Transformation Plan

Here is a sample of how the **Initiative Details** section of a CTP might look after at completion. Here are a few important things to remember about this sample:

- This sample is meant to inspire your thinking of what a *Tactic* could be and what some *Key Tasks* might look like. We encourage you to combine this sample with your thoughts about how to better serve the Medicaid population to create new *Tactics* and *Key Tasks*.
- This sample is **not** intended to suggest projects or *Tactics* that your organization should select.
- Even if you do select some of these same *Tactics*, SWACH is **not** suggesting that any of these *Key Tasks*, *Tactic Measures*, *Phase*, *Completion Dates, Type of Technical Assistance or Assistance Description* are the right answers for your organization. For this reason, we discourage you from copying this content and pasting into your CTP.
- Please contact us at transformation@southwestach.org if you have any questions about this sample, how to use it or would like to discuss further.

Bi-directional Integration						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
BH specialist as part of clinical team	Hire a BH Specialist as part of an existing primary care team	Identify practice champion at site level	Planning	TY2Q3	Technical Assistance	Will also need funding for each task to support planning
	25% of patient population will be supported by BH Specialist by Q2 2020	Complete needs assessment--patient and clinical level-identify opportunities for improvement	Planning	TY2Q3	Technical Assistance	Click or tap here to enter text.
		Review diagnostic and attribution data at clinical level	Planning	TY2Q3	Technical Assistance	Click or tap here to enter text.
		Identify target population within clinic and develop problem statement the intervention will address	Planning	TY2Q4	Funding	Click or tap here to enter text.
		Chose a model for continuous quality improvement and develop a workplan	Planning	TY2Q4	Funding	Click or tap here to enter text.

Community Clinical Linkages						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Increase/enhance partnerships with community partners through policy, protocol or formal agreement	Current number of partnerships compared to new/proposed number of community partnerships	Identify current number of partnerships and determine whether policy, protocols or formal agreements in place	Implementation	TY2Q3	Choose an item.	Click or tap here to enter text.
	Number of policies, protocols or formal agreements in place	Work with community partner to determine what type of formal agreement is most appropriate for improved care coordination and referral	Implementation	TY2Q3	Choose an item.	Click or tap here to enter text.
		Identify a need of current population served and select a community partner to establish new partnership to meet the need	Implementation	TY2Q4	Choose an item.	Click or tap here to enter text.

Community Clinical Linkages						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
		Explore standardized agreements and partnerships to impact need of a population and improve care coordination	Scale & Sustain	TY2Q4	Training Needs	Training suggestions: Potential partner identification and/or introduction Templates for policy, or agreement

Opioid						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Promote culture shift to understand and treat OUD as a chronic disease affecting the brain	Meeting agendas, notes and record of participants	Leadership commitment to 3 one-hour QI meetings/ trainings for all staff on OUD as chronic brain disease, relation to trauma and role of peers in engagement and support	Planning	TY2Q4	Choose an item.	Click or tap here to enter text.
	Completed post assessment questionnaires from participants	Identify setting champion to lead/facilitate discussion on topic	Planning	TY3Q1	Choose an item.	Click or tap here to enter text.
		Develop or use provided discussion questions and guidelines as framework for discussion	Planning	TY3Q1	Choose an item.	Click or tap here to enter text.
		Coordinate times, places and participants	Planning	TY3Q2	Choose an item.	Click or tap here to enter text.
		Watch the presentations, hold discussion, complete post assessment questionnaire	Implementation	TY4Q1	Choose an item.	Click or tap here to enter text.

Chronic Disease Management						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Increase resources to support patient engagement in chronic disease self-management education programs	Identify chronic disease population(s) to target, record baseline and set goals	Identify current number of patients who fall into chronic disease population selected and stratify by high, moderate and low risk	Implementation	TY2Q3	Choose an item.	Click or tap here to enter text.
	Number of new resources or tactics in place: reflected in policies, protocols or workflow	Assign staff to work with specific population, research patient engagement best practices and chronic disease self-management programs to offer in clinic or contract with existing non-clinical or community partner.	Implementation	TY2Q3	Choose an item.	Click or tap here to enter text.
		Identify a need of current population served and select a community partner to establish new partnership to meet the identified need	Implementation	TY2Q4	Choose an item.	Click or tap here to enter text.
		Use tools and provide support for chronic illness care that is language and culturally appropriate; Use teach back to ensure patient understands education and measure engagement	Scale & Sustain	TY2Q4	Training Needs	Population target suggestions; Training suggestions; Potential partner identification and/or introduction Templates for policy, or agreement

System Change						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
Complete health equity, stigma, and trauma informed care assessment	Assessment completed	Identify a team within our organization to support the assessment process.	Planning	TY3Q3	Choose an item.	Click or tap here to enter text.

