

State Health Care Innovation Plan Annual Status Report

Engrossed Second Substitute House Bill 2572, Chapter 223, Laws of 2014,
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State Health Care Innovation Plan Annual Status Report



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Executive Summary

The five-year State Health Care Innovation Plan created a framework for health system transformation that is far-reaching in its core strategies for achieving better health, better care, and lower costs for at least 80 percent of Washingtonians.

The Innovation Plan, now called Healthier Washington, gained strong support in the 2014 legislative session with bipartisan passage of Engrossed Second Substitute House Bill (E2SHB) 2572 and related funding to further develop Healthier Washington elements. This was followed by the \$65 million federal award of a Round Two Model Test grant, which launched in February 2015. In 2016, the State reached agreement in principle on a five-year Medicaid Transformation Demonstration for up to \$1.5 billion that will accelerate the aims of Healthier Washington. This 2017 annual status report summarizes progress toward achieving the aims of Healthier Washington and anticipated future efforts.

Healthier Washington builds the capacity to move health care purchasing from volume to value, improve the health of state residents, and deliver coordinated whole-person care.

In 2016, Healthier Washington transitioned largely from design to significant implementation of a three-year test under the federal grant. Activities fulfilled requirements outlined in E2SHB 2572 and implementation of Healthier Washington efforts broadly. Progress included the following accomplishments.

- Nearly 11,000 public employees enrolled in new networks of clinically integrated delivery systems that are rewarded for the quality and value of care delivered.
- The Health Care Authority (HCA) launched fully-integrated physical and behavioral health care purchasing in the Southwest Washington region of Clark and Skamania counties, providing a model as the state transitions to statewide integrated Medicaid purchasing by 2020.
- Accountable Communities of Health statewide moved to collective action to address community health priorities.
- Washington became the first state in the nation to formally review, certify and advocate the use of high-quality patient decision aids as part of an effort to adopt and spread shared decision making.

Healthier Washington also advanced efforts surrounding clinical practice transformation to support providers in moving to integrated and value-based systems, aligned performance measurement, and improved health care quality and price transparency.

Significant progress has been made in achieving the aims of Healthier Washington. The State's efforts and resources over the years were critical in positioning the state for successful implementation of the effort. The \$65 million infusion of federal resources over four years and the



five-year Medicaid Transformation Demonstration, as well as continued legislative consultation, will ensure that Washington State remains a leader in health system transformation and achieves its goals of better health, better care, and lower costs by 2019.

Background

Building upon previous state efforts to accelerate better health and health care at lower cost, the federal Center for Medicare & Medicaid Innovation (CMMI) in 2013 awarded Washington State nearly \$1 million to develop a five-year State Health Care Innovation Plan. Washington was one of three states in the nation to receive a State Innovation Models (SIM) Pre-Testing Award.

With HCA as the coordinating agency, the planning grant catalyzed bold conversations among a dozen state agencies and hundreds of community members and stakeholders about health and health care strategies to achieve better health, better care, and lower costs. It enabled extensive and rapid cross-community and multi-sector engagement to define the elements necessary to achieve transformative health and health care system change. The resulting Innovation Plan, submitted to CMMI in January 2014, created a framework and systems supports for health system transformation that leverages the state's innovative culture, along with its health and delivery system expertise, to execute Washington's plan, called Healthier Washington.

Healthier Washington encompasses three core strategies:

1. **Pay for value instead of volume, with the state leading by example as “first mover.”** Traditionally, providers of health care services are paid every time they provide a service, even when the service doesn't work. Healthier Washington calls for rewarding providers when they achieve good outcomes. Information on effectiveness and cost will be collected and shared to help providers and consumers choose the best treatment options.
2. **Integrate care and social supports for individuals with physical and behavioral (mental health and substance abuse) comorbidities.** The current system creates barriers to addressing physical health, mental health, chemical dependency, and basic living needs as early as possible and at the same time. Healthier Washington calls for methods of integrating care and connecting with community services to achieve the best possible result for individuals. It also adjusts how we pay for services to make care for the whole person possible.
3. **Build healthy communities and people through prevention and early mitigation of disease throughout the life course.** Virtually all health care is delivered at the local level. Driven by local partners, Healthier Washington calls for a regional approach that provides resources to communities. Working together, communities can bring about changes that will improve health for the people they serve.



Overview of E2SHB 2572

The Innovation Plan gained strong support in the 2014 legislative session with bipartisan passage of E2SHB 2572 and Second Substitute Senate Bill (2SSB) 6312, and funding to further develop Innovation Plan elements in anticipation of a second SIM funding opportunity. The passage of these bills into law provided further support for Healthier Washington elements around quality and price transparency; community mobilization; clinical practice transformation support; and integrated purchasing of physical health, mental health, and substance abuse services on a regional basis.

E2SHB 2572 outlines mechanisms for the State to improve how it purchases health care, a foundational strategy of Healthier Washington.

Provisions include:

- Designating and supporting Accountable Communities of Health (ACHs), regional collaboratives responsible for aligning community actions and initiatives to achieve healthy communities and populations, improve quality and lower costs. This included awarding grants to support the start-up of two pilot communities.
- Using purchasing mechanisms to reduce extraneous medical costs across medical programs. As such, HCA and the Department of Social and Health Services (DSHS) may restructure Medicaid procurement on a phased basis to support integrated physical health, mental health and chemical dependency treatment services, consistent with 2SSB 6312 and recommendations provided by a behavioral health task force. Additionally, HCA will use purchasing and payment incentives for Medicaid and Public Employee Benefits (PEB) that promote quality, efficiency, cost savings, and health improvement.
- Establishing a statewide all-payer claims database (APCD)—to which public purchasers must submit claims data—to support transparent public reporting of health care information. Data suppliers, including carriers and self-funded employers, may submit claims data voluntarily.
- Developing standard statewide health performance measures through creation of a Governor-appointed performance measures committee tasked with identifying and recommending statewide performance measures through a transparent process that includes opportunities for public comment.

State Innovation Models Grant

The State Health Care Innovation Plan and landmark legislation form the basis of Washington's State Innovation Models Round Two Model Test grant, which was awarded by CMMI in December 2014. The Healthier Washington grant builds the capacity to move health care purchasing from volume to value, improve the health of state residents, and deliver coordinated whole-person care.

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The \$65 million effort makes targeted investments in five foundational areas to achieve health system transformation:

1. **Community empowerment and accountability.** Washington is driving local innovation through Accountable Communities of Health (ACHs), which develop a sustainable presence in their communities and partner with the State to achieve Healthier Washington goals. Regionally organized ACHs align the activities and investments of diverse sectors—providers, public health, housing, education, social service providers, health plans, county and local government, philanthropy, consumers, businesses, and Tribes—to drive integrated delivery of health and social services and improve population health. ACHs will be held accountable for performance results and rapid-cycle learning and improvement.
2. **Practice transformation support.** The Practice Transformation Support Hub supports providers across the state to effectively coordinate care, increase capacity, and benefit from value-based reimbursement strategies. Housed at the Department of Health (DOH), the Hub capitalizes on consultant and community expertise in clinical practice transformation. This investment area also supports shared decision making tools to engage individuals and families in their health, and strengthens Washington’s multi-disciplinary workforce.
3. **Payment redesign.** In partnership with purchasers, providers and payers, Washington is leveraging its purchasing power to be the first mover in shifting 80 percent of the health care market from traditional fee-for-service to integrated, value-based payment models. Healthier Washington implements four payment and delivery test models to integrate physical and behavioral health, pioneer new payment methodologies for the state’s primary care and rural health delivery system, and applies the State’s purchasing power to drive accountable delivery and payment models.
4. **Analytics, interoperability and measurement.** New analytical infrastructure for monitoring and reporting on health system performance will support broad deployment of common performance measures to guide health care purchasing. Healthier Washington invests in an innovative solution portfolio that builds analytic and measurement capacity and develops a diverse tool set needed for the translation and visualization of data from multiple sectors into actionable information.
5. **Project management.** Implementation is coordinated through a public-private leadership network with a dedicated interagency team and legislative oversight. Strategic investments in accountable project management ensure real-time evaluation and continuous improvement on all Healthier Washington initiatives.





In February 2016, the Healthier Washington grant transitioned from a design year—intended to allow for onboarding of staff and consultants, refinement of the grant budget and other pre-implementation activities—to a three-year Model Test. From February 2016 through January 2019, Healthier Washington will advance implementation of the grant's investment areas and perform on accountability targets.

Medicaid Transformation Demonstration Project

In November 2016, after months of detailed negotiations, HCA—in partnership with DSHS—and the federal Centers for Medicare & Medicaid Services (CMS) reached an agreement in principle on a five-year Medicaid demonstration waiver to continue and accelerate implementation of Healthier Washington. The five-year demonstration provides up to \$1.1 billion of incentives for delivery system reform and \$375 million to support critical services for Apple Health clients over five years. The demonstration's goals reinforce the overarching goals of Healthier Washington, of which the

Medicaid Transformation Demonstration is an implementation mechanism. The goals of the five-year demonstration are as follows:

- Reduce avoidable use of high-cost services such as acute care hospitals, psychiatric hospitals, and nursing home facilities;
- Improve population health, with a focus on prevention and proactive management of diabetes and cardiovascular disease, pediatric obesity, smoking, mental illness, and substance abuse for Apple Health clients;
- Accelerate Medicaid payment reform to pay providers for better health outcomes; and
- Bend the Medicaid cost curve below national trend.

With an agreement in principle in place, HCA spent the remainder of 2016 negotiating with CMS the specific terms of the demonstration, with execution and implementation of the effort expected to launch in early 2017.

Action and Progress toward Achieving the Aims of the Innovation Plan

Significant progress was made in 2016 in advancing the aims of Healthier Washington. While Healthier Washington has multiple implementation mechanisms—including the SIM Test grant, foundational legislation, philanthropic support, and the Medicaid Transformation Demonstration—much of the work accomplished in 2016 to implement elements of Healthier Washington was catalyzed by the Healthier Washington grant.

Healthier Washington grant expenditures in the previous year totaled nearly \$7.2 million, and the grant budget for 2016 is approximately \$25 million. A summary of Healthier Washington grant expenditures to date is included in Appendix A.

Three areas of notable progress are highlighted below: Paying for Value, Accountable Communities of Health, and shared decision making—all of which have strong legislative foundations and have been guided throughout the year by legislative consultation.

For more information on 2016 accomplishments, please see Appendices B and C for Healthier Washington grant quarterly reports to CMMI.

Paying for Value

Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019. In achieving this vision, Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend. Paying for



value is key to achieving the triple aim of better care, smarter spending and healthier populations and—most importantly—ensuring that systems contribute to the health of the whole person. Meeting this goal will require shifting reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes as measured by the common measure set. Washington State will utilize its position in the marketplace to drive transformation as both a “first mover” and “market convener.”

Washington State purchases health care coverage for more than 2 million people through Medicaid and the Public Employee Benefits Program, making it the largest health care purchaser in the state. As part of Healthier Washington, the State is leveraging its purchasing power to lead by example and accelerate the adoption of value-based reimbursement and alternative payment strategies. This “Paying for Value” strategy is exemplified by Healthier Washington’s payment redesign models. In April 2016, Washington began purchasing Medicaid services in 10 regional service areas throughout the state. For public employees, our movement toward value began in the Puget Sound region. While work has progressed on all Healthier Washington payment model tests in 2016, two models achieved significant milestones that changed care and payment for Washington providers and consumers in 2016.

State employees receive value through Accountable Care Networks

Nearly 11,000 public employees enrolled in two new UMP Plus networks in the five-county Puget Sound region in 2016. The program was launched in January in collaboration with Puget Sound High Value Network and the University of Washington Medicine Accountable Care Network and pays providers based on the value of care delivered. Measures of value include state employees’ satisfaction with their health care experience, as well as improved health outcomes. HCA contracts directly with these two clinically integrated delivery systems that are accountable clinically and financially for the care of enrolled state employees and their families.

Both UMP Plus networks implement the following accountability and health transformation requirements:

- **Shared risk.** Both networks are at risk for meeting specific financial and quality targets.
- **Member experience.** Both networks offer timely and convenient access to primary care and specialty providers, as well as expanded service hours for primary care and urgent care, along with 24/7 consulting nurse and tele-urgent care services.
- **Care transformation.** The Accountable Care Networks must provide appropriate, evidence-based care as recommended by the Dr. Robert Bree Collaborative. The appropriate infrastructure is needed to perform expected rapid-cycle improvements, so the networks are required to have electronic medical records and other infrastructure to integrate clinical and claims data.



- **Data.** Providers need data in order to be financially and clinically accountable for a population. The State shares medical and pharmacy data with the networks to integrate into workflow and direct patient care.
- **Benefit design.** To incent state employee participation, the networks offer a unique benefit design to further improve member experience and promote the use of high quality health care services. Features include 30 percent lower monthly premiums than the UMP Classic plan, lower medical and prescription drug deductibles, and no cost-sharing for office visits to primary care network providers. Plus, members who complete a wellness assessment and earn a wellness incentive will pay no or a reduced medical deductible.

In 2017, the networks will expand their reach to four additional counties: Grays Harbor, Skagit, Spokane and Yakima.

While targeted, the effects of this payment model test will extend beyond state employees to the Washington delivery system. To meet financial and health transformation contractual requirements, network partners are re-engineering their systems of care infrastructure, which will benefit all people who receive care within the network and its partners, regardless of payer.

Early adoption of fully integrated managed care

Critical to advancing the health of the whole person is the integration of behavioral health and physical health services in a seamless delivery and payment system. Building upon the commitment by the Governor and legislature in E2SHB 2572 and 2SSB 6312, Washington has the following mandate: By 2020, Medicaid beneficiaries in every service area in Washington will be served by managed care systems providing a fully-integrated set of physical and behavioral health services.

The transition was accomplished this year in two phases. On April 1, HCA launched fully-integrated managed care in the Southwest Washington region of Clark and Skamania counties. The Regional Support Network (RSN) in Southwest Washington ceased operations, and Medicaid beneficiaries transitioned to coverage by one of two fully-integrated managed care plans of their choosing: Molina Health Care of Washington or Community Health Plan of Washington. Additionally, HCA and Beacon Health Options launched a regional crisis response system to replace and improve upon the prior mental health crisis system managed through the RSN.

In the remainder of the state, care is delivered through separate but closely coordinated behavioral health and physical health managed care contracts. As the managed care systems gain experience with the integrated model in the Southwest region, the remaining regions have been given the opportunity to convert in subsequent contracting cycles; all regions will be converted by 2020. In fall 2016, the North Central region of Grant, Douglas and Chelan counties committed to adopting fully integrated physical and behavioral health through managed care in January 2018.

Since April, HCA and the managed care plans have seen anecdotal improvement for Southwest Washington's nearly 101,000 Medicaid beneficiaries who receive the full continuum of physical and behavioral health benefits through the plans. Enhanced accountability and coordination has

resulted in standardized processes for the plans, as well as early results that include decreased emergency department use. More information can be found in a report on the first 90 days of the delivery of whole-person care in Southwest Washington (Appendix D).

The leadership shown by the counties and the Southwest Washington Accountable Community of Health has set the stage for longer-term sustainability of the fully-integrated model. Their investment of time, talent and local resources in convening partners and confirming a commitment to the success of the integrated model not only helped assure continuation of services to their own residents, but sets an example for other regions to follow.

The transition to a fully-integrated managed care system in 2020 will be informed by the experience gained in the first Early Adopter region as well as the investments in the Practice Transformation Support Hub. The Hub—focused on delivery system transformation—has designated primary care and behavioral health integration as one of its areas of focus; DOH staff have been collaborating with leaders in Southwest Washington, as well as examining models that can be brought to clinical practices throughout the state.

Accountable Communities of Health

Accountable Communities of Health (ACHs) bring together leaders from multiple sectors around the state with a common interest in improving health and health equity. ACHs align priorities, resources and action to improve whole-person health and wellness. Specifically, ACHs:

- Promote health equity across the state;
- Address issues that affect health through local health improvement plans;
- Support local and statewide initiatives such as clinical practice transformation and value-based purchasing; and
- Better align resources and activities that improve whole-person health and wellness.

In 2016, all nine ACHs statewide were designated and moved to collective action based on community priorities. Each ACH's initial focus is slightly different, based on regional context, priorities, stakeholders and resources, but there are themes in the health issues addressed and strategies being implemented across multiple regions. Consistent across all ACHs is the theme of improving access to needed services. Ranging from primary care to chronic disease management, behavioral health, and non-clinical or social services, each ACH is striving to improve access to services that will improve health in their regions.

For more information on ACH progress and regional efforts, refer to Appendix E and Appendix F.



ACH Regions Map



HCA 82-008 (7/15)

The Medicaid Transformation Demonstration Project beginning in 2017 will leverage ACHs to transform the Medicaid care delivery system at the local level. Each region, through its ACH, will pursue projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely. The projects will be aimed at health systems capacity building, care delivery redesign, and prevention and health promotion. Each ACH will engage with providers, health plans, social services and other partners in their region to develop project plan proposals tailored to community needs and priorities. Once an ACH's project plan is approved, the ACH will coordinate the project. This is not a grant. ACHs and their partners will receive funds only upon meeting project goals. In the early years of the five-year demonstration, payments will be based on meeting process milestones. Later, payments will be based on improvements in outcome measures.

Shared Decision Making

In 2016, Washington state became the first in the nation to formally review, certify and advocate the use of high-quality patient decision aids as part of an effort to adopt and spread shared decision making as an innovative and evidence-based practice. This milestone builds upon legislation passed in 2007 and 2012, which included granting authority to HCA's chief medical officer to certify patient decision aids.

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Patient decision aids are tools that help people engage in shared health decisions with their health care provider. Research shows that use of patient decision aids leads to increased knowledge, more accurate risk perception, and fewer patients remaining passive or undecided about their care.

With a grant from the Gordon and Betty Moore Foundation, HCA worked with state and national stakeholders to develop a process to certify patient decision aids. Washington State's leadership in creating the decision aid certification process provides a model that other states can adopt.

HCA began accepting patient decision aids for certification in spring 2016, and in August announced the certification of four patient decision aids focused on maternity care.

The state's two Accountable Care Networks are integrating shared decision making strategies into their practices. In the coming years, HCA intends to certify patient decision aids focused on spine care/joint replacement, cardiac care, and end-of-life care.

More Healthier Washington Progress

In addition to the accomplishments outlined above, Healthier Washington has made progress on other efforts outlined in E2SHB 2572 aimed at delivery system support to effectively coordinate care, increase capacity, and benefit from value-based reimbursement opportunities. These activities are briefly described below.

Practice Transformation Support Hub

The Practice Transformation Support Hub supports transformation of the health delivery system through investment in knowledge, training and tools that effectively coordinate care, promote clinical-community linkages, and transition to value-based payment models. In 2016, the Hub—coordinated by the Department of Health—procured the consultant services of state experts that will provide practice coaching, facilitation and training services, launch a web-based resource portal that provides a clearinghouse of curated resources and training, and launch a regional network that will connect clinical providers with community supports. These training and coaching resources and tools will support the state's clinical providers as they integrate physical and behavioral health care services, deliver care in value-based systems, and align clinical practice with community-based services.

Measurement

The passage of E2SHB 2572 required the development of a statewide common measure set to inform health care purchasing. With the 2014 adoption of a “starter” set of 52 measures across the domains of prevention, chronic illness and acute care, the state's Performance Measures Coordinating Committee continues to evolve with state priorities and will be consistent with other measure sets to reduce provider burden. Since the adoption of the “starter” set of measures, the Committee has recommended the addition of performance measures related to behavioral health and pediatrics. The common measures are included in State-financed contracts, and in 2017 a subset of the measures will be linked to financial incentives in Apple Health and PEBB contracts.



All-Payer Claims Database

The Legislature in 2015 built upon E2SHB 2572 and passed legislation that established a statewide all-payer health care claims database (APCD) to support transparent public reporting of health care information. All payers in Washington will be required to submit health care information to the APCD. The Office of Financial Management (OFM) is overseeing this work. OFM in 2016 contracted with a lead organization to develop the APCD, and it is anticipated that the APCD will be fully functional by the end of 2017.

Next Steps

Washington State is leading the nation in implementation and achievement of the triple aim of better care, smarter spending and healthier populations. Foundational legislation, the award of the Healthier Washington grant, and the agreement in principle to implement a Medicaid Transformation Demonstration Project have facilitated the alignment of strategies and accelerated action toward the state's goals to pay for value, integrate care to serve the whole person, and link clinical and community supports. Maintaining momentum and engaging the right partners across the state in clinical practices, communities, business and others to spread effective models and perform on the established aims will be critical in the coming year as we continue to work toward a healthier Washington.





Grant Years 1&2 Combined - Budget Status Report

Partner Agency Activity by Investment Area

Expenditures for February 2015-October 2016

Source: Enterprise Agency Financial Reporting

All Partner Agencies By Investment Area	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	FTE's Spent
Community Empowerment	\$ 6,639,396	\$ 6,206,541	\$ 432,855	93%	5.0
Practice Transformation	\$ 4,797,045	\$ 1,172,714	\$ 3,624,331	24%	5.0
Payment Redesign	\$ 3,440,897	\$ 1,427,394	\$ 2,013,503	41%	3.8
Analytics, Interoperability & Measurement	\$ 12,099,357	\$ 4,270,759	\$ 7,828,598	35%	13.4
Project Management	\$ 5,571,163	\$ 4,238,442	\$ 1,332,721	76%	11.3
TOTAL	\$ 32,547,858	\$ 17,315,851	\$ 15,232,007	53%	38.5

HCA	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	28.0 FTE's
Community Empowerment	\$ 6,217,283	\$ 6,099,259	\$ 118,024	98%	2.7
Practice Transformation	\$ 2,225,812	\$ 690,257	\$ 1,535,555	31%	1.0
Payment Redesign	\$ 3,392,015	\$ 1,421,191	\$ 1,970,824	42%	3.8
Analytics, Interoperability & Measurement	\$ 9,922,040	\$ 3,020,458	\$ 6,901,582	30%	7.4
Project Management	\$ 5,241,582	\$ 3,986,893	\$ 1,254,689	76%	9.9
TOTAL	\$ 26,998,731	\$ 15,218,058	\$ 11,780,674	56%	24.80

DOH	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	FTE's Spent
Community Empowerment	\$ 253,443	\$ 49,127	\$ 204,316	19%	1.3
Practice Transformation	\$ 2,515,888	\$ 427,113	\$ 2,088,775	17%	4.0
Payment Redesign	\$ 48,882	\$ 6,203	\$ 42,679	13%	
Analytics, Interoperability & Measurement	\$ 1,328,954	\$ 834,317	\$ 494,637	63%	1.0
Project Management	\$ 123,020	\$ 98,788	\$ 24,232	80%	0.5
TOTAL	\$ 4,270,187	\$ 1,415,549	\$ 2,854,638	33%	6.8

DSHS	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	5.2 FTE's
Community Empowerment	\$ 168,670	\$ 58,154	\$ 110,516	34%	1.0
Practice Transformation	\$ 55,345	\$ 55,345	\$ 0	100%	
Payment Redesign	\$ -	\$ -	\$ -		
Analytics, Interoperability & Measurement	\$ 319,859	\$ 64,443	\$ 255,416	20%	2.0
Project Management	\$ -	\$ -	\$ -		
TOTAL	\$ 543,874	\$ 177,942	\$ 365,932	33%	3.0

DSHS - RDA	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	FTE's Spent
Community Empowerment	\$ -	\$ -	\$ -		
Practice Transformation	\$ -	\$ -	\$ -		
Payment Redesign	\$ -	\$ -	\$ -		
Analytics, Interoperability & Measurement	\$ 528,504	\$ 358,318	\$ 170,187	68%	3.0
Project Management	\$ -	\$ -	\$ -		
TOTAL	\$ 528,504	\$ 358,318	\$ 170,187	68%	3.0

OFM - GOV OFFICE	Budget GY1 & 2	Total Spent GY1 & 2	Balance GY1 & 2	Total % Spent	0.9 FTE's
Community Empowerment	\$ -	\$ -	\$ -		
Practice Transformation	\$ -	\$ -	\$ -		
Payment Redesign	\$ -	\$ -	\$ -		
Analytics, Interoperability & Measurement	\$ -	\$ -	\$ -		
Project Management	\$ 206,561	\$ 145,985	\$ 60,576	71%	0.9
TOTAL	\$ 206,561	\$ 145,985	\$ 60,576	71%	0.9

Healthier Washington

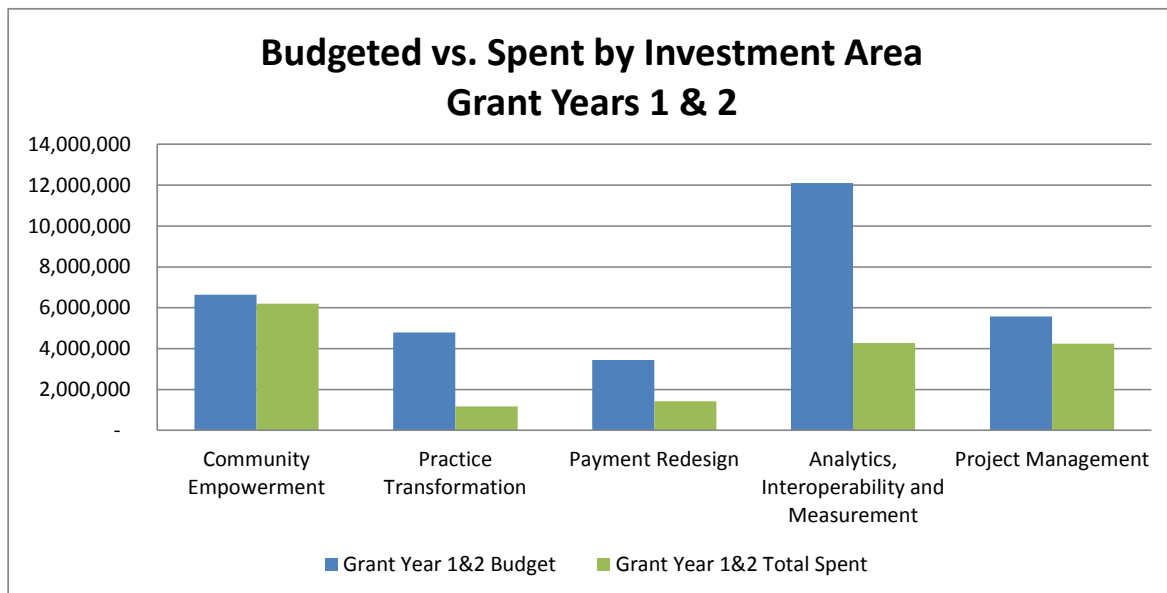
Grant Years 1 & 2 - Budget Status Report

Expenditures for February 2015 - October 2016

Combined expenditures for all Partner Agencies (HCA, DOH, DSHS, OFM-GOV)

From: Enterprise Agency Financial Reporting

	Grant Year 1&2 Budget	Total Spent	
Community Empowerment	6,639,396	6,206,541	93%
Practice Transformation	4,797,045	1,172,714	24%
Payment Redesign	3,440,897	1,427,394	41%
Analytics, Interoperability and Measurement	12,099,357	4,270,759	35%
Project Management	5,571,163	4,238,442	76%
	32,547,858	17,315,851	53%



Washington State Innovation Models 1st Quarter Progress Report

February 1 – April 30, 2016

The Healthier Washington team submits quarterly reports to the Center for Medicare and Medicaid Innovation (CMMI) focusing on the progress made toward the program milestones and goals of the Healthier Washington initiative.

The information here follows CMMI's request to highlight only a few Healthier Washington elements within the specified progress report domains below. Within this summary, you will find highlights of the successes and lessons learned from this past quarter. To submit questions or feedback go to www.hca.wa.gov/hw to contact the Healthier Washington team.

Success Story or Best Practice

- Model 1 / Early Adopter of Fully Integrated Managed Care Program went “live” on April 1, 2016. Only a few operational issues surfaced and were managed quickly. The ACH in the region has published a robust set of “lessons learned” to help the state learn from this ground-breaking experience, and inform the planning for other regions to adopt. (Note: North Central regional service area has declared their intention to fully integrate before 2020.)
- HCA announced in April its process to receive submissions of Patient Decision Aids to be certified by the HCA chief medical officer, with input from a review panel of subject matter experts and an expert evidence review where needed. A full strategic communications plan is being assembled with FAQs, fact sheets, and other key materials produced for outreach to stakeholders and potential participants.
- Healthier Washington co-sponsored a conference on value-based purchasing. Other co-sponsors included King County, the Washington Health Alliance, and the Washington Roundtable. Attendance included more than 90 health care stakeholders, representatives from purchasers, providers, health plans, brokers and other interested parties. Feedback from attendees was overwhelmingly positive. Feedback from the conference will be used to shape future events and to spread and scale strategies.

Challenges

Encounter-based to value-based payment model has held several working sessions with stakeholders on developing a workable model for community access hospitals. The team is developing an acceleration plan in an attempt to preserve the January, 2017 pilot date.

The Greater Washington multi-payer model has continued to evolve from a both policy and procedure perspective, from a data aggregation strategy to an advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. A plan is being developed to expedite a final decision and move forward.

One of the biggest risks we've experienced on the SIM program is the ability to use of all of the SIM funding available to the state. A dramatic under-spend in Grant Year 1 positioned HCA to aggressively plan a compression of the spend in Grant Year 2. Our carryover agreement has been submitted. We are waiting on CMS to approve the carryover agreement and allow us to finalize our Year 2 budget. The

operations team closely monitors expenditures by each team and is prepared to assist all team leads in processing payments. Robust dashboards have been developed to enable the team to stay on track.

Governance

No changes have occurred in governance of the Analytics, Interoperability and Measurement (AIM) team in this period, however, an AIM director was appointed. Additionally, AIM hired five new team members, including two data scientists, two data analysts, and one technical analyst. Nearly 90 percent of AIM funded positions have been filled.

Patricia Lashway was appointed to the Healthier Washington Executive Governance council upon her appointment as Interim Secretary of the state Department of Social and Health Services. Secretary Lashway replaced Kevin Quigley as DSHS Secretary on the governance council.

The Healthier Washington Core Team (a key decision-making group) now meets bi-weekly and during the “off” weeks the time is used to “design” work for the upcoming meeting. Meetings are now much more informative and allow for cross-cutting dialogue.

Stakeholder Engagement

Accountable Communities of Health (ACH) held bi-weekly development council calls with ACH leads. Q1 topics included “consumer” engagement, Medicaid transformation, value-based purchasing, practice transformation and sustainability. A quarterly convening was held in March with an emphasis on Medicaid transformation, community engagement and ACH projects/evaluation.

To support integration of physical and behavioral health in our early adopter region, daily calls took place with the fully-integrated managed care plans, county officials, ACH representatives, and behavioral health providers. The calls promptly identified and resolved implementation issues. The Health Care Authority convened the Early Warning System Steering Committee comprised of county officials, ACH representatives, behavioral and physical health providers, criminal justice system representatives, managed care plans, and consumers.

The team working on alternative payment models for federally qualified health centers (FQHC) and rural health clinics (RHC) has held several convenings with stakeholders to advance both lines of work:

A Paying for Value conference was co-sponsored with King County, the Washington Health Alliance and the Washington Business Roundtable.

In April, a webinar series was launched, starting with the “ACP: Concept to Contract,” to educate health stakeholders on different components of the Accountable Care Program.

The Performance Measures Coordinating Committee convened in March to discuss ongoing evolution of the common measure set and what topic areas should be reviewed.

Meetings were held with stakeholders to develop a new multi-payer pilot strategy (model 4).

The AIM team collaborated with the three identified AIM-ACH liaisons. AIM also was the focus of a Healthier Washington quarterly webinar.

Population Health

The External Advisory Board for the Plan for Improving Population Health (P4IPH) has begun convening under the leadership of Dr. Gary Goldbaum. The External Advisory Board is working to identify key focus areas that will serve as a starting point for the P4IPH framework. CMMI has refocused our efforts on process and we have decided on a dynamic website for the P4IPH final product.

ACH leaders continued to engage as members of the P4IPH External Advisory Board. Developments focused on strategies to ensure investments are sustainable, including delivery system transformation and clinical-community linkages as a critical step toward upstream investment.

Health Care Delivery System Transformation

The first quarter of GY2 (Feb-April) was focused on the request for proposal (RFP) development for the three Practice Transformation Support Hub components:

1. practice coaching, facilitation and training,
2. regional health connectors, and
3. the web-based Resource Portal.

The Practice Transformation Support Hub director departed in February and the team carried on to complete the RFPs and publish them. Responses were due April 25.

A significant decision was made to negotiate an inter-agency agreement with the University of Washington to use their web design and content curation services. The vendor selection decisions made with regards to RFPs 1 and 2 will allow us to finalize our plans to deploy connectors in every region as well as the ability to offer coaching and training services.

Payment and/or Service Delivery Model(s)

The Health Innovation Leadership Network (HILN) focused its April quarterly meeting on paying for value, demonstrating for health system leaders across the state the roles of providers, purchasers, consumers and others in transforming the system through incentives.

In February and March the Health Care Authority held “knowledge transfer” sessions for the early adopter region between the two fully-integrated managed care organizations (MCOs), various stakeholder groups across the state and the Southwest Washington community. These sessions provided opportunities to ensure that the MCOs were adequately prepared to accept responsibility for managing behavioral health services in the region. HCA conducted a readiness review of the MCOs to ensure adequate networks, policies and procedures were in place before implementation. On April 1, fully-integrated managed care launched in Clark & Skamania counties for 120,000 Medicaid beneficiaries. Between April 1 – April 30 HCA worked with the MCOs and local stakeholders to refine policies and procedures and troubleshoot minor implementation issues.

The payment and delivery redesign work for critical access hospitals focused on specific delivery components that will drive payment redesign discussions. For FQHC/RHC APM 4 development, we have begun to draw clarity around the framework and are addressing detailed issues affecting the model.

The state's accountable care program partners (ACP) continued operations and stabilization after the January 1, 2016 launch. Weekly meetings with both ACP partners occur to monitor implementation, including care transformation activities. Teams and ACP partners engaged in contract amendments and expansion planning to offer the ACP product in additional counties beyond the five-county Puget Sound region in 2017. Spread and scale strategy activities began, starting with a purchaser conference on March 1.

A new vision for a pilot approach to a multi-payer initiative is being designed to leverage an integrated network of small, independent providers.

Leveraging Regulatory Authority

Washington State continues to pursue a Section 1115 waiver from the Centers for Medicare and Medicaid Services. The waiver team issued a statewide solicitation for project ideas to be used in the development of a Medicaid Transformation project framework. It was encouraging to see the number of submissions relating to the integration of physical and behavioral health, which is a key goal under SIM. We continued to engage our ACHs to a significant degree in identifying potential opportunities through the waiver to advance person-centered and value-based care across the state.

Workforce Capacity

The CHW Task Force recommendation report is under review with the objective of integrating recommendations into the Healthier Washington operational plan.

Health Workforce Sentinel Network survey is under development and progressing well with input from various stakeholders. It is on track to have the survey implemented in summer 2016.

Health Information Technology

AIM drafted a request for information (RFI) for a "Business Intelligence/Analytics Platform" and released it on April 2. This document was our first attempt at defining clearly the business, technical and functional requirements of the infrastructure we will need for AIM. We hope to use vendor responses to the RFI to guide the rest of our work in designing, procuring and implementing a "BI/Analytics Platform" to meet our Healthier Washington investment area and stakeholder needs.

Continuous Quality Improvement

The University of Washington evaluation team has finalized its evaluation plan, met with team members working on payment redesign, defined the data elements for evaluation of two proposed payment models, and submitted rapid cycle reflections on the progress of the payment models, HUB, and AIM team support for the SIM evaluation.

The program management team recently began use of a new portfolio management tool called TeamDynamix. The tool allows all team members to see the work list and activities of all other team members. Entries by team members allow senior leaders and project management leaders to view the "health" of the project. While the tool doesn't accommodate all of our team needs, it is a useful work plan tracker that will allow us to build planning capacity in our team leads.

Healthier Washington

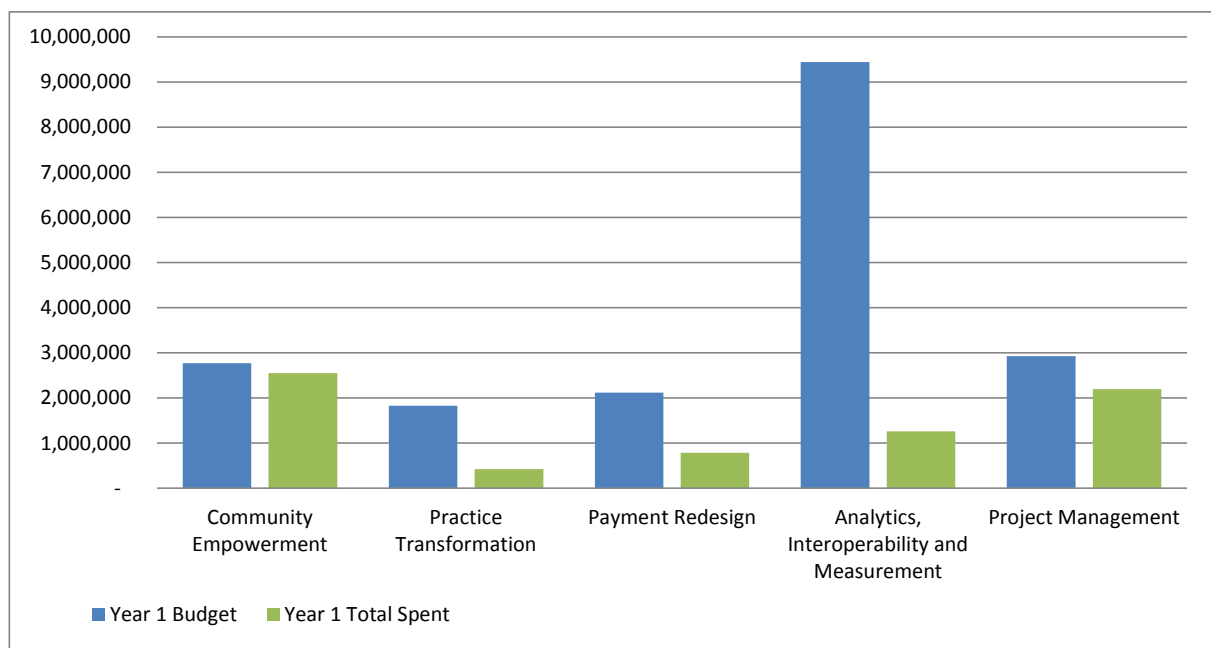
Year 1 Quarter 4 Update - Budget Status Report

Expenditures for February 2015-March 2016

Combined expenditures and FTE's for all Partner Agencies (HCA, DOH, DSHS, OFM-GOV)

From: Enterprise Agency Financial Reporting

	Year 1 Budget	Total Spent	
Community Empowerment	2,769,598	2,551,664	92%
Practice Transformation	1,830,774	428,397	23%
Payment Redesign	2,116,825	784,451	37%
Analytics, Interoperability and Measurement	9,443,606	1,262,484	13%
Project Management	2,923,744	2,194,265	75%
	19,084,547	7,221,261	38%



All Partner Agencies By Investment Area	Year 1 Budget	Dollars Spent					% Spent	FTE's Spent
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 2,769,598	\$ 732,254	\$ 361,678	\$ 134,892	\$ 1,322,841	\$ 2,551,664	92%	4.0
Practice Transformation	\$ 1,830,774	\$ 8,308	\$ 40,341	\$ 60,110	\$ 319,638	\$ 428,397	23%	4.9
Payment Redesign	\$ 2,116,825	\$ 11,801	\$ 174,214	\$ 143,699	\$ 454,737	\$ 784,451	37%	3.6
Analytics, Interoperability & Measurement	\$ 9,443,606	\$ 0	\$ 28,902	\$ 346,670	\$ 886,912	\$ 1,262,484	13%	9.0
Project Management	\$ 2,923,744	\$ 75,640	\$ 197,855	\$ 736,138	\$ 1,184,632	\$ 2,194,265	75%	12.4
TOTAL	\$ 19,084,547	\$ 828,003	\$ 802,989	\$ 1,421,509	\$ 4,168,761	\$ 7,221,261	38%	33.9

HCA	Year 1 Budget	Dollars Spent					% Spent	28.0 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 2,632,894	\$ 732,254	\$ 361,678	\$ 128,595	\$ 1,307,686	\$ 2,530,213	96%	3.0
Practice Transformation	\$ 703,309	\$ 8,308	\$ 40,341	\$ 26,618	\$ 216,898	\$ 292,164	42%	1.0
Payment Redesign	\$ 2,004,756	\$ 11,801	\$ 174,214	\$ 143,699	\$ 454,737	\$ 784,451	39%	3.6
Analytics, Interoperability & Measurement	\$ 7,958,585	\$ 0	\$ 28,902	\$ 259,999	\$ 607,454	\$ 896,354	11%	5.0
Project Management	\$ 2,526,939	\$ 75,640	\$ 197,855	\$ 735,887	\$ 1,103,330	\$ 2,112,713	84%	11.0
TOTAL	\$ 15,826,484	\$ 828,003	\$ 802,989	\$ 1,294,799	\$ 3,690,105	\$ 6,615,896	42%	23.6