System Change						
Tactic	Tactic Measures	Key Tasks for this Tactic	Phase	Completion Date	Type of Assistance	Assistance Description
	Click or tap here to enter text.	Identify consultant to support our organization in a facilitated assessment.	Planning	TY3Q3	Technical Assistance	Will want to work with SWACH to identify a consultant to support us in a facilitated assessment. We will be interested in any recommendations on assessments tools and organizing an internal team to support assessment efforts.
		Work with consultant to identify an assessment tool.	Planning	TY3Q3	Choose an item.	Click or tap here to enter text.
		Work with team to ensure assessment is completed.	Planning	TY3Q3	Choose an item.	Click or tap here to enter text.
Complete a plan to address health equity, stigma and trauma informed care	Plan completed	Develop an action plan that strengthens internal policies and procedures such as hiring practices, governance, program delivery, data disaggregation.	Planning	TY3Q4	Choose an item.	We will need support on how to build off the assessment results and build this into an action plan.
	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.
		Click or tap here to enter text.	Choose an item.	Choose an item.	Choose an item.	Click or tap here to enter text.

Racial Equity Lens

Surface Assumptions and Set Outcomes

- What assumptions are we bringing into the issue?
- What is/are the outcome(s) we are hoping to create
- How will these outcomes increase or decrease racial equity?
- How will these outcomes increase or decrease other forms of equity?

Engage Multiple Perspectives

- How are we intentionally engaging multiple perspectives?
- How are we engaging stakeholders who will be impacted by this policy, decision, or practice?

Attend to Unintended Outcomes

- What are the potential unintended outcomes? How will you address these?
- What barriers exist to more equitable outcomes? How will you address these?