DOH *	Year 1 Budget	Dollars Spent					% Spent	7.4 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 39,395					0	0%	
Practice Transformation	\$ 1,030,156			\$ 22,419	\$ 87,777	\$ 110,196	11%	2.9
Payment Redesign	\$ 39,395					0	0%	
Analytics, Interoperability & Measurement	\$ 877,794			\$ 86,671	\$ 151,348	\$ 238,019	27%	1.0
Project Management	\$ 155,010			\$ 251	\$ 21,917	\$ 22,167	14%	0.5
TOTAL	\$ 2,141,750	\$ -	\$ -	\$ 109,341	\$ 261,042	\$ 370,383	17%	4.4

DSHS *	Year 1 Budget	Dollars Spent					% Spent	5.2 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 97,309			\$ 6,296	\$ 15,155	\$ 21,452	22%	1.0
Practice Transformation	\$ 97,309			\$ 11,073	\$ 14,963	\$ 26,036	27%	1.0
Payment Redesign	\$ 72,674					0	0%	
Analytics, Interoperability & Measurement	\$ 227,353					0	0%	
Project Management	\$ 111,336					0	0%	
TOTAL	\$ 605,980	\$ -	\$ -	\$ 17,369	\$ 30,119	\$ 47,488	8%	2.0

DSHS - RDA	Year 1 Budget	Dollars Spent					% Spent	3.0 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	0					0		
Practice Transformation	0					0		
Payment Redesign	0					0		
Analytics, Interoperability & Measurement	\$ 379,874				\$ 128,110	\$ 128,110	34%	3.0
Project Management	0					0		
TOTAL	\$ 379,874	\$ -	\$ -	\$ -	\$ 128,110	\$ 128,110	34%	3.0

OFM - GOV OFFICE	Year 1 Budget	Dollars Spent					% Spent	0.9 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	0					0		
Practice Transformation	0					0		
Payment Redesign	0					0		
Analytics, Interoperability & Measurement	0					0		
Project Management	\$ 130,460				\$ 59,385	\$ 59,385	46%	0.9
TOTAL	\$ 130,460	\$ -	\$ -	\$ -	\$ 59,385	\$ 59,385	46%	0.9

* Grant Year 1 invoicing not final

This report includes expenditures currently claimed against Grant Year 1

Following Federal guidance, further expenditures against Grant Year 1 are pending Carryover approval by CMMI

Healthier Washington

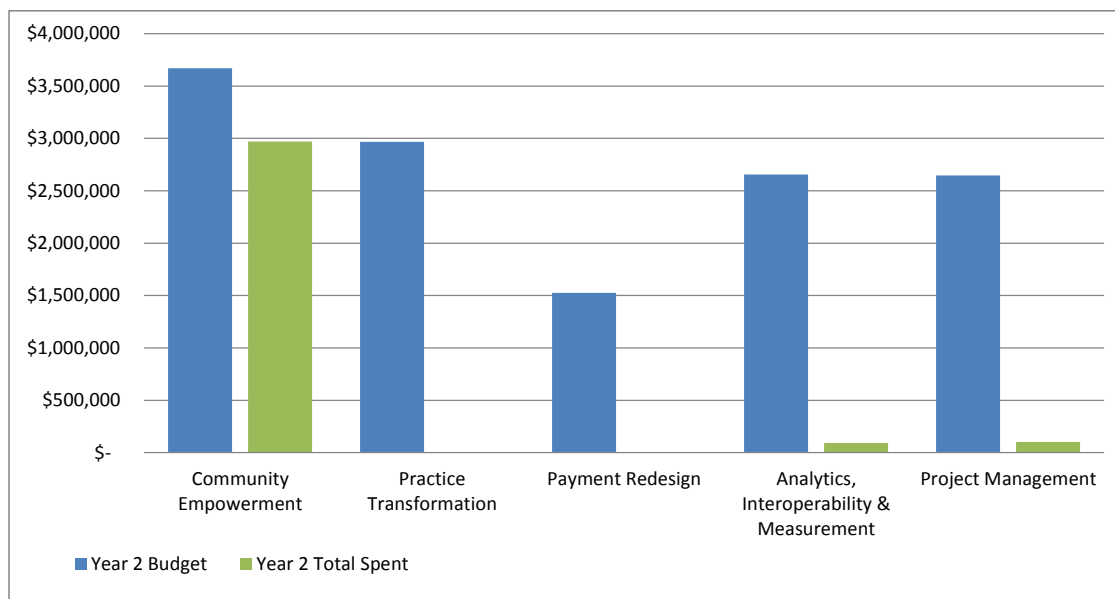
Year 2 Quarter 1 - Budget Status Report

Expenditures for February-April 2016

Combined expenditures and FTE's for all Partner Agencies (HCA, DOH, DSHS, OFM-GOV)

From: Enterprise Agency Financial Reporting

	Year 2 Budget	Total Spent	
Community Empowerment	\$ 3,669,797	\$ 2,970,584	81%
Practice Transformation	\$ 2,966,270	\$ 127	0%
Payment Redesign	\$ 1,524,071	\$ 684	0%
Analytics, Interoperability & Measurement	\$ 2,655,752	\$ 92,814	3%
Project Management	\$ 2,647,420	\$ 100,811	4%
TOTAL	\$ 13,463,310	\$ 3,165,020	24%





Grant Year 2 Quarter 1 Budget Status Report
Partner Agency Activity by Investment Area
Expenditures for February-April 2016
Source: Enterprise Agency Financial Reporting

All Partner Agencies By Investment Area	Year 2 Budget	Dollars Spent					% Spent	FTE's Spent
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 3,669,797	\$ 2,970,584				\$ 2,970,584	81%	
Practice Transformation	\$ 2,966,270	\$ 127				\$ 127	0%	
Payment Redesign	\$ 1,524,071	\$ 684				\$ 684	0%	
Analytics, Interoperability & Measurement	\$ 2,655,752	\$ 92,814				\$ 92,814	3%	
Project Management	\$ 2,647,420	\$ 100,811				\$ 100,811	4%	
TOTAL	\$ 13,463,310	\$ 3,165,020				\$ 3,165,020	24%	

This report includes expenditures currently claimed against Grant Year 2
 Following Federal guidance, further expenditures are pending Grant Year 1 Carryover approval by CMMI
 Interagency Partner budgets and expenditure data will be reported after Grant Quarter 2 (May-July 2016)

Washington State Innovation Models 2nd Quarter Progress Report

May 1 – July 31, 2016

The Healthier Washington team submits quarterly reports to the Center for Medicare and Medicaid Innovation (CMMI) focusing on the progress made toward the program milestones and goals of the Healthier Washington initiative.

The information here follows CMMI's request to highlight only a few Healthier Washington elements within the specified progress report domains below. Within this summary, you will find highlights of the successes and lessons learned from this past quarter. To submit questions or feedback go to <http://www.hca.wa.gov/about-hca/healthier-washington> to contact the Healthier Washington team.

Success Story or Best Practice

The three components of the Hub moved forward this quarter, having negotiated an interagency agreement with University of Washington for a web-based resource portal and having completed the RFP process and named Qualis Health as the Apparently Successful Bidder on contracts to develop a Regional Connectors Network and deliver Practice Coaching, Facilitation and Training.

All nine Accountable Communities of Health (ACHs) submitted plans for their regional health projects by the July 29 deadline.

Read more about this

[Practice Transformation Support Hub](#)

[Accountable Communities of Health](#)

Challenges

Practice Transformation Support Hub. Turnover of leadership on the Practice Transformation Support Hub team delayed the publication of Requests for Proposals for Regional Connectors Network and deliver Practice Coaching, Facilitation and Training. The new director, Mary Beth Brown, has taken the helm and activities have moved forward.

Alternative Payment Model 2: Encounter-based to value-based. The Model 2 team faced significant challenges navigating stakeholder relationships regarding development of alternative payment models for Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs). Over the last quarter the Model 2 team held two working sessions and worked closely with stakeholders to advance model development. In order to meet established timelines and commitments, the Model 2 team is moving forward with a solicitation for FQHCs and RHCs to identify first movers for adoption on January 1, 2017.

Alternative Payment Model 4: Greater Washington Multi-payer. The Model 4 team encountered a challenge when the apparent lead organization withdrew its participation due to unrelated business reasons. Shortly thereafter, the Model 4 team engaged in exploratory discussions with other interested provider groups and payers. Subsequent discussions have been positive and productive. The Model 4 team is currently working with interested providers and payers to finalize a statement of work and contract in the third quarter with a launch date on or before January 1, 2017.

Plan for Improving Population Health. There were challenges when, based on CMMI feedback, the Department of Health (DOH) modified the Plan's direction. Some external stakeholders had hoped it would primarily focus on upstream prevention. Our modified direction emphasizes both clinical and upstream, with a focus on aligning their respective strategies and resources. We are addressing stakeholders' input with a structured feedback process, including multi-sector partner events.

Governance

There were no substantive changes to the Healthier Washington governance structure in the second quarter, though there have been some noteworthy developments:

- The Healthier Washington Leads team continues to meet as a way for project leads to discuss internal processes, get peer-to-peer feedback and guidance on operational tasks and project maturation, and elevate decisions to the Healthier Washington core team. It was decided that the leads group should be officially chartered as a way to solidify the purpose and responsibility of the group within the SIM effort.
- The third Healthier Washington Summit was held on July 19, 2016, and the focus was on understanding and communicating our component parts and moving forward as a cohesive Healthier Washington system. Healthier Washington executive leadership announced test areas of diabetes and well-child visits that will allow us to test alignment of the component parts of SIM as a system. The summit was well attended, informative, and motivational.

Stakeholder Engagement

Key stakeholder engagement activities in the second quarter included:

- The Health Innovation Leadership Network convened for its quarterly meeting with a focus on integration of physical and behavioral health. The meeting represented opportunities and action of multiple sectors, including payers/purchasers, providers and community.
- State partners continue to engage ACH staff and leads on the Development Council Call. This is the most consistent engagement mechanism and allows us to be responsive. The ACH team also held a convening in June with a focus on value-based purchasing, held a webinar on supportive housing, and participated in several tribal engagement workshops in partnership with HCA and American Indian Health Council.
- HCA held weekly calls with managed care organizations, behavioral health providers, ACHs, county staff, and a consumer representative in Southwest Washington to address issues about the integration of physical and behavioral health (payment model 1). HCA increased engagement with other counties, to educate county commissioners on the benefits of implementing the model in their region.
- The Model 2 team has worked with FQHCs and RHCs in two intensive working sessions. The focus of the sessions has been to drive toward adoption of alternative payment model 4 on January 1, 2017. CAH stakeholders have been convened in two working sessions this quarter, getting closer to resolution around delivery components of the model.
- The Model 3 team continued to educate and engage key stakeholders involved in purchasing and transformation through events, webinars, and individual outreach. Specifically, Model 3 met with a CEO of a large group practice to learn more about their plans to adopt accountable care

strategies, and the HCA director was the keynote speaker at an annual broker conference where she presented our Paying for Value strategy.

- The ad-hoc performance measures workgroup convened to take a second review of pediatric measures in the Statewide Common Measure Set. Other work has been completed to align measures going into 2017 state purchasing contracts with those in the common measure set.

Read more about this

[Health Innovation Leadership Network](#)

[Accountable Communities of Health](#)

[Paying for value](#)

[Integrated Physical and Behavioral Health](#)

[Performance Measures](#)

Population Health

In response to CMMI feedback, the Department of Health (DOH) adjusted the Plan's strategy. Instead of a one-time document, DOH is developing a website to house the Plan's elements, including strategies, tools and resources. It will include population health strategies within and outside clinic walls, and emphasize multi-tiered alignment of strategy, policy and resources. The intention is to transition the site to the Practice Transformation web portal, ensuring that the Plan remains a living and sustainable resource. To further assist multi-sector partners with connections to value-based purchasing, we have contracted with Dr. Sanne Magnan, co-chair of the National Academy of Medicine's Roundtable on Population Health Improvement. She will deliver the opening plenary at the state public health conference, as well as provide workshops and stakeholder events in both Eastern and Western Washington in early fall.

The P4IPH Interagency and External Advisory group held a joint meeting in late May. Agenda included presentation on State Health Assessment by Cathy Wasserman, state epidemiologist for non-infectious disease, and discussion of criteria for prioritizing population health measures.

All nine ACHs submitted project proposals in the second quarter and are nearing the launch of the required ACH SIM projects. Each of these projects demonstrates some degree of linkage between population health and health care delivery systems and our approach going forward will be to emphasize this unique opportunity within the ACHs to continue reinforcing this approach. Themes include: community health workers (CHWs) and blood pressure management; CHWs and care transitions / reduction in hospital readmissions; CHWs pathways "hub" model for increased coordination; CHWs in a health-housing partnership; care coordination and behavioral health risk assessment; co-location of behavioral and primary care; whole-person care collaborative; coordinated opioid response; education and awareness of long-acting reversible contraceptives.

Health Care Delivery System Transformation

The Practice Transformation Support Hub continued activities related to supporting health care delivery system and provider practice transformation. Activities this quarter included:

- Posted 2 RFPs to select a Hub vendor for 1) Practice Coaches and 2) Health Connectors. The team also developed an inter-agency agreement to select the University of Washington for web portal development.
- Conducted a survey of providers through the Clinical Engagement Accelerator Committee to identify progress and barriers as related to integration of clinical and behavioral health services and progress to value-based payment.
- Participated in conversations with Washington State Medical Association leaders about the work of the Hub and how they could be involved in providing ongoing input.
- Participated in a joint meeting of the Washington State Association of Local Public Health Officers (WSALPHO) and the Washington Association of Family Practice Physicians to talk about opportunities for public health and primary care providers to work together, including on practice transformation.

Read more about this

[Practice Transformation Hub web page](#)

[Practice Transformation Support Hub Fact Sheet](#)

Payment and/or Service Delivery Models

Between June 1, 2016 and August 1, 2016 HCA continued technical assistance to the fully-integrated managed care organizations participating in Payment Model 1, and rapidly addressed transition issues as they arose. Highlights from the first 90 days of fully-integrated managed care implementation include:

- Molina Healthcare of Washington and Community Health Plan of Washington (CHPW) created back up strategies to manually process claims and support cash flow security to providers.
- CHPW and Molina have worked collaboratively to standardize processes, and achieved approximately 85 percent alignment of authorization requirements, contracting structures, and data submission processes.
- Based on data supplied by the Emergency Department Information (EDIE) system, emergency department visits for Molina members enrolled in a fully-integrated plan averaged 6 percent lower for April through June.

The Payment Model Test 2 team explored avenues to move forward with a solicitation of FQHCs and RHCs to identify first movers that are interested in Alternative Payment Model (APM) 4 adoption on January 1, 2017. CAH payment and delivery system redesign work began to draw clarity around final model delivery system elements.

The two Accountable Care Networks (ACNs) developed under Payment Model Test 3 finalized their 2017 expansion plans in July. One or both ACNs will be available in four additional counties starting in January 2017: Grays Harbor, Skagit, Spokane, and Yakima. During the last two weeks in July the ACN operations and communications staff conducted a survey of public employees currently enrolled in one of the two networks. Survey results and patient testimonials will be used to inform messaging and educational materials for 2017 open enrollment.

In June, the Payment Model 4 team began conversations with an interested provider organization to participate as the lead organization in Model 4. A meeting was scheduled for August with the intention of adhering to original timeline to launch Model 4 by or before January 2017. At the same time, the Model 4 team conducted exploratory discussions with a different provider and payer.

Read more about this

[Paying for value web page](#)

Leveraging Regulatory Authority

The team continued development of the Medicaid Transformation waiver proposal and, in particular, the link to HCA's Value-Based Roadmap. Significant opportunities for ACHs to collaborate with their provider communities were identified and will aid in moving toward alternative payment models that reward value. This also creates additional opportunities for reinforcement of the APM goals of Model Test 2.

Read more about this

[Medicaid Transformation web page](#)

[Paying for value web page](#)

Workforce Capacity

The Industry Sentinel Network, which the initiative supported, completed its first round of data collection survey July 31. There was strong participation and response in this first round: 106 responses from 177 facilities. Facility types included but were not limited to Specialty Medical Clinics, Behavioral-medical health clinics, FQHC or community clinics, primary care medical clinics, acute care hospitals large and small, education, nursing and personal care facilities, dental and psychiatric/substance abuse hospitals. The survey results will be reviewed and analyzed and then presented at the Health Workforce Council September 30. The next round of data collection will launch in November as planned.

Discussions with team leads from each operational area on the role of community health workers continued in May 2016. Operational next steps will be reviewed with Core Team August 30, 2016.

Health Information Technology

The Analytics, Interoperability and Measurement (AIM) program experienced a great period of change and growth during this quarter. In May, June and July we:

- Released the first Healthier Washington Data Dashboard to all Accountable Communities of Health (ACHs) and local health jurisdictions around the state. These interactive dashboards support the business intelligence and analytics needs of ACHs and local health jurisdictions, providing access to metrics and population health data, to aid in identifying and implementing community priorities and strategies that improve health. The dashboards will build upon themselves over time, with regularly refreshed data and additional metrics and functionalities released every 12 weeks to stakeholders across the state. All data in the dashboards is de-identified and aggregated and the starter set of metrics selected for inclusion into the dashboards were derived from the Statewide Common Measure Set and prioritized by ACHs across the state.
- Decided on an overall approach for procuring and implementing an analytics infrastructure, and started procuring the first components - a master data management tool and a data model. In July, we drafted content for a master data management request for proposals.
- Worked closely with the ACHs and the Center for Community Health and Evaluation to identify likely data needs for each ACH's regional health project.
- Engaged with Payment Model leads to provide data and analysis support.
- Collaborated with our SIM evaluators (University of Washington and RTI) to continue defining data needs, and put in place appropriate processes and controls to provide data to them.
- Continued work on acquiring two key data sources for Healthier Washington work – Public Employee Benefits (PEB) data, and Medicare data.

Continuous Quality Improvement

Healthier Washington has been collaborating with our state and national evaluators (University of Washington and RTI) to continue defining data needs, and put in place appropriate processes and controls to provide data. More specifically, during this period the University of Washington:

- Obtained approval for its detailed Design Review/Data Security plan from state information security oversight (WaTech)
- Submitted a 250+ page application to the Washington State Institutional Review Board (WSIRB) for the SIM Evaluation project – Years 2-4.
- Refined evaluation approaches and identified desired and feasible data elements to obtain from HUB vendors (Portal and Connectors/Coaches), Payment Models 2 and 3 data suppliers, and for our SIM overall evaluation.
- Held multiple collaborative work sessions with RDA, DOH and the HW team to better understand what is happening in the field and align evaluation activities accordingly.
- Provided coaching to ACHs on project measures and evaluation plans through our partner evaluator Center for Community Health Education.

Healthier Washington has enhanced the capabilities of our change control process by 1) clarifying specific criteria and methods to review, approve, and communicate across the program, 2) create a change request system that both logs and drives the process, and 3) updated our Decision Making Framework.

The overall project management effort has been enhanced by using additional opportunities to review project by project and across projects, project plan, risk and issue, and change request information. One example is partnering with the existing monthly budget review meetings held with the investment areas. These two efforts have created more opportunity for both communication and collaboration across projects, and between the projects and the operations team.

Additional Information

Accountable Communities of Health - Seven ACHs have made progress in the second quarter toward the milestone of “legal status.” This transition is community-driven and is based on the desire to establish the ACH as the direct point of authority and decision making, as opposed to an independent backbone organization serving as the final point of authority. HCA has provided some guidance on this subject for consideration, and there is agreement that legal status is the next phase in ACH development and direct accountability for ACH-related funding and activities, in addition to sustainability planning. Two of the nine ACHs were already legal entities. Two of the remaining seven are currently pursuing LLC models. The remaining five are pursuing 501c3 status and several have either filed documentation or received approval from the state. The process surrounding tax-exemption is another phase and we are unsure of the timeline for ACHs to obtain tax-exemption.

Shared Decision Making – The Shared Decision-Making (SDM) team moved forward significantly on the process for soliciting decision aids for certification, as the first state in the nation to do so. They refined their process for certification and received seven decision aids from developers seeking certification. In June, HCA staff traveled to a National Quality Forum (NQF) gathering to participate in the development of a national certification process, and began discussions with NQF to convene a national SDM Network among SIM-funded states.