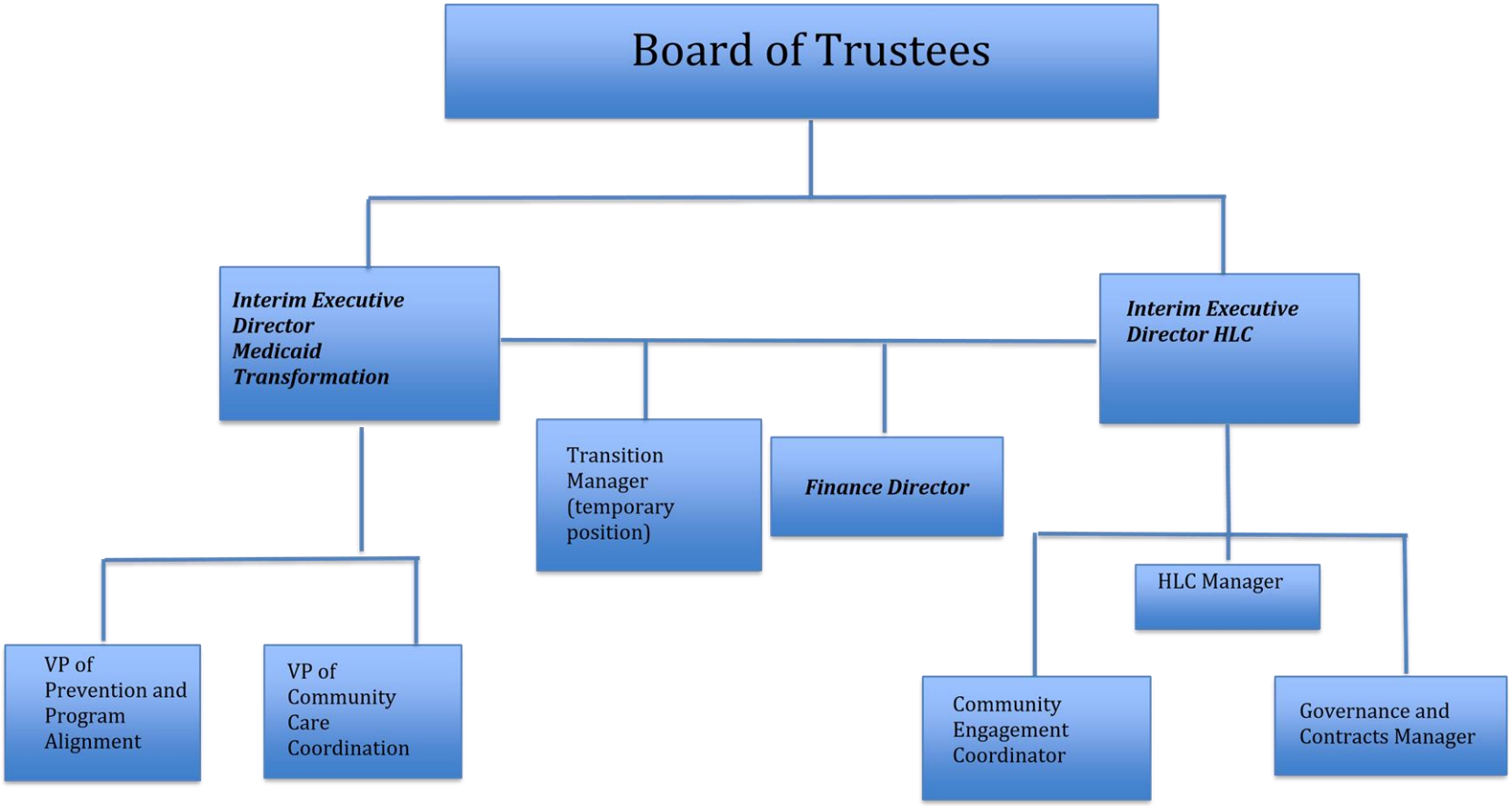
Communicate

- How and when will the process be communicated?
- How and when will decisions, policies, and practices be communicated?
- Howe will you ensure communication takes place in an inclusive, culturally sensitive, and responsible manner?

Evaluate

- How will feedback from staff and stakeholders be collected?
- Who will we share evaluations with?
- What did we learn from this?
- How will we incorporate this learning next time?
- How will you use evaluation and learning to raise racial awareness?

Center for Equity & Inclusion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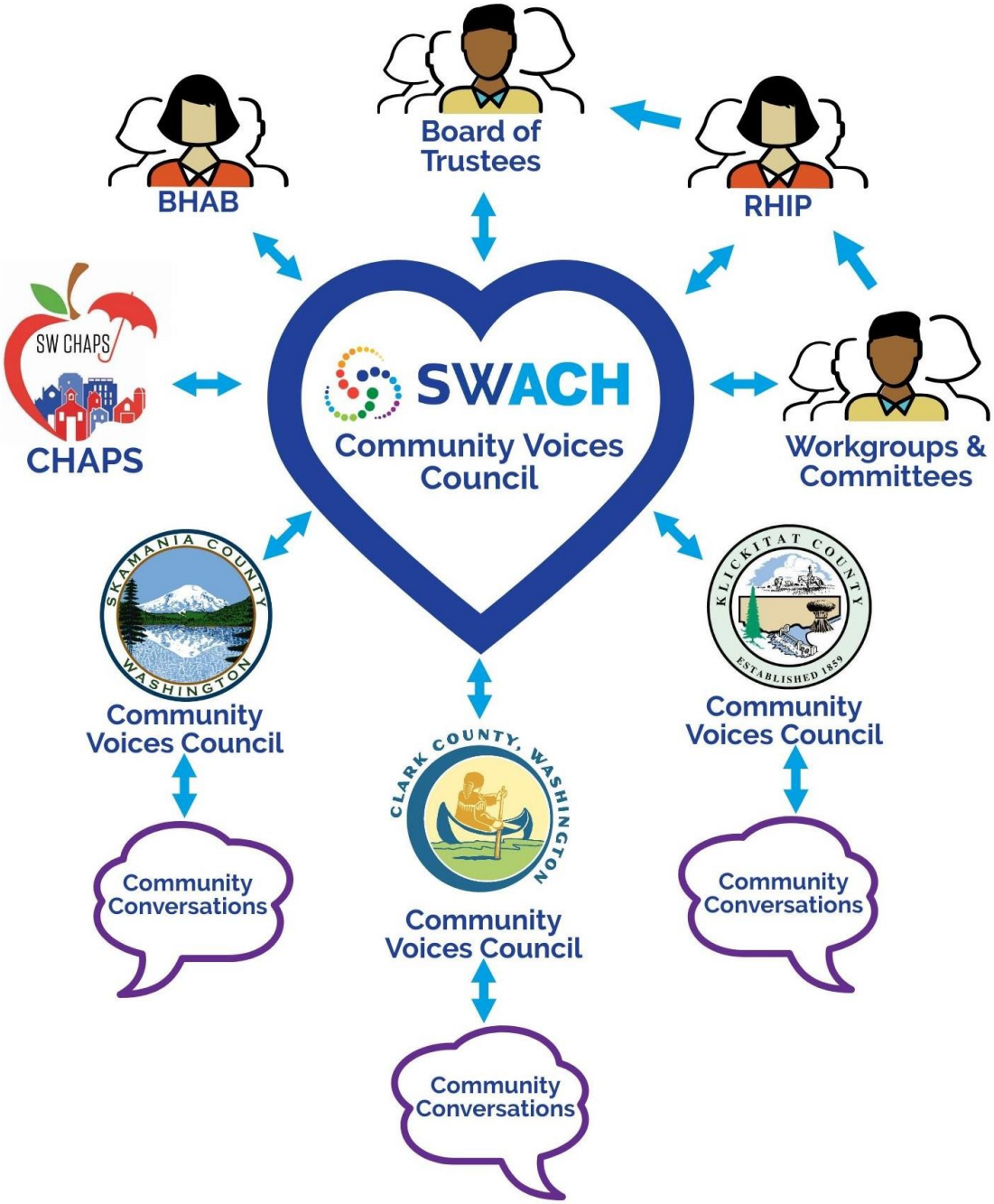
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