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		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 2,769,598	\$ 732,254	\$ 361,678	\$ 134,892	\$ 1,397,093	\$ 2,625,916	95%	4.0
Practice Transformation	\$ 1,830,774	\$ 8,308	\$ 40,341	\$ 60,110	\$ 558,444	\$ 667,202	36%	4.9
Payment Redesign	\$ 2,116,825	\$ 11,801	\$ 174,214	\$ 143,699	\$ 577,273	\$ 906,987	43%	3.7
Analytics, Interoperability & Measurement	\$ 9,443,606	\$ -	\$ 28,902	\$ 346,670	\$ 2,307,955	\$ 2,683,526	28%	11.3
Project Management	\$ 2,923,744	\$ 75,640	\$ 197,855	\$ 736,138	\$ 1,435,263	\$ 2,444,897	84%	12.3
TOTAL	\$ 19,084,547	\$ 828,003	\$ 802,989	\$ 1,421,509	\$ 6,276,027	\$ 9,328,528	49%	36.2

HCA	Year 1 Budget	Dollars Spent					% Spent	28.0 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 2,632,894	\$ 732,254	\$ 361,678	\$ 128,595	\$ 1,353,084	\$ 2,575,611	98%	3.00
Practice Transformation	\$ 703,309	\$ 8,308	\$ 40,341	\$ 26,618	\$ 239,059	\$ 314,325	45%	1.00
Payment Redesign	\$ 2,004,756	\$ 11,801	\$ 174,214	\$ 143,699	\$ 577,273	\$ 906,987	45%	3.66
Analytics, Interoperability & Measurement	\$ 7,958,585	\$ 0	\$ 28,902	\$ 259,999	\$ 1,451,580	\$ 1,740,480	22%	6.28
Project Management	\$ 2,526,939	\$ 75,640	\$ 197,855	\$ 735,887	\$ 1,281,312	\$ 2,290,695	91%	10.71
TOTAL	\$ 15,826,484	\$ 828,003	\$ 802,989	\$ 1,294,799	\$ 4,902,308	\$ 7,828,099	49%	24.65

DOH	Year 1 Budget	Dollars Spent					% Spent	7.4 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 39,395					\$ -	0%	
Practice Transformation	\$ 1,030,156			\$ 22,419	\$ 275,113	\$ 297,532	29%	2.9
Payment Redesign	\$ 39,395					\$ -	0%	
Analytics, Interoperability & Measurement	\$ 877,794			\$ 86,671	\$ 610,438	\$ 697,109	79%	1.0
Project Management	\$ 155,010			\$ 251	\$ 66,191	\$ 66,442	43%	0.5
TOTAL	\$ 2,141,750	\$ -	\$ -	\$ 109,341	\$ 951,742	\$ 1,061,083	50%	4.4

DSHS	Year 1 Budget	Dollars Spent					% Spent	5.2 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 97,309			\$ 6,296	\$ 44,009	\$ 50,305	52%	1.0
Practice Transformation	\$ 97,309			\$ 11,073	\$ 44,272	\$ 55,345	57%	1.0
Payment Redesign	\$ 72,674					\$ -	0%	
Analytics, Interoperability & Measurement	\$ 227,353				\$ 43,408	\$ 43,408	19%	1.0
Project Management	\$ 111,336				\$ 6,777	\$ 6,777	6%	0.2
TOTAL	\$ 605,980	\$ -	\$ -	\$ 17,369	\$ 138,465	\$ 155,834	26%	3.2

DSHS - RDA	Year 1 Budget	Dollars Spent					% Spent	3.0 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	0					\$ -		
Practice Transformation	0					\$ -		
Payment Redesign	0					\$ -		
Analytics, Interoperability & Measurement	\$ 379,874				\$ 202,529	\$ 202,529	53%	3.0
Project Management	0					\$ -		
TOTAL	\$ 379,874	\$ -	\$ -	\$ -	\$ 202,529	\$ 202,529	53%	3.0

OFM - GOV OFFICE	Year 1 Budget	Dollars Spent					% Spent	0.9 FTE's
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	0					\$ -		
Practice Transformation	0					\$ -		
Payment Redesign	0					\$ -		
Analytics, Interoperability & Measurement	0					\$ -		
Project Management	\$ 130,460				\$ 80,984	\$ 80,984	62%	0.9
TOTAL	\$ 130,460	\$ -	\$ -	\$ -	\$ 80,984	\$ 80,984	62%	0.9

This report includes expenditures currently claimed against Grant Year 1

Healthier Washington

Grant Year 2 - Quarter 2 - Budget Status Report

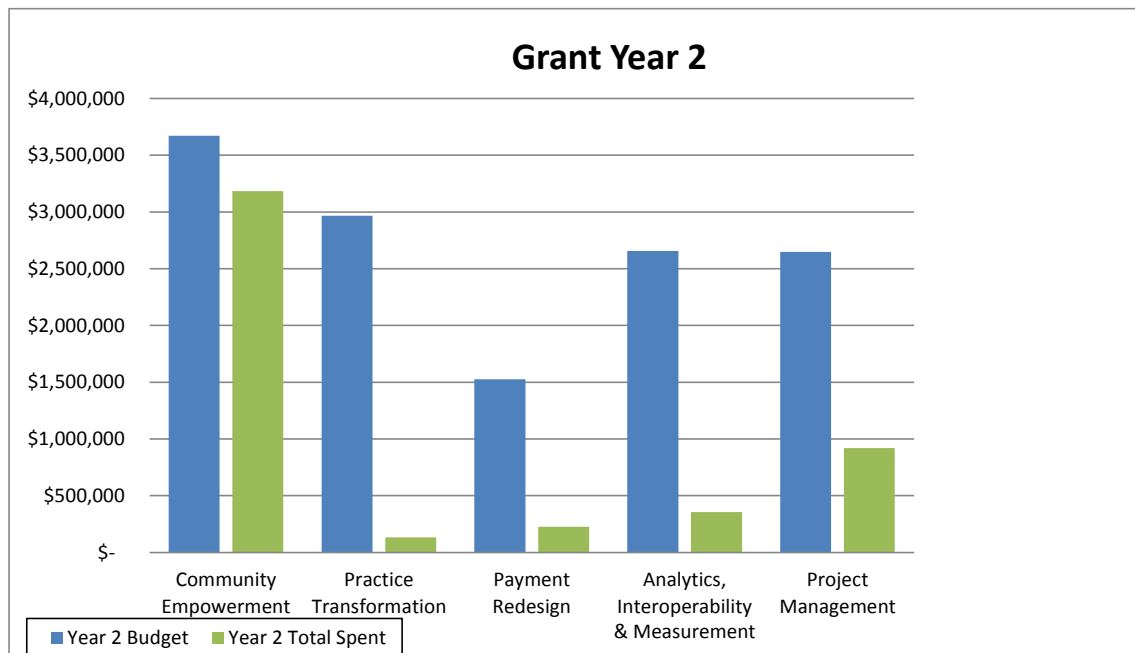
Expenditures for February - July 2016

Combined expenditures and FTE's for all Partner Agencies (HCA, DOH, DSHS, OFM-GOV)

From: Enterprise Agency Financial Reporting

	Year 2 Budget	Total Spent	
Community Empowerment	\$ 3,669,797	\$ 3,183,068	87%
Practice Transformation	\$ 2,966,270	\$ 132,286	4%
Payment Redesign	\$ 1,524,071	\$ 224,909	15%
Analytics, Interoperability & Measurement	\$ 2,655,752	\$ 355,378	13%
Project Management	\$ 2,647,420	\$ 917,905	35%
TOTAL	\$ 13,463,310	\$ 4,813,546	36%

Sum of Amount	
Row Labels	Total
CMM6	4,813,545.84
A5F11	3,183,067.62
A5F12	132,285.63
A5F13	224,909.35
A5F14	355,377.93
A5F15	917,905.31
Grand Total	4,813,545.84





Grant Year 2 - Quarter 2 - Budget Status Report
Partner Agency Activity by Investment Area
Expenditures for February-July 2016
Source: Enterprise Agency Financial Reporting

All Partner Agencies By Investment Area	Year 2 Budget	Dollars Spent					% Spent	FTE's Spent
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total		
Community Empowerment	\$ 3,669,797	\$ 3,027,761	\$ 155,307			\$ 3,183,068	87%	3.00
Practice Transformation	\$ 2,966,270	\$ 22,161	\$ 110,124			\$ 132,286	4%	1.00
Payment Redesign	\$ 1,524,071	\$ 68,028	\$ 156,881			\$ 224,909	15%	3.66
Analytics, Interoperability & Measurement	\$ 2,655,752	\$ 144,808	\$ 210,570			\$ 355,378	13%	6.28
Project Management	\$ 2,647,420	\$ 278,048	\$ 639,858			\$ 917,905	35%	10.71
TOTAL	\$ 13,463,310	\$ 3,540,805	\$ 1,272,740	\$ -	\$ -	\$ 4,813,546	36%	24.65

This report includes expenditures currently claimed against Grant Year 2
 Interagency Partners continue to spend down Grant Year 1 budgets

Delivery of Whole-Person Care in Southwest Washington

Report on the First 90 Days
of Fully Integrated Managed Care



Contact Information:

[Molina Healthcare of Washington, Inc.](#)

1-800-869-7165



[Community Health Plan of Washington](#)

1-866-418-1009



[Beacon Health Options](#)

1-855-228-6502

Questions about the report may be sent to earlyadopterquestion@hca.wa.gov at the Health Care Authority.



Guide to abbreviations used in this report

BH	Behavioral Health
BHO	Behavioral Health Organization
BHSO	Behavioral Health Services Only
CCS	Catholic Community Services
CCW	Coordinated Care of Washington
CHPW	Community Health Plan of Washington
CLIP	Children's Long-Term Inpatient Facility
CMT	Collective Medical Technologies
COPEs	Community Options Program Entry System
CRRG	Clinical Rapid Response Group
DSHS	Department of Social & Health Services
E&T	Evaluation & Treatment
ED	Emergency Department
EDIE	Emergency Department Information Exchange
EWIs	Early Warning Indicators
EWS	Early Warning System
FIMC	Fully Integrated Managed Care
HCA	Washington State Health Care Authority
HCS	Home and Community Services
ITA	Involuntary Treatment Act
LRA/CR	Least Restrictive Alternative/Conditional Release
MCO	Managed Care Organizations
MHW	Molina Healthcare of Washington
PACT	Program for Assertive Community Treatment
PCP	Primary Care Provider
RCW	Revised Code of Washington
RDA	Research and Data Analysis
RSN	Regional Support Network
SUD	Substance Use Disorder
SWRHA	Southwest Washington Regional Health Alliance
SWWA	Southwest Washington
WiSe	Wraparound with Intensive Services
WSH	Western State Hospital
QOC	Quality of Care

See the [Healthier Washington Glossary](#) for definitions of some terms.

On April 1, 2016 the Washington State Health Care Authority (HCA) launched fully integrated managed care (FIMC) in partnership with Clark and Skamania counties (Southwest Washington). For the first time, Washington State Medicaid beneficiaries have access to the full continuum of physical health, as well as substance use disorder (SUD) and mental health services (referred in this report as behavioral health), through a managed care plan of their choice.

All Medicaid beneficiaries transitioned to coverage by one of two fully-integrated managed care plans: [Molina Healthcare of Washington](#) (MHW) or [Community Health Plan of Washington](#) (CHPW). Additionally, HCA and [Beacon Health Options](#) launched a [regional crisis response system](#) to replace and improve on the previous mental health crisis system managed through the state's regional support network (RSN).

This report analyzes the first 90 days of FIMC implementation, using data collected through the Early Warning System (EWS), daily calls with key implementation players, and anecdotes from clients and providers.

While the implementation of FIMC holds great promise to transform the delivery system and improve health outcomes, the goal during the first 90 days was to successfully transition behavioral health provider contracts and payments from the county and RSN to CHPW, Molina and Beacon Health Options, and to ensure continuity of care and access to services for Medicaid beneficiaries. Success in the first 90 days is defined by stability.

The state, Managed Care Organizations (MCOs), Beacon, and community partners were committed to achieving three priorities during this transition:

1. Ensure continuity of care and access to care for all clients;
2. Ensure behavioral health providers received timely and accurate payments;
3. Reduce administrative burdens and align as much as possible the processes and procedures for behavioral health providers.

The report supports the conclusion that the FIMC program has achieved success in the first 90 days and met its intended goals. In addition, anecdotal evidence suggests that in the first 90 days, care coordination for patients with co-occurring physical and behavioral health conditions is beginning to improve, including improved referrals between behavioral health and primary care providers, and that behavioral health providers are experiencing reduced administrative burdens.

The first 90 days of implementation have not been without challenges, the most significant of which were the back-office changes and reconfigurations necessary for behavioral health providers to transition to billing managed care organizations rather than the regional support network or county. As shown in this report, these challenges are being addressed rapidly and collaboratively between the provider community, the MCOs, and the state, and have in no way impeded access to care for clients. Lessons

learned in Southwest Washington will be applied going forward as the state transitions to full integration between now and 2020.

FIMC “First 90 Days” Highlights

- As of April 1, 2016, 100,982 Medicaid beneficiaries were enrolled in the FIMC program with Molina or CHPW, meaning they receive the full continuum of physical and behavioral health benefits through their managed care plan.
- 14,631 clients are enrolled in the [Behavioral Health Services Only](#) (BHSO) program and receive specialty mental health and substance use disorder services through either CHPW or Molina. The BHSO program was designed to provide behavioral health coverage to clients who receive physical health coverage through the Medicaid fee-for-service system or have other coverage (American Indian/Alaskan Natives, Medicare and Medicaid dual coverage, etc.).
- All behavioral health providers that had been under contract with the county substance use disorder (SUD) program or the RSN (mental health) signed contracts with the MCOs and Beacon, and the provider network has been enhanced and expanded with the addition of one new provider in the Southwest region who had not previously been contracted to serve Medicaid.
- Medicaid payment rates to providers were no less than 100 percent of the rate before April 1, 2016. Additionally, MCOs continued paying providers using the same payment methods that were in place before April 1, 2016, to ensure stability for providers during this transition process.
- Molina and CHPW created back up strategies to manually process claims and support cash flow security to providers in case of initial system problems with claims submission.
- CHPW and Molina have worked collaboratively to standardize processes and minimize the administrative burden on providers, and achieved approximately 85 percent alignment of authorization requirements, contracting structures, and data submission processes.
- Based on data supplied by the Emergency Department Information (EDIE) system, emergency department visits for Molina members enrolled in a fully-integrated plan averaged 6 percent lower for April through June. While this is promising data, due to the seasonality of ED visits, material reductions in ED visits are best evaluated within a same time period each year.
- Western State Hospital discharges in the first 90 days held steady at the same rate of discharge before the transition.

Early Warning System

To prepare for a Medicaid transformation of this magnitude, HCA with Clark and Skamania counties created an Early Warning System that allowed a feedback loop and triage process to identify and resolve systemic issues that may result with the launch of full integration. Led by a steering committee, the Early Warning System responds to transition-related issues that require cross-system collaboration and rapid resolution.

EWS Steering Committee

The Southwest Washington Regional Health Alliance (SWRHA) Board of Directors voted to manage data collection and hosting of the Early Warning System Steering

Committee effective April 1, 2016 as part of their general Accountable Community of Health “Health Improvement & Measurement Planning” responsibilities.

The Early Warning System Steering Committee consists of a cross-system membership of providers, managed care plans, state and county representatives, and criminal justice system representatives. Additionally, Commissioner Chris Brong of Skamania County and Clark County Chair Marc Boldt participated in the Early Warning System Steering Committee during the transition to ensure proper steps were being taken to track the impacts of FIMC implementation. Steering Committee membership includes but is not limited to:

- Clark County – Vanessa Gaston
- Skamania County – Tamara Cissell
- Washington State Health Care Authority – Isabel Jones
- Consumer Communities – Melanie Maiorino
- Public Health Department and Accountable Community of Health (SWRHA) – Dr. Alan Melnick
- Behavioral Health Providers – Craig Pridemore
- Primary Care Providers – Nicoletta Alb
- Community Health Plan Washington – Vanessa Mousavizadeh
- Molina Healthcare – Julie Lindberg
- Beacon Health Options – Inna Liu
- Law Enforcement – Comm. Randy Tangen
- Tribal Representatives – Steve Kutz
- Accountable Community of Health (SWRHA) – Tabitha Jensen

Extraordinary Emphasis on Provider Input

I am a director at a medium size behavioral health organization that provides outpatient mental health and substance abuse treatment as well as supported housing. We serve approximately 4,000 unique individuals a year that are primarily Medicaid beneficiaries. I was very concerned about early adopter and the impact that it would have on access, scope of services, workforce depletion, payment dynamics and a myriad of other issues. The transition has been a lot of work, however, all of the concerns that I had did not materialize. In my opinion, that is due to the emphasis place on provider input—which was really extraordinary— county leadership, HCA leadership and collaborative approaches from the health plans. I feel very optimistic that there is a solid platform for making positive changes to the delivery system in Southwest Washington that is a direct result of FIMC.

John “Bunk” Moren, Executive Director, Community Services Northwest

Final Early Warning System Indicators

Through a consensus process the EWS Steering Committee identified the following Early Warning System metrics.

SW-WA Early Adopter - Early Warning System Early Warning Indicators (EWIs)	
EWI Category	Quantitative Early Warning Indicator(s)
Payment & Utilization Patterns	1. Delay or decrease in provider payments for BH and PH
	2. An increase in proportion of claims with errors or denials for BH
	3. Spikes in Emergency Department use
Client Experience of Care	6. Spikes in grievances or Ombuds complaints
	12. Behavioral health access to care challenges for foster and foster-to-adopt youth
Crisis System, Western State Hospital, and Jail System	11. Spikes in crisis calls
	4. Spikes in jail use (behavioral health-related) and unduplicated re-bookings
	5. Spikes in use of Western State hospital beds
*Qualitative Early Warning Indicator(s):	
7. Drops in numbers of Medicaid enrollees seeking treatment	
8. Increased wait time for CD inpatient treatment	
9. Extended wait times for outpatient BH and PH care	
10. Consumers frequently being shifted between different providers due to client choice; access and level of care issues	
13. Rx - increases or decreases in number or type of medications on formulary, volume of prior authorizations, number of denials	
*Qualitative EWIs will act as a secondary warning system, supplementing quantitative EWIs. Qualitative information will be collected via survey, key informant interviews, and provider/consumer self-report.	

Data Summary

The following is a summary of data collected by the Early Warning System Steering Committee during the first 90 days.

Indicators 1 & 2: Claims Processing and Payment – Molina

Molina: April to June 2016 Results

Behavioral health claim volumes were low in April, with steady increases through May and June, with the most significant increase in the last two weeks of June. The percentage of claims paid within 30 days remained constant from baseline with performance running above 99 percent for both physical and behavioral health claims, with the exception of one two-week reporting period.

Due to the small claims volume, the percent of behavioral health claims denied varied between reporting periods but on average remained consistent with the baseline performance. The percent of denied physical health claims in the first 90 days of FIMC implementation averaged one percentage point lower than the baseline period.

Primary Drivers

The low volume of claims received in April and May was due to 1) normal claim lag (the time it takes to submit claims after the first claims were incurred), and 2) providers not having their systems ready to submit claims to Molina. Knowing providers were having some system challenges, Molina made advanced payment options available to providers to ensure adequate cash flow.

Most denied BH claims were due to one large provider who had submitted duplicate claims, and submitted a high-volume service on the wrong claim form. These claims were denied and the provider has resubmitted correct claims.

Mitigation Strategies

Molina instituted several systems to support providers getting paid accurately and timely, which include the following:

- A process to manually review 100 percent of initial claims for all providers before releasing for payment to ensure accurate payment and avoid denials due to submission errors.
- A rapid response claims team to work through any issues quickly.
- A proactive claims data run for all BH providers to identify potential problems, outreach to providers and support to work through identified opportunities.
- Weekly group all-topic meetings scheduled with BH providers to bring forward any issues and/or concerns, which could include claims related issues, data reporting questions, and encounter questions, and non-claim related support.

Indicator 1&2: Claims Processing and Payment – CHPW

CHPW: April to June 2016 Results

Results for the first quarter show that few claims for behavioral health were submitted in April, followed by significantly increased volume by the end of June. As behavioral health claim submissions increased, technical issues or submission errors resulted in below target turnaround times in claims processing, while processing times for physical health continued on trend at near 100 percent processed within 30 days.

Primary Drivers

Variance from expected performance was primarily driven by large numbers of claims submitted by one behavioral health provider with a specific issue, e.g., duplicate claims.

Mitigation Strategies

To support timely provider payment, CHPW proactively audits 100 percent of Fully Integrated Managed Care claims before processing in order to identify opportunities to engage providers early, to resolve issues at their root, and to prevent denial or delayed payment. When a problem is identified, the CHPW Provider Relations and Operations teams are immediately deployed to offer technical assistance. They continue to track progress side by side with the provider until claims are processed according to standard. Interim payment may be made as a temporary solution. Bi-weekly calls are held with behavioral health providers to provide further technical assistance, identify systemic issues, and provide a resource-sharing platform.

In addition, CHPW and Molina hosted local provider trainings jointly as well as separately, to offer guidance and written instructions about how to request prior authorization (when required), submit claims, and request technical assistance. Both MCOs have hosted local provider forums and facilitate regular meetings by telephone to share information, answer questions, and address issues identified by providers.

Indicator 3: Emergency Department (ED) Utilization Patterns

Molina: April to June 2016 Results

Considerations for review of data:

- ED data for CHPW was not reportable for this reporting period. Spikes in ED utilization for CHPW members have not been identified either through the partial data available or anecdotally.
- In order to provide real-time ED data to the EWS committee, Molina has relied on Emergency Department Information Exchange (EDIE) data supplied by Collective Medical Technologies (CMT), thus this data should be considered preliminary data until Molina can validate with claims data.
- Because FIMC and Behavioral Health Services Only (BHSO) are new programs, there is no exact ED utilization baseline data for these populations.
- Because there is presumed to be significant overlap of members in Apple Health before April 1, 2016, and FIMC members after April 1, Molina used three months of AH ED claims data as a benchmark comparison for FIMC.
- There is no ED baseline data for BHSO members because most of this enrollment was Medicaid fee-for-service before April 1 and not enrolled with Molina.

For EWS reporting periods starting in July, Molina will add ED claims data to the report. This data will have a two- to three-month lag.

Highlights of the ED visit data include the following:

- FIMC and BHSO populations are reported separately due to variations in acuity.
- ED trends for both FIMC and BHSO populations have been flat since April.
- Comparing FIMC utilization to AH January to March 2016 ED utilization using EDIE/CMT data, FIMC ED visits/1,000 averaged 6 percent lower for April through June. While this is promising data, due to the seasonality of ED visits, material reductions in ED visits are best evaluated within a same time period each year.
- Comparing FIMC utilization to AH January through March 2016 ED utilization using Molina claims data, FIMC ED visits/1,000 for April and May averaged 9 percent lower than the three-month baseline period but the claims data is not complete yet for April and May.

Working Through the Issues as They Appear

We found the transition to have gone pretty much as expected – mostly smooth but with some hiccups— as we work through interfaces between systems. There were and still are some difficulties with billing and a bit of a learning curve for both us and the MCOs, but we’re working through the issues as they appear and the MCOs are generally proving to be positive and cooperative partners.

Craig Pridemore, Chief Executive Officer, Columbia River Mental Health Services

Indicator 4: Criminal Justice System Data

Clark & Skamania Sheriff's offices: April to June 2016 Results

A vital indicator identified by the Early Warning System Steering Committee during FIMC implementation was the tracking of jail bookings for individuals with behavioral health issues. After April 1, 2016, an inordinately high rate of jail bookings related to mental health or substance use disorder would have been a key indicator of potential problems with the new system of care.

In order to determine baseline for this indicator, data was collected from the former RSN, Southwest Behavioral Health. The baseline report calls out two categories of RSN individuals: 1) Individuals who are receiving services at the time of booking (active) and 2) Individuals who received services in the past but were inactive in the RSN system at the time of the booking.

The percentage of “active” or RSN-involved individual booking was very low at only 4.09 percent for the calendar year 2015, and the total percentage of those booked who were ever in the RSN system was 25.17 percent.

While these statistics are not fully representative of all Southwest Washington residents living with behavioral health conditions, assessment of RSN data provides the most accurate portrayal of those individuals who are frequently interacting with emergency and criminal justice systems in Southwest Washington, and individuals who were impacted by the FIMC transition.

The Clark County Sheriff's Office assessment of baseline percentages suggests that April 2016 booking numbers are falsely inflated due to the implementation of a new database system at the same time as the April 1, 2016 launch of FIMC. Sheriff's office staff struggled to gain proficiency in the new system and internal quality control measures quickly resulted in successful course correction.

May and June 2016 booking data is in direct alignment with established baseline and prior historic averages for the month of May and June in 2015. There are no concerns or irregular trends.

It should be noted that Skamania County Sheriff's Office was unable to provide baseline data due to database systems limitations. Further, Skamania data provided for first 90 days of FIMC did not give specific detail related to behavioral health factors related to arrest and booking. However, the Skamania County Sheriff's Office has not noted any substantial increases or decreases to local booking rates in April, May, and June 2016.

Based on data collected thus far, the conclusion can be drawn, albeit anecdotally for Skamania County, that FIMC has not resulted in increased county jail bookings for individuals with behavioral health conditions in Clark and Skamania counties.

Indicator 5: Western State Hospital
Health Care Authority: April to June 2016 Results

Individuals with serious or long-term mental illness who meet the criteria for involuntary treatment and receive a court order for 90 or 180 days of treatment are admitted to Western State Hospital (WSH) as a bed becomes available and per the state wait list criteria.

Based on the percent of the population served in Southwest Washington, CHPW, Molina, and Beacon Health Options were allocated a portion of Southwest Washington's 40 beds at WSH. Molina Healthcare was allocated 25 beds; CHPW eight beds; and Beacon Health Options seven beds. All three organizations have consistently stayed below their individual allocations and as a group have been four to six beds below the state allocation since April 1, 2016.

CHPW, Molina, and Beacon Health Options have each appointed a WSH liaison to work closely with WSH staff, Home and Community Services (HCS) staff, and other community partners in developing discharge plans, and in finding appropriate settings once individuals are ready for discharge.

WSH staff report high satisfaction in working with the organizational liaisons, citing a proactive approach to discharge planning, problem solving, and identification of barriers to discharge. In the first three months since implementation the WSH liaisons facilitated discharges for six people, in line with the rate of discharge prior to April 2016 (approximately two per month).

WSH Civil Census for Southwest Washington Aggregated Average Monthly Census Southwest Washington Allocation = 40 beds		
Month	Average Census	# Discharges
April 2016	35	1
May 2016	35	2
June 2016	34	3
Total		6

Notably, the MCO liaisons have also worked closely with HCS staff and behavioral health community partners to create care and crisis plans for 12 individuals preparing to discharge to the new DSHS Home and Community-Based Services Enhanced Services Facility expected to open in 2016, which is based in Clark County. This new type of facility will serve some of the most complex individuals in the state who are discharging back to the community. Preparing these individuals for a smooth and sustained discharge requires an unprecedented degree of collaboration with the behavioral health community to develop care and crisis plans. The two MCO liaisons, in partnership with the HCS liaison, lead these efforts.

Client Spotlight

A Molina Member's Experience

A Molina Liaison helped locate an adult family home for an individual who was leaving Western State Hospital and planned for a pre-placement visit. The liaison arranged follow up appointments for mental health treatment with an outpatient provider as well as team level of care that was program assertive community treatment.

There were complications with this discharge; the member was diagnosed with diabetes in between the completion of the Comprehensive Assessment Reporting Evaluation (CARE) and the time of discharge. Discharge orders related to diabetic management were not included in the Home and Community Services (HCS) CARE assessment, and there were no official orders regarding how the member's diabetes should be managed in the adult family home.

In addition, the social worker had not been able to locate a payee in Clark County before discharge. The Molina Liaison worked with Western State Hospital, the adult family home, the newly assigned primary care clinic, the pharmacy, and mental health case manager to ensure member was able to get a quick follow up appointment, get medications filled, and get the correct orders written for the adult family home.

The liaison also worked to secure transition to a local payee.

This member is in the Behavioral Health Services Only (BHSO) program with Molina, and has Medicare as the primary insurer, and Medicaid fee-for-service as secondary. The Molina eligibility staff worked with the Health Care Authority's eligibility staff to ensure the member was active in coverage immediately after discharge to meet any urgent medical needs.

While this was not a perfect discharge, it reflects Molina's commitment to continuing to work with clients and their placement locations to facilitate smooth transition back into the community.

Indicator 6: Client Experience of Care – Molina

CHPW and Molina Healthcare use 10 grievance categories when addressing member grievances, as required in contract with HCA. These categories include: health plan-specific issues; concerns with written materials provided by the plan; access to care issues for the provider network; plan coverage and benefits; eligibility and membership in a plan; quality of customer service provided by the plan; billing and/or claims issues; problems with referrals and authorizations, and general quality of health care within the network.

Grievance Categories:

Health Plan
Written Materials
Access
Coverage and Benefits
Eligibility/Membership
Quality of Service (QOS)
Billing/Claims
Other
Referral/Authorization
Quality of Care (QOC)

Molina: April to June 2016 Results

The number of grievances reported by members increased slightly in April and May from baseline, with a significant (five-fold) increase in the month of June.

Primary Drivers

The primary driver of the June grievance increase was due to a retraining of all Molina member contact center representatives on how to recognize and document grievances in the first and second week of June. The increased volume of grievances related to grievance training was expected and is considered a desirable outcome. The five-fold increase in grievances reporting was consistent with Molina members statewide for all other

lines of business.

The second issue impacting grievance counts was a high-volume primary care provider (PCP) leaving a large provider group and the reassignment of members to a different provider group per the direction of the initial provider group. Thus 1,400 members had to change both primary care provider and medical group.

Mitigation Strategies

Better identification of grievances allows Molina to better identify opportunities for improvement. The majority of the June grievances were related to PCP assignment/re-assignment (30 percent), followed by ID card issues (12 percent), and eligibility verification (8 percent). Grievances specifically categorized as related to behavioral health represented .1 percent of the grievances. In Southwest Washington where Molina identified a significant increase in PCP change requests from one particular provider group's members, the Member Contact Center outreached to the members who had submitted grievances to collect additional information. Molina was able to reach and interview 69 percent of the members. The information was aggregated and key themes were shared with the provider directly.

As noted, a large driver of the grievances was related to PCP reassignment. It is regrettable when members have to be reassigned involuntarily and Molina makes every effort to avoid these situations. However, 100 percent of the members were successfully reassigned and Molina continues to work to open additional access within its existing network to provide more PCP choices.

Client Spotlight

A Molina Member's Experience

A Molina case manager was assigned to work with a client who had been admitted to the hospital or treated in the emergency department on 24 out of 31 days that month. The client also had been dismissed from two primary care clinics that month.

The case manager organized a multi-disciplinary care team that included mental health provider staff, Community Connectors (community health workers), a Health Homes care coordinator, and hospital psychiatric liaisons. She also worked with the client to find a new primary care provider and establish care.

The client's care team identified strengths and barriers and created an action plan, including a process for follow up communication with the team.

The following month, the client's use of hospital care and emergency department visits dropped to eight --a third of the client's use in previous months. In the next three months the client's emergency department visits dropped to three and the client has had no inpatient stays.

Molina's Community Connector has helped the client form productive relationships with new providers. Molina's case management team currently talks to the client two to three times a day.

Between the Community Connector and the case manager, the Molina health plan has remained an integral piece of ensuring the client's many service providers are connected, integrated and working as one team.

Indicator 3: Client Experience of Care – CHPW

CHPW: April to June 2016 Results

The number of grievances submitted by members was relatively stable. A spike in the number of grievances due to health care coverage ID cards was identified early in the period.

Primary Drivers

The spike in grievances due to ID cards was due to the lag between receipt of a health plan ID card and the eligibility updates in the state's health care management information system. This spike was a consequence of a State policy change in determining the eligibility date. As of April 1, 2016, the eligibility date is retroactive to the first of the month, rather than the first day of the month following application for benefits. Grievances in this area decreased after the initial spike, though are expected to continue to be an issue for enrollees seeking to use services within the first days of retroactive eligibility being established. It should be noted that this issue did not pertain solely to the FIMC region but affected members of all MCO plans across the state.

Mitigation Strategies

When CHPW identifies an increase in grievances, patterns and root causes are identified and a team is assembled to determine action steps for resolution. On a daily basis incoming calls are monitored by the CHPW Customer Service Leadership Team in order to quickly identify any issues that lead to a spike in grievances. That information is shared with other department leads so that resolution and/or talking points can be shared with the customer service representatives. The sharing of such information occurs via email, as well as during morning information huddles that take place three

days per week and are attended by the entire Customer Service Department. Additionally, the information is aggregated and reviewed on a bi-weekly and monthly basis. The information is analyzed quarterly to look at the effectiveness of interventions that are implemented.

Client Spotlight

A CHPW Member's Experience

When a member asked to change medication providers the member was referred to medical case management for care coordination by CHPW's behavioral health care management team.

The case manager consulted with the member's outpatient mental health provider, to discuss the case manager's role and identify the member's providers at the facility.

The case manager shared information with the member about collaboration with the member's provider and talked about options.

The case manager talked about the importance of complying with the medication regimen and treatment regardless of choice of providers. And, they developed a medication schedule for the member.

The case manager and mental health therapist worked together to support the member in following the medication schedule and succeeding in the community.

Through the education and encouragement provided by the case management and linkage with a therapist, the member chose to remain with the current provider, came to recognize the importance of treatment compliance and is successfully functioning in the community.

The member also felt they didn't need the level of services offered at the current residence, a supportive living center. Working with the member's therapist, the case manager discussed alternative housing options and helped the member apply for the Community Options Program Entry System (COPES) so the member could get community services.

The member now lives in an apartment and requires minimal support.

The member was accepted into COPES and will receive caregiver assistance at home. The member now works with a case manager through his outpatient mental health provider.

Indicator 6: Ombudsman Utilization Data

Beacon Health Options: April to June 2016 Results

From April to June 2016, the behavioral health ombudsman served 22 individuals in April, 22 individuals in May, and 19 individuals in June. In total in the fourth quarter of fiscal year 2015/2016 the behavioral health ombudsman served 63 individuals, as compared to 40 individuals in the same time period in FY 2014-2015. As reported by the ombudsman, this increase is related to:

- Transition from reporting only mental health grievances to reporting both mental health and substance use disorder grievances;
- Influx of Medicaid expansion consumers;
- Access to formal appeal and grievance process by substance use disorder services enrollees have that was formerly only given to mental health services recipients;
- Changes in regional mental health service authorization process as transition from RSN to MCOs occurs;
- Increased access to care for individuals seeking substance use disorder treatment. As more people are able to navigate treatment, it is expected that there will be more grievances reported.

April saw an increase in grievances related to consumer rights, dignity and respect and physician and medications. In May there were more grievances related to dignity and respect and physician and medications. June saw higher grievances related to consumer rights. At least 50 percent of the grievances were brought to resolution through information and referral. Average days to resolution ranged from 2.8 days in April, 4.5 days in May and 3.4 days in June, or 3.5 days to resolution on average during the fourth quarter of FY 2015/2015. This is compared to 3.6 average days of resolution in Q4 FY 2014/2015.

No Interruption in Mental Health Services

Consumers of public mental health services were completely uninterrupted by the April 1, 2016 roll out of the early adopter plan in Southwest Washington. The transition was really almost seamless. One case stands out as experiencing difficulties accessing services but the issues were not with the transition of care but rather miscommunication. The ombudsman's office has been really pleased with the collaborative work this new era has inspired. Kudos to the managed care organizations for hitting the ground running, to the providers for maintaining the highest level of integrity in services provision and to the Health Care Authority for being available, willing and ready to seek solutions to any concerns.

**Melanie Maiorino, Behavioral Health Ombudsman, Southwest
Washington**

Indicator 11: Crisis Hotline

Beacon Health Options: April to June 2016 Results

The crisis line received 1,516 calls in April, 1,605 calls in May and 1,484 calls in June. The data is broken down by calls directly to the toll-free number and calls routed to the toll-free number through the Skamania office line phone tree during business hours.

The April figures for the Skamania office line phone tree are lower than May and June due to the routing set on the end of the business day on March 31, 2016. It was correctly routed by May 2016. On average, 92 percent of calls are answered within 30 seconds. The average speed of answer is 14 seconds and the average abandonment rate is 3.3 percent.

SWWA Crisis Line- Clark and Skamania County Direct Call Utilization Data					
Month	Total calls	Calls Answered w/in 30 sec	% Calls answered w/in 30 sec	Avg speed of answer	% Abandonment Rate
Apr-16	1516	1489	98.2	13	2.7
May-16	1605	1465	91.3	13	2.6
Jun-16	1484	1476	86.0	17	4.6
TOTAL/AVG	4605	4227	91.8	14	3.3

Indicator 11: Crisis Diversion and Involuntary Commitments

Beacon Health Options: April to June 2016 Results

Crisis system data collected from Beacon Health Options suggests a stable crisis system, with mental health and SUD detention rates consistent with baseline data.

Clark County: From April through June 2016 the Clark County crisis team conducted:

- 335 crisis calls, 64 ITA investigations in April, 28 detentions and 13 individuals who voluntarily admitted;
- 278 crisis calls, 59 ITA investigations in May, 23 detentions and 15 individuals were voluntarily admitted;
- 294, 55 ITA investigations in June, 23 detentions and 19 individuals voluntarily admitted

Of the total number of in person meetings, only 28 percent required hospitalization resulting in a diversion rate of 71 percent.

For comparison to available baseline data from Southwest Behavioral Health, an average of 19 individuals per month were detained in 2013, and an average of 24 individuals per month in 2014. Baseline data on voluntary admissions is not available.

Skamania County: From April through June 2016, the Skamania County crisis team conducted:

- 10 crisis calls in April, 2 ITA investigations, 0 detentions;
- 8 crisis calls in May and 4 ITA investigations, 0 detentions;
- 11 crisis calls in June and 4 ITA investigations, 0 detentions.

On average, the crisis team responded to 48 percent of crisis calls with an in- person meeting after providing phone support. As a result, 100 percent of crisis calls the Skamania County crisis team responded to in person were diverted from higher level of care.

This is consistent with available baseline data from 2015, in which no individuals were detained in Skamania County.

Clark County Mobile Crisis	Skamania County Mobile Crisis																																								
April 2016	April 2016																																								
<table> <tr> <th colspan="2">Mobile Crisis and ITA</th></tr> <tr> <td>Total calls received</td><td>335</td></tr> <tr> <td>Resolved after call</td><td>235</td></tr> <tr> <td>Required in person follow up</td><td>110</td></tr> <tr> <td colspan="2"></td></tr> <tr> <td>ITA Investigation</td><td>64</td></tr> <tr> <td>Detained</td><td>28</td></tr> <tr> <td>Voluntary Admit</td><td>13</td></tr> <tr> <td>Discharged with Referral</td><td>10</td></tr> <tr> <td>Other</td><td>3</td></tr> </table>	Mobile Crisis and ITA		Total calls received	335	Resolved after call	235	Required in person follow up	110			ITA Investigation	64	Detained	28	Voluntary Admit	13	Discharged with Referral	10	Other	3	<table> <tr> <th colspan="2">Mobile Crisis and ITA</th></tr> <tr> <td>Total calls received</td><td>10</td></tr> <tr> <td>Resolved after call</td><td>6</td></tr> <tr> <td>Required in person follow up</td><td>4</td></tr> <tr> <td colspan="2"></td></tr> <tr> <td>ITA Investigation</td><td>2</td></tr> <tr> <td>Detained</td><td>0</td></tr> <tr> <td>Voluntary Admit</td><td>0</td></tr> <tr> <td>Discharged with Referral</td><td>2</td></tr> <tr> <td>Other</td><td>0</td></tr> </table>	Mobile Crisis and ITA		Total calls received	10	Resolved after call	6	Required in person follow up	4			ITA Investigation	2	Detained	0	Voluntary Admit	0	Discharged with Referral	2	Other	0
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Indicator 11: Substance Use Disorder Commitments

Beacon Health Options: April to June 2016 Results

HCA received baseline data from Pioneer Human Services to determine the rate of SUD commitments per RCW 70.96A.140. In 2014, 92 people from Clark County received SUD involuntary commitment services, or an average of 7.6 per month. In the past seven years, two people from Skamania County have received SUD involuntary commitment services.

Consistent with baseline rates:

- Six people from Clark County were committed to SUD treatment in April;
- Seven people from Clark County were committed to SUD treatment in May;
- Five people from Clark County were committed to SUD treatment.
- Zero individuals from Skamania County were committed to SUD treatment in April, May or June 2016.

Indicator 12: Foster System Coordination

Coordinated Care: April – June 2016 Results

Medicaid foster clients who live in Skamania or Clark County receive behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients choose between CHPW and MHW for specialty mental health and substance use disorder health services and receive physical health services and mild-moderate mental health services through the statewide foster care plan with Coordinated Care of Washington (CCW).¹

CHPW and Molina have collaborated to ensure strong care coordination for these clients, including:

- Using the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW;
- Collaborating through case conference on individual cases requiring care coordination;
- Sharing a list of in-network behavioral health providers. Coordinated Care targeted all of these providers for contracting to ensure member continuity of care;
- Developing formal agreements to allow for data sharing.

¹ This is the same system as foster clients experience in all other regions of the state. Foster clients in all other regions receive behavioral health benefits through the regional Behavioral Health Organization and are enrolled in the statewide foster care managed care plan through Coordinated Care of Washington for physical health and mild-moderate mental health.

Beyond the Early Warning System Data

Implementation Issues and Solutions

To ensure a smooth implementation and a mechanism for rapid problem-solving HCA hosted daily phone calls in April 2016 with key implementation stakeholders, including CHPW, Molina, Beacon, Clark and Skamania counties, providers, and a representative from the Regional Health Alliance. During the second month of implementation, calls decreased to three times per week, and decreased to once per week beginning in June.

The following is a summary of the main implementation issues that arose on the calls, and resolution.

Implementation Issues and Solutions

➤ *Educating SUD providers outside Clark and Skamania*

Issue:	Resolution:
During the first several days of implementation, HCA and DSHS received reports that SUD providers outside of Southwest Washington thought they could not accept clients or referrals from clients residing in Clark or Skamania counties.	<p>HCA and DSHS issued a joint letter to SUD providers statewide, with information on how to use ProviderOne to identify a client's managed care plan. The letter directed SUD providers to contact the managed care plan if they have a client from Southwest Washington in treatment.</p> <p>Additionally, Molina and CHPW reissued communications to providers about single-case agreements, which allow providers without a contract with CHPW or Molina to be reimbursed for services provided to Southwest Washington residents. These efforts, along with additional education and communication efforts between the state, providers and plans resolved the issue.</p>

Implementation Issues and Solutions

➤ *Protected Addresses*

Issue:	Resolution:
Clients with protected addresses are assigned to Thurston/Mason BHO, but request services in Southwest Washington (as well as other regions – statewide issue). Providers in Southwest Washington were unsure how to bill for services for these clients.	<p>Clients with protected addresses, such as victims of domestic violence, must contact HCA to enroll into CHPW or Molina.</p> <p>Additionally, HCA communicated to providers in Southwest Washington that when a client with a protected address arrives for services, they should have the client contact HCA to enroll in CHPW or Molina for coverage.</p>

Implementation Issues and Solutions

➤ *American Indian/ Alaska Natives (AI/AN) Enrollment*

Issue:

As of April 1, 2016 AI/AN clients in Clark and Skamania counties were auto-enrolled in “behavioral health services only” coverage and fee-for-service physical health coverage. For AI/AN clients who had previously opted-in to managed care for physical health services, this had the effect of removing their enrollment from managed care for physical health.

Resolution:

AI/AN clients or their heads of household in Clark or Skamania counties may enroll in the FIMC program at any time either online at www.wahealthplanfinder.org or by calling the Medical Assistance Customer Service Center at 1-800-562-3022. HCA shared this information with the Cowlitz Tribe on April 13, 2016.

Implementation Issues and Solutions

➤ *Interpreter Services*

Issue:

Before April 1, 2016, mental health providers in Southwest Washington were able to obtain interpreters from private language agencies and receive reimbursement from the RSN. On April 1, 2016, HCA transitioned providers in Southwest Washington to the use of CTS LanguageLink, which is HCA’s statewide interpreter services vendor. CTS LanguageLink is primarily designed and contracted to provide interpreter services in the outpatient setting and had not been contracted to provide translation services in behavioral health settings before April 1, 2016. Certain providers in Southwest Washington, such as crisis service providers and Evaluation and Treatment providers require access to services on a rapid basis, and are not able to provide 72-hour notice for interpreter service requests. Additionally, some languages were not as readily available through CTS. Providers were concerned that they no longer had a mechanism to receive reimbursement if they worked with a different language agency.

Resolution:

By May 3, 2016, HCA developed a process to allow behavioral health providers to access interpreters from private language agencies, as they had before April 1, when they cannot obtain an interpreter through CTS. This process allows behavioral providers to submit an invoice to CTS and be reimbursed for the cost of the private language agency interpreter, as they did before April 1 under the RSN system.

Implementation Issues and Solutions

➤ *Juvenile Justice/WISe*

Issue:

The Clark County Juvenile Justice Center supports a program called Connections, which provides wraparound and specialized probation services to juvenile offenders with behavioral health support needs. At times, there are youth who receive services from both Connections and the WISe program through Catholic Community Services (CCS). CCS provides intensive wraparound services to youth and their families in the mental health system. The concern was a duplication of services without clarity of responsibility.

Resolution:

Two different approaches were implemented to provide clarity to this issue. Connections and the WISe programs function from a team model and each program has multiple teams. The experience level of team members as it relates to clinical and community knowledge dictates the length and path of the conversations. Both programs are focused on the highest level of support for families while avoiding any duplication of efforts. This continues to be achieved through ongoing communication and coordination. In addition to this practice, Molina initiated several meetings with the staff of Juvenile Justice, Beacon Health Options, and the MCOs – including Coordinated Care for foster youth, foster alums, and foster-to-adopt enrollees – to gain knowledge from each other and to discuss how they can work together to better support youth in the juvenile justice system. The management staff at Juvenile Justice described the response to this issue as being incredibly helpful and proactive.

Implementation Issues and Solutions

➤ *Client addresses in CLIP, SUD Residential and Western State Hospital*

Issue:	Resolution:
<p>HCA has uncovered a variety of issues related to client addresses during the transition to FIMC. Correct client addresses are of greater importance in the transition to full integration, because Medicaid beneficiaries cannot be enrolled in coverage with CHPW or Molina unless they have a correct address/ZIP code in the Clark and Skamania coverage area. HCA has learned that addresses in ProviderOne are typically changed to the facility address when clients go to:</p> <ul style="list-style-type: none"> • Children’s Long-Term Inpatient Facility (CLIP); • Substance use disorder residential treatment; • Western State Hospital <p>This has the effect in Southwest Washington of removing the client from enrollment in CHPW/Molina coverage, and enrolling them in the BHO that corresponds to the address.</p> <p>This address change creates a variety of issues, because the BHO receives a premium payment and becomes financially at-risk for the individual; however they are not the entity that authorized the original treatment. And, typically the individual is discharged back to the Southwest region and CHPW or Molina need to coordinate discharge planning and a treatment plan to prepare for discharge. Upon investigating this issue further, HCA has determined that it is of critical importance that addresses not be changed in ProviderOne simply because an individual has relocated temporarily to receive treatment in an inpatient or residential setting.</p>	<p>HCA and DSHS jointly established an address workgroup to identify solutions to the problem of changed addresses. In May, HCA proposed solutions to the BHO Administrators, which were approved. The solution will allow addresses at SUD residential facilities and CLIP facilities to stay in place as the client’s home address, rather than reverting to the facility address. HCA and DSHS are jointly working on a process & communications plan to initiate this change with CLIP facilities and SUD residential providers.</p>

Beyond the EWS Data: Collaborative Systems Developed in Southwest Washington

Behavioral Health Planning Council

The Southwest Washington Region created the Behavioral Health Planning Council, consisting of representatives from Clark and Skamania counties, consumer organizations, the Behavioral Health Provider Alliance, Beacon Health Options, Council for the Homeless, Molina Healthcare, and Community Health Plan of Washington (CHPW). The primary focus of this council is to improve and strengthen the Behavioral Health System Continuum of Care to address unmet consumer needs in a coordinated and integrated manner for the region. The Behavioral Health Planning Council meets monthly and is in the process of developing an ongoing regional plan, using the following guiding principles:

- Make data-driven decisions
- Assess if a topic is a priority/need
- Foster community partnerships
- Support development of provider capacity
- Include consumer voice
- Collaborate and execute with action

The Behavioral Health Planning Council is currently mapping out the existing regional behavioral health systems and identifying top priorities to focus on using community needs assessment data. The group has already started to collaborate on efforts to improve access to services for people with behavioral health disorders and in need of housing. The council has already started working collaboratively on various projects. An example of one is the joint funding a Behavioral Health Specialist to work directly with Lincoln Place, which implemented a “housing first” program in Vancouver, Washington. Partners working on this project include Clark County, Molina Healthcare, CHPW, Beacon Health Options and providers Community Services NW and Share Vancouver. Another effort is focused on providing housing support and treatment to two new apartment complexes that will provide housing targeting people with behavioral health disorders.

The Behavioral Health Planning Council has also created a work group to develop a legislative proposal to submit to the Governor and Legislature during the next legislative session. The proposal will request capital funds to support creating a regional crisis stabilization center to help divert people from emergency rooms, jails and Western State Hospital.

Clinical Rapid Response Group (CRRG)

The Clinical Rapid Response Group (CRRG, pronounced *surge*) was established by CHPW, Molina, and Beacon Health Options to enable immediate response to any difficult clinical scenarios in which the guarantor for services is not immediately obvious. For these situations, decision makers from each funding source (Medicaid or non-Medicaid) have agreed to set up a same-day conference call with each other and the providers to assess the circumstances and determine the immediate and ongoing funding obligations. The CRRG group has been successful in establishing a protocol that

is able to respond to emerging needs immediately and develop a plan of action and communication loop. The CRRG was deployed on one occasion during the first 90 days of implementation and it had the successful outcome of determining short-term funding and long term obligations for services. More importantly, the individual who needed services was able to receive them without delay or administrative interference that could have been a barrier had the CRRG not been in place.

Looking Ahead

As Southwest Washington stabilizes transition-related processes, strategic planning work has begun to increase integration of care and services at multiple levels, and identify and close critical gaps in the continuum of services and supports. The primary areas of focus are:

- 1) Expand and enhance the full continuum of behavioral health services, particularly crisis response services, detox beds and developing a more structured mobile outreach program for substance use disorder treatment;
- 2) Increase coordination and communication between medical and behavioral health providers;
- 3) Convene physical and behavioral health providers to explore co-location opportunities, and
- 4) Develop collaborative relationships with housing providers to expand affordable, supportive housing services.

Initial specific goals include:

- 1) Expand children's crisis mobile response services and development of short-term respite services;
- 2) Increase the number of Evaluation and Treatment (E&T) beds for adults and children to reduce single-bed certifications and out-of-region placements;
- 3) Develop a training curriculum on the core elements of clinical integration all providers can adopt, such as effective use of Release of Information, and brief screening and intervention models; and
- 4) Accelerate co-location efforts that are already under way.

The newly formed Behavioral Health Strategic Planning Council, a coalition of MCOs, Beacon Health Options, behavioral health providers, Clark and Skamania counties staff, and consumer and housing representatives is leading the planning to improve the behavioral health system of care. Working collaboratively with the ACH, a similar coalition will be convened this year by the MCOs and Beacon to drive strategy planning for broader health systems integration.

Additionally, beginning with the first nine months implementation baseline period, Department of Social & Health Services (DSHS) Research and Data Analysis (RDA) staff will measure the four key performance targets (mental health treatment penetration; SUD treatment penetration; hospital readmission rates; and emergency department use), and will report results quarterly. The HCA also plans a formal evaluation of the FIMC program.

ACH Project Development

Center for Community Health and Evaluation
September 2016



An Accountable Community of Health (ACH) is a regional coalition consisting of representatives from a variety of sectors, working together to improve population health. There are nine ACHs operating across the state as part of the Healthier Washington initiative, which are currently funded through a State Innovation Models (SIM) federal grant. ACHs are intended to strengthen collaboration, develop and implement regional health improvement efforts, and provide feedback to state agencies about their regions' health needs and priorities.

A key responsibility of the ACHs in Healthier Washington is to facilitate and coordinate projects that bring together multiple sectors to collaboratively address a health priority within their region. In July 2016, all nine ACHs submitted initial project proposals to the Health Care Authority (HCA) and have since moved forward with further planning and preparation for project implementation.



This report discusses the role these health projects are playing in ACH development as coalitions, the preliminary details of the ACH projects in each region, and the opportunities for capacity building as a result of the ACH projects.

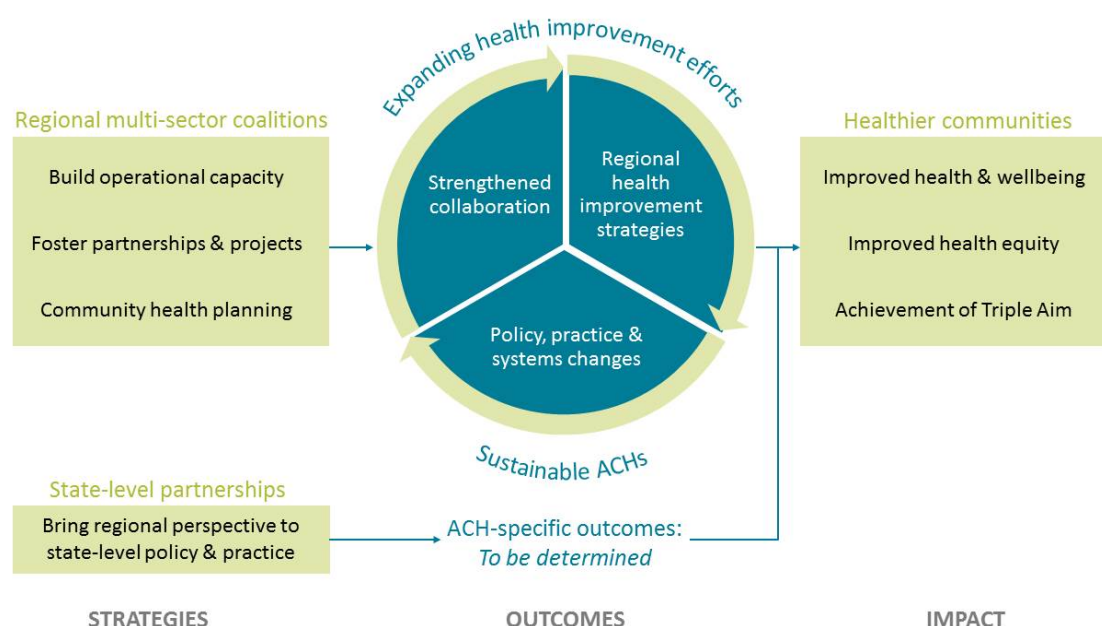
Projects are a key step in ACH development

The projects ACHs are engaged in now are the first iteration of continuous regional health improvement efforts, as envisioned in the ACH Theory of Change (p. 2), which was developed by the Center for Community Health and Evaluation (CCHE) in partnership with the HCA and with input from the ACHs.

Reading from left to right, in 2015 the ACHs began organizing and engaging stakeholders from many sectors and community perspectives across their regions—some of which had never worked together before. Much of the ACHs' first year focused on building their coalitions, including operational and governance structures, decision-making processes, and shared regional agendas with health improvement priorities.

In 2016, ACHs have started work on the center of the Theory of Change, with selection of their first projects, and will begin to lead their regions through a continuous cycle of implementing health improvement projects and strategies that will grow, spread, and hopefully be sustained over time.

Accountable Communities of Health | Theory of Change



ACHs are moving to action

With the selection of their first projects, ACHs have shifted their focus to collective action. Central to that shift is selecting a regional health improvement project that will demonstrate their coalition's capacity to facilitate collaboration and coordinate activities across stakeholders to advance a common goal. ACHs were required by the HCA to select and submit a proposal for their project by July 31, 2016. All nine ACHs successfully submitted proposals by the deadline and received approval and \$50,000 additional funding for their project ideas from the HCA, marking a key milestone for ACH development.

Approaches to the project selection process varied in scope, intensity, and transparency across the regions. Identifying and agreeing on a project took significant time and deliberation for many ACHs. Examples of steps taken by these ACHs include:

- Calling for project ideas from ACH member organizations and community stakeholders
- Developing a review process for project submissions, with assessment criteria that consider ACH regional priorities, opportunities for cross-sector engagement, and feasibility of activities
- Deliberation by a committee of ACH members to select a project for recommendation to the ACH's decision-making body
- Review and selection of a project by the ACH's decision-making body

Capacity Building In Action The process of selecting and planning their first collaborative health improvement projects is a critical exercise for ACHs. They will need to continue making collective decisions and commit to joint activities to carry out their projects. The lessons learned about priority setting and transparent decision making will help ACHs make process improvements and inform future efforts coordinated by the ACHs, such as spreading projects or policy and systems level changes that contribute to health systems transformation.

ACHs are building collaborative partnerships

The development of project proposals and the continued work around planning and implementation has brought together a number of stakeholders in collaborative efforts. The HCA requires that all ACH projects engage individuals or organizations from more than one sector. As a result, many ACH projects are bringing together health care and non-health care stakeholders within their regions.

Capacity Some stakeholders have collaborated previously, but for many stakeholders the ACHs are helping to foster new partnerships, where organizations are working together for the first time, or more intentionally and more in-depth than before. Further developing these partnerships, as well as determining how all ACH members can support project efforts, will help strengthen each ACH's ability to work collectively.

Sectors and organizations contributing to ACHs' projects vary across regions, and include:

- Behavioral health
- Community health clinics
- Education (K-12 and college/university)
- First responders
- Hospitals
- Housing
- Medicaid managed care (MCOs)
- Primary care providers
- Public health
- Social services
- Substance abuse treatment

ACHs are also engaging with Tribes and Urban Indian Health Programs. The interest and engagement of a wide variety of organizations in ACH projects signifies that stakeholders recognize that many sectors influence population health and that ACHs have the potential to bring the right people together to affect meaningful change.

ACH projects vary by region

No two ACHs are implementing the same project. Each ACH's project is slightly different, based on regional context, priorities, stakeholders, and resources—but there are themes in the health issues addressed and strategies being implemented across multiple regions.

Consistent across all ACHs is the theme of improving access to needed services. Ranging from primary care to chronic disease management, behavioral health, and non-clinical or social services, each ACH is striving to improve access to services that will improve health in their regions.

Capacity Each ACH's project topic is also relevant to future statewide population health improvement and health care delivery transformation. As such, projects are an opportunity for shared learning and idea exchange across the regions in addition to capacity building within individual ACH regions. At cross-ACH meetings, there has already been discussion of keeping each other informed of project progress, so strategies that are proven to be successful can be shared and scaled-up across multiple ACHs.

Below are brief summaries of each ACH's project. Similar details, as well as a short description of each ACH's governance structure and regional health priorities can be found in the appendix.

Five ACHs are focusing on care coordination

Care coordination is the focus of five ACHs' projects, but the target population for each ACH varies, from chronic disease patients or individuals at-risk of hospital readmissions, to those living in public or affordable housing.

Four of these ACHs are utilizing Community Health Worker (CHW) strategies: Better Health Together, Greater Columbia ACH, King County ACH, and Pierce ACH. Greater Columbia is also using a nursing (RN-BSN) care transition/coordinator role as part of their activities. Although each ACH is implementing slightly different tactics, these projects aim to build clinic-community linkages, help patients access appropriate health care, and connect patients to social services and community resources that address their non-clinical needs related to the social determinants of health. The other ACH doing care coordination, Cascade Pacific Action Alliance, has already moved to action with a school-based strategy to connect students with behavioral health services in the community.

Better Health Together (BHT)

Project title: Pathways Hub Pilot

The ACH will implement two community pilots to “coordinate the coordinators,” using a model that has been implemented elsewhere across the U.S. One will be a jail transition pilot to connect people transitioning out of the Ferry County jail and their families to stabilizing services. The second focus is still to be finalized. Within these pilots, the ACH will coordinate five Medicaid Managed Care Plans, four primary care clinics/health systems, and three social determinants of health organizations to implement a standardized process to identify and address the needs of 150 at-risk individuals by connecting them to community based, coordinated services.

Going through our regional priorities planning, an issue emerged about coordinating the coordinators. Each of the health-related sectors has a version of care coordinators. The Pathways Model creates a framework for centralizing community referrals.

– ACH backbone staff member

Cascade Pacific Action Alliance (CPAA)

Project title: Youth Behavioral Health Coordination Pilot Project

The ACH project is addressing adverse childhood experiences (ACEs) through prevention and mitigation using school-based behavioral health referrals. In four pilot sites across four counties, the ACH is coordinating with school districts, clinicians, and behavioral health care providers to identify students with behavioral challenges as early as possible and connect the children and their families to community-based interventions and treatment services.

Capacity Building In Action CPAA was the first ACH to implement their project. The ACH engaged school districts and designed the project to place new care coordinators or licensed behavioral health providers in schools. The pilot project launched at Monticello Middle School in Cowlitz County in September 2015. In its first year, the project served over 60 students and the school reported improvements in attendance and disciplinary actions resulting from the program. The ACH is leveraging the lessons learned as they work to spread the project to three additional school districts and provide behavioral health therapy in some rural schools.

Greater Columbia ACH

Project title: Readmission Avoidance Pilot

The ACH project will coordinate the clinical care and social supports for patients at risk for hospital readmission using a combination of care transition support and connections to social services. Nursing students (RN-BSN) will help with discharge planning for patients to assess follow-up medical and social needs and to improve care transitions and communication across care settings. CHWs will connect patients to community resources to address non-clinical patient needs. Patients in the program will be geocoded to identify community ‘hotspots’.

King County ACH

Project title: Prevention and Management of Chronic Disease in Low-Income and Immigrant Populations through Housing-based and Community Health Worker Interventions in King County

The ACH project will leverage existing CHW initiatives operating at 10 public and affordable housing properties with the goal of strengthening and spreading this intervention. Currently, CHWs work with the housing residents to coordinate care for Medicaid enrollees from historically underserved communities with or at risk of chronic disease. The ACH will analyze the impact of the CHW programs, while also working with ACH partners to increase investment and build institutional relationships.

Pierce County ACH

Project title: Blood Pressure Project to Link Community Health Workers and Health Care Systems

The ACH project will utilize CHWs to offer chronic disease prevention in non-clinic settings, including educating patients about blood pressure self-monitoring, collecting blood pressure data, and connecting patients to chronic disease treatment services. The project will coordinate recruiting, hiring and training people with appropriate cultural and linguistic skills as CHWs. The project has a longer term goal of creating a multi-agency CHW “Hub”.

The ACH provides the opportunity for these agencies from different sectors to focus on health equity, prevention and health promotion - major components of the transformed health system.

– ACH project submission

Four ACH projects are developing diverse strategies

The four remaining ACHs are working on a variety of other health improvement issues through a diverse set of strategies. This variation of approaches to health improvement provides an early glimpse into the broad range of health improvement topics and tactics that ACHs could tackle in future endeavors.

North Central ACH

Project title: Whole Person Care Collaborative

The ACH is supporting care transformation by forming a whole person care collaborative to help health care providers implement delivery system changes. The goal is to improve the capacity of provider organizations across the North Central region to define and implement effective Whole Person Care in primary care clinics through collaboration and sharing resources.

North Sound ACH

Project title: Prevention via Increasing Awareness and Accessibility of Long-Acting Reversible Contraception (LARC)

The ACH project works to improve maternal health, with a specific focus on activities that will increase awareness about long-acting reversible contraception (LARC) as an effective contraceptive method, as well as increasing access to LARC. The ACH will bring together health care, Medicaid Managed Care, and community organizations to train providers and educate consumers about LARC to increase contraceptive options and decrease unintended pregnancy.

Olympic Community of Health (OCH)

Project title: Olympic Peninsula Coordinated Opioid Response

The ACH project is the beginning of a comprehensive initiative to coordinate and implement a community response to the regional opioid crisis, including opioid abuse, dependence, and overdose. The ACH is engaging the Salish Behavioral Health organization, tribal nations, and Kitsap, Jefferson, and Clallam counties in this work. The project will first focus on an assessment and planning phase before the ACH develops and coordinates implementation of a multi-strategy, region-wide effort.

No single sector or county can solve this problem alone.

– ACH project submission

Southwest Washington Regional Health Alliance (SWWA RHA)

Project title: Co-location of Primary Care in Behavioral Health Settings

The ACH project will help connect behavioral health patients to primary care by addressing obstacles and implementing strategies to develop a nontraditional, reverse co-location model where physical health services will be provided by nurse practitioners, in-house at two behavioral health sites. A key goal is to identify barriers for behavioral health patients who need access to primary care and help those individuals connect with a provider.

ACHs are learning to measure progress and outcomes

A key component of a successful project is the development of concrete measures to understand progress and to provide continuous learning opportunities as the project grows. As part of their project proposals to HCA, the ACHs were required to identify potential outcomes, indicators, and data sources for measuring progress. Project submissions varied widely in the level of detail and types of outcomes and indicators suggested. Some ACHs provided broad, high-level indicators to track project progress, while other ACHs articulated specific metrics tied to existing public health or health care data sources. In addition, some only focused on short-term process measures related to project implementation, while others focused on long term impact measures to assess population health improvement.

Capacity Building In Action Measuring project progress and success may be a challenging component of health improvement projects, but it is the ACHs' first opportunity to concretely demonstrate their value-add to their regions. Developing an evaluation framework will require stakeholders to agree on clear outcomes and indicators to assess project progress, as well as key milestones

to help hold each other accountable during project implementation. This will facilitate data-driven decision-making as the projects move forward and help ACHs communicate about their projects with key partners, regional stakeholders, other ACHs, and state agencies.

ACHs will need to develop strong process measures and milestones to understand their incremental progress toward long term goals, since health improvement projects can take years to reach the scope and impact necessary to improve regional population health measures. This will allow ACHs to highlight project effectiveness and ACH value-add to their respective regions in the short-term, and help demonstrate the positive impact of project activities on target sub-populations. Although several ACHs have cited it as a challenge within current resources, developing the infrastructure and capacity to collect and interpret data across their regions will allow ACHs to coordinate and implement current and future projects and activities.

As an evaluation partner, the Center for Community Health and Evaluation (CCHE) is providing coaching services to the ACHs specifically on data and measurement, to help ACHs expand upon their initial measurement ideas and form evaluation plans that will track key milestones, assess early outcomes, and inform project development, improvement, and reporting. CCHE is working with several of the ACHs on designing project logic models, selecting indicators, and developing data collection strategies. This includes identifying existing data sources the ACHs can partner with, such as Healthier Washington's AIM (Analytics, Interoperability, and Measurement) team.

Long term outcomes are aligning with broader Healthier Washington measures

CCHE is also working with ACHs to map their projects to the long term health outcomes elevated in Healthier Washington's [Common Measure Set](#). The HCA has adopted a set of 55 metrics as a standard way to measure the impact of the Healthier Washington initiative. The common measures are being incorporated into other state contracts, including those with health plans and providers, with the expectation that adoption of these measures will grow over time. The ability to understand regional ACH impact on these measures will demonstrate the role ACHs play in moving the Healthier Washington initiative forward. However, it is likely to take years of activities, as well as spreading and scaling successful projects, to achieve impact on a regional or state-level population health metric.

The figure to the right categorizes the Common Measure Set into three areas of focus and highlights (in bold) areas of overlap with potential long term outcomes for ACH projects. While some ACH projects map directly to the common measure set, others will be more challenging to align given the social determinants of

Mapping long term ACH project goals and areas of focus in the Common Measure Set

Prevention	Acute Care	Chronic Illness
Access to primary care	Avoidance of overuse/ potentially avoidable care	Appropriate use of medications
Adult screening(s)		
Childhood: early and adolescent	Behavioral health	Asthma
Immunizations	Cardiac	Depression
Obesity/ Nutrition/ Physical activity	Hospital readmissions	Hypertension and cardiovascular disease
Oral health	Obstetrics	Diabetes
Tobacco cessation	Patient safety	
Unintended pregnancy	Stroke	
Cross cutting: Patient experience and cost of care		

health focus that projects have, which is not fully represented in the Common Measures set. It will be important to capture additional long-term measures to demonstrate the ACH value in their regions.

Next steps: Implementation, evaluation and continuous learning

ACHs moving forward with project implementation

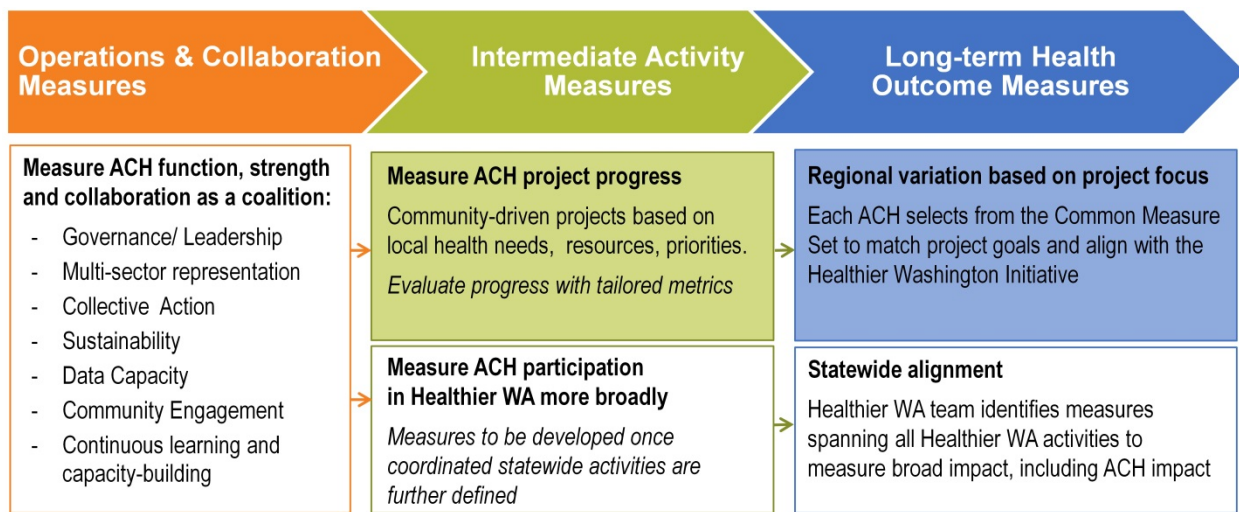
Project selection and planning are important ACH milestones, but they are only the beginning of the health improvement process. In the coming months, ACHs will need to continue with regional assessments, baseline data collection, action planning, stakeholder engagement, and activity implementation. ACHs will launch their projects in earnest and begin measuring preliminary outcomes and communicating progress to key audiences.

Maintaining project momentum will be vital for ACHs to demonstrate their role as conveners and coordinators of regional population health efforts. Each of the ACHs' projects highlights how that role can take a variety of forms. Some ACHs are focusing on a short-term early win project to demonstrate collaboration. Some ACHs have projects that are complementary to other Healthier Washington activities, such as the Practice Transformation Hub, to showcase how alignment of resources can advance regional and state goals. Other ACHs are developing regional initiatives or comprehensive models that highlight the ACHs' potential as key contributors to other health innovation initiatives in the future. All these approaches are important in strengthening the ACHs, reinforcing cross-sector partnerships, and proving the ACHs' value.

Ongoing evaluation of the ACH initiative

Development of the ACH projects and associated measures is a key step in understanding the impact of the ACHs overall. As an evaluation partner, CCHE will continue to work with ACHs and the HCA to evaluate the ACHs' impact as depicted by the ACH Chain of Impact below. Each ACH's progress on their projects provides a concrete example of their contributions to health improvement within their region, as well as an opportunity to develop their capacity to take collective action.

The ACH Chain of Impact



Leveraging lessons learned will be essential

As highlighted throughout this report, implementing projects provide a wealth of capacity building opportunities for ACHs, such as improving their collaborative and transparent decision-making processes, bringing new stakeholders to the table, taking collective action on project activities, and holding each other accountable for project success.

Leveraging the lessons learned from this process will help ACHs develop more effectively as individual regions and as members of a statewide initiative. The incorporation of continuous learning and capacity building into both individual ACH operations and the ACH initiative as a whole is essential. The following initial lessons learned and key considerations are emerging based on project proposals, cross-ACH learning opportunities and conversations with individual ACHs:

- **Collaborative, transparent decision-making is central to the development and success of ACHs.** The decision-making process used by ACHs to select their projects should inform adjustments to decision-making in the future so they can continue to strengthen regional commitment and implementation of collective decisions. For example, some ACHs are discussing the processes they used to select a project, reflecting on what worked well and what did not, so they can refine the process.
- **Relationship-building, trust, and partnership takes time.** ACH projects are an opportunity to bring together multi-sector stakeholders and form lasting partnerships that can be leveraged in the future, especially when addressing the social determinants of health, but **adequate time and effort must be invested in continuous learning.** As projects move forward, ACHs have the opportunity to regularly discuss project successes and barriers, to help refine activities and identify opportunities for all ACH members to be involved, either by implementing activities or helping inform the community about project efforts.
- **Thoughtful data collection and measurement of activities and outcomes will help ACHs** monitor project success and communicate results to regional partners, state agencies, and future potential funders. It will also help build infrastructure and capacity within their regions that will be critical to future regional efforts.
- **Promoting peer-to-peer learning between regions has already proved valuable to ACH development.** Existing ACH discussion forums can be leveraged to facilitate cross-ACH discussion, peer-support, and sharing of best practices. The HCA can also leverage technical assistance and evaluation partners to support peer learning and address emerging issues in ACH development.
- **Oversight of Healthier Washington more broadly puts HCA in a unique position to help elevate lessons learned and areas for growth across ACHs,** as well as opportunities for synergy between ACH development, regional projects, and other Healthier Washington activities. By communicating these insights and any expectations or requirements in a clear and timely fashion to ACHs, HCA can help guide and enhance ACH development and project implementation.

I heard from other regions some ideas that I'd love to bring to our region and scale up...learning from what other regions are doing on health priorities that we have, too.

– ACH backbone staff member

Appendix: ACHs At-a-glance Handout

ACH	Counties	Backbone	Governance (decision-making in bold)
Better Health Together (BHT) website	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	Better Health Together	15-member Board of Directors that governs both ACH and BHT programs. 80 regional organizations participate in an ACH Leadership Council. Rural county coalitions are emerging for local activation.
Cascade Pacific Action Alliance (CPAA) website	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	CHOICE Regional Health Network	44-member Regional Coordinating Council which uses a consensus decision-making model. Seven county level forums convene local stakeholders.
Greater Columbia (GC ACH) website	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	Benton-Franklin Community Health Alliance	17-member Board of Directors as well as an open participation Leadership Council that regularly includes 30-50 regional participants.
King County website	King	Public Health-Seattle & King County	25-member Interim Leadership Council with an Interim Steering Committee. Workgroups include Council and community members.
North Central (NCACH)	Chelan, Douglas, Grant, Okanogan	Chelan-Douglas Health District	17-member Governing Board and three county-level Coalitions for Health Improvement (CHIs) that convene local stakeholders.
North Sound (North Sound ACH) website	Island, San Juan, Skagit, Snohomish, Whatcom	Whatcom Alliance for Health Advancement	29-member Governing Body that includes regional stakeholders from all five counties. A Steering Committee.
Olympic Community of Health (OCH) website Facebook	Clallam, Jefferson, Kitsap Instagram Twitter	Kitsap Public Health District	22-member Governing Board includes 15 sectors and seven tribes. Executive Committee and Regional Health Assessment and Planning Committee reviews health assessments and advise board on regional priorities.
Pierce County website	Pierce	Tacoma-Pierce County Health Department	23-member Board of Trustees. Pierce Health Innovation Partnership that engages 30-40 regional stakeholders.
Southwest Washington Regional Health Alliance (SWWA RHA) website	Clark, Skamania	Southwest Washington RHA	22-member Board of Directors that governs both ACH and Early Adopter Behavioral Health activities. A Community Advisory Council includes 13 Medicaid enrollees.

ACH	Regional Priorities	Regional Projects (under the State Innovation Model (SIM) grant)
Better Health Together (BHT) website	<ul style="list-style-type: none"> • Access to oral health care • Community-based care coordination • Linkages in housing, food security & income stability systems • Obesity reduction & prevention • Whole-person care 	Pathways Hub Pilot: For two pilots, the ACH will coordinate five Medicaid Managed Care Plans, four primary care clinics/health systems, and three social determinants of health organizations to implement a standardized process to identify and address the needs of 150 at-risk individuals by connecting them to community based, coordinated services.
Cascade Pacific Action Alliance (CPAA) website	<ul style="list-style-type: none"> • Access to care & provider capacity • Adverse childhood experiences (ACEs) prevention & mitigation • Chronic disease prevention & management • Economic & educational opportunities • Health integration & care coordination 	Youth Behavioral Health Coordination Pilot Project: In four pilot sites across four counties, the ACH is coordinating with school districts, clinicians, and behavioral health care providers to identify students with behavioral challenges as early as possible and connect these children and their families to community-based interventions and treatment services.
Greater Columbia (GC ACH) website	<ul style="list-style-type: none"> • Behavioral health • Care coordination • Healthy youth & equitable communities • Obesity/diabetes • Oral health: primary caries prevention 	Readmission Avoidance Pilot: The ACH will coordinate the clinical care and social supports for patients at risk for hospital readmission. Nursing students (RN-BSN) will help with discharge planning for patients to assess follow-up medical and social needs and to improve care transitions and communication across care settings. Patients in the program will be geocoded to identify community 'hotspots'.
King County website	<ul style="list-style-type: none"> • Access to care • Care coordination for complex needs • Health equity • Housing-Health intersections • Prevention: chronic disease & social determinants of health • Physical/behavioral health integration 	Prevention and Management of Chronic Disease in Low-Income and Immigrant Populations through Housing-based and Community Health Worker Interventions in King County: The ACH will leverage three organizations' Community Health Worker (CHW) initiatives in 10 public and affordable housing properties to coordinate care for Medicaid enrollees from historically underserved communities with or at risk of chronic disease.
North Central (NCACH)	<ul style="list-style-type: none"> • School-based obesity prevention • Whole Person Care health care transformation 	Whole Person Care Collaborative: This initiative will improve the capacity of provider organizations across the North Central region to define and implement effective Whole Person Care in primary care clinics through collaboration and sharing resources.
North Sound (North Sound ACH) website	<ul style="list-style-type: none"> • Behavioral health integration & access • Care coordination • Dental & primary care access • Health disparities • Housing • Prevention 	Prevention via Increasing Awareness and Accessibility of Long-Acting Reversible Contraception (LARC): The ACH will bring together health care, Medicaid Managed Care, and community organizations to train providers and educate consumers about LARC to increase contraceptive options and decrease unintended pregnancy.
Olympic Community of Health (OCH) website	<ul style="list-style-type: none"> • Access to care • Behavioral health integration & access • Chronic disease prevention & management • Healthy aging: safety & support • Prevention: lifelong health for children 	Olympic Peninsula Coordinated Opioid Response: The ACH will lead a comprehensive initiative to assess, plan, coordinate and implement a multi-sector, community response to the regional opioid crisis, including opioid abuse, dependence, and overdose. The ACH is engaging the Salish Behavioral Health Organization, Tribes, and Kitsap, Jefferson, and Clallam counties in this effort.
Pierce County website	<ul style="list-style-type: none"> • Access to care • Behavioral health • Chronic disease • Health equity & social determinants of health 	Blood Pressure Project to Link Community Health Workers (CHWs) and Health Care Systems: The ACH will coordinate recruiting, hiring and training people with appropriate cultural and linguistic skills as CHWs. CHWs will offer chronic disease prevention in non-clinic settings. The project will create a multi-agency CHW "Hub".
Southwest Washington RHA (SWWA RHA) website	<ul style="list-style-type: none"> • Access to care • Behavioral health integration • Care coordination 	Co-location of Primary Care in Behavioral Health Settings: The ACH will help address obstacles and implement strategies to develop a nontraditional, reverse co-location model where physical health services are provided in-house at two behavioral health sites.

Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health

Center for Community Health and Evaluation
January 2016



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Overview

An Accountable Community of Health (ACH) is a regional coalition consisting of leaders from a variety of different sectors working together to improve health in their region. As part of the Healthier Washington Initiative, nine ACHs began formally organizing across Washington in 2015. They are intended to strengthen collaboration, develop regional health improvement plans and projects, and provide feedback to state agencies about their regions' health needs and priorities. The Health Care Authority (HCA) is supporting ACH development through guidance, technical assistance (TA), and funding from the State Innovations Model (SIM) grant.

ACH structures created, first steps taken in collaboration and community engagement.

All nine regions were formally designated as ACHs. Requirements for designation included establishing operations and governance structures, multi-sector and community engagement, regional health improvement plan (RHIP) efforts, and initial sustainability planning.

HCA encouraged ACHs to be creative and community-driven when establishing their governance and operations. Each ACH formed a different structure, resulting in a natural experiment where best practices can emerge from various ACH approaches.

Governance. ACHs have governing bodies that range in size (15-44 participants) and decision-making procedures. Some ACHs have additional groups at the region or county level that provide input to the governing bodies.

Backbones. There are three types of organizations providing operational support to ACHs: local public health, community-based organizations, and nonprofits that play a dual role as backbone and ACH.

Community engagement. ACHs are all working towards multi-sector engagement, but have defined sectors differently and incorporated representation at differing levels of their governance structures. ACHs are also using various strategies for public participation, ranging from comment periods during board meetings to open events where all attendees can engage in discussion.

Regional priorities and projects are emerging. Collaborative work towards a shared regional agenda has been challenging, but ACHs have developed regional needs inventories and are identifying health priorities that will inform their RHIPs. A few ACHs are selecting and planning their first projects, which all the ACHs will focus on in 2016. The aim of their projects is to improve regional health, promote health equity, and advance the Triple Aim. The long-term impact will be assessed using Washington's Common Measure Set.

Moving forward – ACHs demonstrating their value. In the coming year, ACHs will turn their attention from building a strong foundation to active collaboration on local health improvement projects. ACHs will also be involved in broader Healthier Washington strategies as other programs become more defined. Both ACHs and the state consider sustainability a key focus and the shift to more action-oriented activities will provide ACHs with opportunities to demonstrate their value propositions to both regional and statewide stakeholders. Support, guidance, and partnership from the state to the ACHs will continue to develop as the state, regional, and Healthier Washington landscapes evolve.

Introduction

What are ACHs?

An Accountable Community of Health (ACH) is a regional coalition consisting of leaders from a variety of different sectors working together to improve health in their region. With support from the state government, nine ACHs began formally organizing across Washington in 2015 to build capacity to work collaboratively, develop regional health improvement plans, jointly implement or advance local health projects, and advise state agencies on how to best address health needs within their geographic areas.

The ACH premise is that community-based, cross-sector coalitions can be an effective part of health system transformation since they:

- Take advantage of local knowledge and relationships to drive change in places where individuals are directly served;
- Allow those involved at the local level to each focus on what they do best, but in ways connected to and complementary of the contributions of others nearby; and,
- Facilitate collaboration to address both clinical care and social factors affecting health such as poor nutrition and inadequate housing.

It's going to require a paradigm shift for everyone and our stakeholders. It's more than saying we'll work together. It's a new way of thinking.

This collaborative and synergistic work will not happen if regions depend solely on random, informal contacts between stakeholders, but instead requires the structure and intentional action brought by ACHs to achieve regional health improvement. Washington is not alone in moving forward with this new ACH approach. Variations on the model are being tested in a few other states (see Appendix A).

ACHs are an essential component of Washington's Health Innovation Plan, known as "Healthier Washington," a five-year plan, funded through a \$65 million State Innovation Models (SIM) federal grant. In addition to ACHs, Healthier Washington includes several other large scale initiatives, including improving how Washington pays for health care services by testing models that emphasize paying for value, integrating physical and behavioral health care, and implementing a practice transformation hub to improve health care delivery (for links to Healthier Washington resources, see Appendix B).

Healthier Washington will help people experience better health throughout their lives and receive better – and more affordable – care when they need it.

– Healthier Washington Website

Washington's nine ACHs are at different stages of development as they each search for ways to improve health, given their regional context and priorities. This report is an overview of development during the first year of SIM funding. The Health Care Authority (HCA) contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the ACHs' progress, provide formative feedback to support ACH development, and document and disseminate best practices.

Where are they? ACH regional boundaries

There is wide variation in what comprises an ACH region, both in terms of geography and population. Seven of the nine ACHs are multi-county areas, ranging from two to ten counties. Washington’s two most populous counties – King and Pierce – comprise their own region. While some regions have a history of collaboration, others are incorporating new communities or counties into their identities as ACHs.

Figure 1. Map of ACH regions

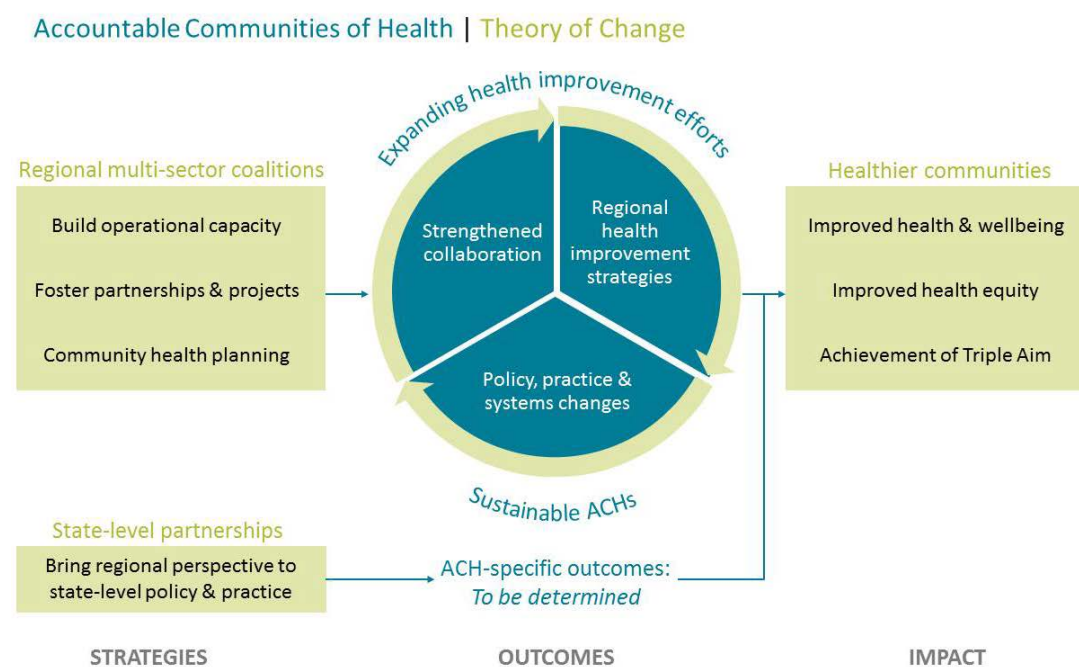


How do ACHs achieve their impact? ACH Theory of Change

CCHE worked with HCA and the ACHs to develop an ACH “theory of change”, or model for how Healthier Washington envisions the ACHs will achieve their impact, as illustrated in Figure 2 (see Appendix C for a detailed version). Reading from left to right, during this first year, ACHs began by establishing operational and governance infrastructure in order to function effectively as a coalition. Building this organizational capacity is necessary to support the ACHs’ work across their regions. They also worked on establishing and broadening cross-sector engagement, and began to develop the components of regional health improvement plans (RHIPs).

As ACHs move forward, they will continue regional planning and strengthening partnerships to carry out health improvement strategies. By fostering these collaborative activities, ACHs are expected to lead their regions through a continuous cycle of implementing targeted projects and strategies that will grow, spread, and be sustained over time. This continuous expansion of health improvement efforts will require a high degree of regional collaboration, funding, and synergy between individual activities. The goal is to achieve widespread policy, practice, and systems change that supports health improvement.

Figure 2. ACH Theory of Change



In addition to regional work, ACHs will contribute to the broader efforts of Healthier Washington. This broader role will be defined as the other parts of Healthier Washington complete their own planning.

The long term vision is that regional health improvement efforts combined with participation in broader Healthier Washington initiatives will result in region-level changes in population health. These outcomes include improved health and well-being, increased health equity, and progress toward the Triple Aim in health care.

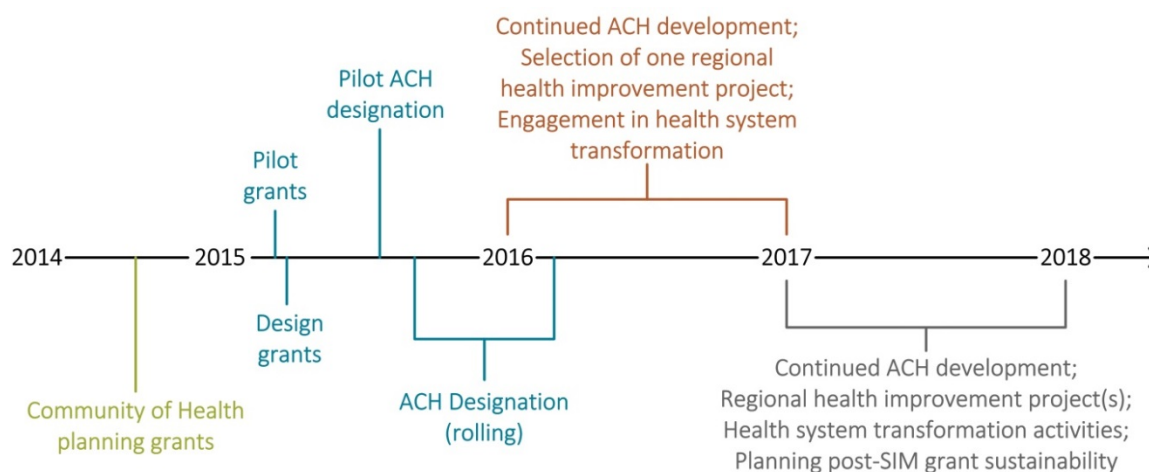
ACH history and development

Community-based, cross-sector coalitions that promote health improvement at the local level have existed in Washington for many years. Support, including funding, from the state has been limited and inconsistent until recently. The conception of ACHs began with Washington's 2013 State Health Care Innovation Plan, which called for the creation of a new partnership between the state and these community-oriented organizations. As a result, ten Community of Health planning grants were awarded in July 2014. State legislation passed in 2014 provided some criteria and funding for two pilot ACH sites (awarded in January 2015).

In 2015, the State Innovation Model (SIM) Test Award brought additional funding and criteria. In March 2015, seven additional regions received ACH design grants, for a total of nine regions that cover all the counties across Washington. Pilot regions received \$150,000 and design grant regions received \$100,000 for the initial year.

The two pilot regions were formally designated ACHs by the HCA in July 2015 and the design grant regions were designated on a rolling basis November 2015 – January 2016. Over the remaining years of the SIM grant, ACHs will receive \$220,000 per year. ACHs will implement their regional projects and facilitate project growth and spread. ACHs will also continue developing sustainability plans. As other Healthier Washington initiatives develop, such as health system transformation efforts, ACHs will begin to play a role that is not yet clearly defined.

Figure 3. ACH development timeline



Evaluation methods

The HCA has contracted with CCHE to evaluate the ACHs. The ACH evaluation closely coordinates with the evaluation of the overall Healthier Washington initiative, led by a team at the University of Washington.

CCHE aims to understand the function and contribution of the ACHs – how they form, agree on community health priorities, engage in health improvement activities, contribute to the Healthier Washington initiative, and work towards becoming sustainable coalitions. As an evaluation partner, CCHE provides timely feedback from multiple data sources to Healthier Washington and HCA staff about success factors, challenges, and lessons learned to inform program improvement. CCHE will also assess the ACHs' impact at the end of the project.

Qualitative and quantitative data were collected from multiple sources to document ACH capacity and progress in 2015, including site visits, interviews with backbone staff and ACH members, participant surveys for each ACH, ACH meeting observation, and extensive document review. When not otherwise attributed, quotes within this document are from ACH backbone staff and participants, or ACH designation applications (for a more detailed description of methods, see Appendix D).

Building the foundation: Formalizing ACH structure

Efforts to formalize ACH mission and vision statements, governance structures, sector participation, backbone roles, and initial pathways to sustainability were the main activities of 2015. This work culminated in nine successful proposals to HCA to be formally designated as Accountable Communities of Health. HCA provided guidance for ACH development, but left significant room for ACHs to grow in ways that reflected their communities, which resulted in variation across the state.

2015: The year of designation

All regions awarded a pilot grant or design grant for ACH development and planning were required to submit a Readiness Proposal to be formally designated as an ACH by the HCA during 2015. The criteria for designation included six categories of ACH readiness (Figure 4), which were shared with all the regions as guidance for preparing their proposals. Formal ACH designation qualifies the coalition for additional grant funding from the state. Proposals were reviewed by a multi-agency state team (DOH, DSHS, and HCA staff) to assess whether each ACH is a functional coalition with a strong foundation for collaboration, governance, and operations to support regional health improvement efforts.

The two pilot grant regions, Cascade Pacific Action Alliance (CPAA) and North Sound ACH, were designated in July 2015. The seven design grant regions were designated on a rolling basis, from November 2015 to January 2016.

Developing a shared mission and vision

One of the initial steps for emerging ACHs was to refine and agree on a mission and vision to guide their development and new collaborations. This step helped clarify why ACH participants were coming together and began to build their regional ACH identity.

Figure 4. Designation criteria

Operational governance structure: At a minimum, an interim operational governance structure and decision-making process with bylaws, charter(s) or other documentation, and a plan for ongoing testing/adjustment.

Balanced, multi-sector engagement: A governing body membership that reflects balanced, multi-sector engagement that includes participation from key community partners representing systems that influence public health, health care, and the social determinants of health (SDOH).

Community engagement: Activities underway and future plans to engage diverse community representatives through the governance structure.

Financial and administrative operations: An appointed backbone organization, or group of organizations, performing operational activities in support of the ACH. Includes backbone accountability to the ACH governance structure and a process for reviewing the backbone and/or selecting another.

Initial regional health improvement planning: Identified priority areas as part of ongoing regional needs inventory and assessment activities. Initial regional health improvement plan or project(s) identified for future development.

Initial operating budget and sustainability planning: Demonstrated capacity for financial management and an initial sustainability planning strategy that includes considerations for enhancing the ACH's revenue base.

For the **Pierce ACH**, developing a mission statement and operating principles was a collaborative process that brought partners together to make a commitment towards a shared understanding of improving population health. The ACH's governance work group drafted recommendations and proposed them to the larger Health Innovation Partnership stakeholder group, who discussed, revised, and eventually finalized the ACH mission and operating principles via consensus.

Certain words and phrases were common in these statements – ideas like building healthier communities, collaborating across systems, better health, the Triple Aim, population health and decreasing health inequities are guiding the work of many ACHs (Figure 5). As indicated in the ACH participant survey responses below, ACHs are achieving their goal of a shared vision and mission, but some participants feel there is still work to be done.

Figure 5. Key words in ACH mission, vision, values & purpose statements



ACH participant survey responses: Development of a shared mission and vision

Sixty-two percent of respondents reported their ACH was either *good* (46%) or *outstanding* (16%) at having a shared vision and mission. Thirty-eight percent of respondents indicated their ACH's shared vision and mission was *adequate* (25%) or *needs improvement* (13%).

Deciding how to govern

A central focus of ACH development during 2015 was forming governance structures to oversee the ACHs' regional decision-making and collaborative health improvement efforts. Documenting these governing procedures (i.e., bylaws or charters) was a requirement for designation. Many ACHs pointed to building a multi-sector governing body that reflects their region as a key challenge and accomplishment of 2015. Each ACH approached governance differently, aiming to best serve the needs and context of their respective region.

Tension between broad involvement and effective decision making.

A challenge for all the ACHs was to involve enough people in governance to appropriately represent regional interests, while ensuring the coalitions remain functional and able to make decisions effectively. A particular challenge was involving the wide variety of organizations needed, including those that had not previously been at the table for conversations about health. In general, during this process ACHs attempted to build on existing relationships and a history of organizations working together because this

We have a group of great people on the governing body, but it took a while to get there with pre-planning, planning, and establishing. But now... there's consensus on how to move forward.

provided a level of trust and shared purpose from the start. Other ACHs struggled to build new relationships, particularly when the ACH boundaries added new counties to what they had historically understood as their region. Some ACHs purposefully incorporated existing coalitions into their governance structure so that they could leverage wider networks.

Diversity of governance structures and processes. As a result, a range of creative approaches to governance emerged, with no single governance structure dominating across the ACHs. All the ACHs developed a region-level governing body, board, or council, but the details varied widely:

Size and sector composition differences. Determining who had a seat on the governing body was a challenge, both in terms of the size and sector composition. Most have 15 to 23 members, one has 29 members, and another has 44 members. As one ACH representative stated, “there are two schools of thought: that everyone needs to be represented and have large boards, and that the group needs to be small enough to make progress.” Seven of the nine ACHs define specific sector representation requirements within their bylaws, although the definitions of sector vary. Two ACHs did not focus on size and sector composition during the year because they were utilizing the existing board of the backbone organization as the ACH governing body.

Decision-making approaches. Decision-making procedures range from groups that start with a majority vote to those that work towards reaching consensus and only vote if necessary. Only one group uses a strict consensus-based model, where members poll using a thumbs-up/thumbs-down process and continue discussion until consensus can be reached. Recognizing the need for expedited decision making when necessary, a few ACHs with larger governing boards identified a subset of members that meet more often to provide support for the backbone. In some ACHs these subsets also have decision making powers.

Incorporating a range of community voices. To encourage grassroots engagement in governance, many ACHs also established a range of broader stakeholder groups that convene to discuss ACH development, contribute ideas for ACH activities, develop partnerships, and feed input to members of their decision making body. Some ACHs have one region-wide group, other ACHs have multiple county-level groups, and a few have both. The size of the stakeholder groups range from about 30 to 50 participants. These groups generally do not have decision making power, but instead convene to brainstorm ideas and give feedback for the region-level, decision-making body to consider.

There is no pattern between these various aspects of ACHs governance structure. One ACH has a large decision making group and numerous county-level stakeholder forums. Another has a medium-size decision making group

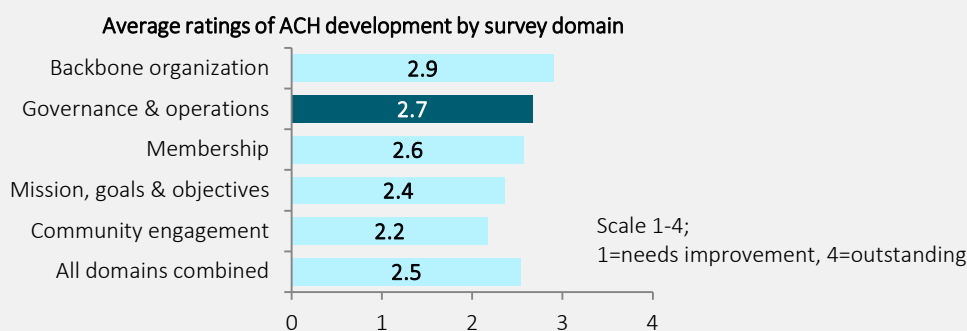
The support team was in response to when we need to act faster than our regular meetings. The team has even representation from each of the counties. They work with [the backbone] to think through things, but they are not a decision-making group.

Structuring it the way we did kept it really authentic and created a safety valve where the smaller, rural, or less well-resourced players are at the table because they feel like they have just as much of a voice.

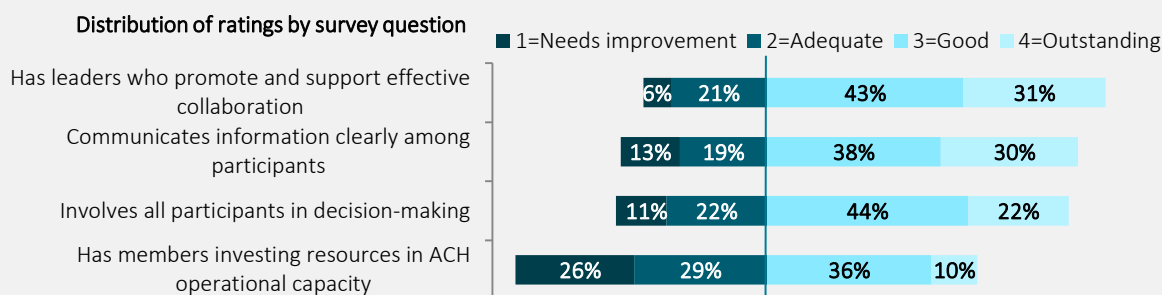
and a steering committee to expedite day-to-day decisions, but no broader stakeholder groups across its counties. The variety of governance structures, and the attitude that there is no ‘one size fits all’ for the ACHs, is a reflection of Healthier Washington’s efforts to let creative, locally-driven coalitions emerge.

ACH participant survey responses: Feedback on governance and operations effectiveness

The governance and operations domain received the second highest rating overall out of five survey domains, with a statewide average rating of 2.7, which corresponds to a score of *good* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).



Respondents rated these aspects highly: leaders who promote and support effective collaboration, clear communication among ACH participants, and involving all members in decision-making. However, respondents indicated opportunities for growth such as ACH participants investing resources in operational capacity.



Backbones: Facilitating progress and collaboration

All ACHs are required to select one or more organizations to serve as their backbone. This backbone organization is responsible for ACH operational functions, such as administrative and financial activities. While the backbone staff may help develop the governance structure and serve as a neutral convener of stakeholders, the backbone staff does not govern the ACH. These staff are also most closely involved in cross-ACH conversations.

Since HCA did not require a specific type of organization to serve in the backbone role, the organization selected for this role varies and none are organized or operate the same way. The organizations serving as the backbone can be classified into three types: public health agencies, community-based organizations, and a single non-profit with a dual role, where there is not a separate backbone organization.

[The backbone’s] other role is to help the ACH innovate and grow and succeed at being functional. Our leaders see that.

Public health backbones. Four ACHs were convened by local public health agencies, where staff provide operational support and, in some cases, data and analytical support to the ACH. In these regions, local public health was often seen as already working on similar issues and/or a neutral convener that brought needed expertise to the table. A few described their role as an interim position. While they thought it made sense for them to be the initial convener of the ACH, they are not sure if it will make sense for them to remain in that role over time and are considering alternative backbone organizations for the future arrangements.

For the **North Central ACH**, the Chelan-Douglas Health District – one of the local public health agencies in the region – stepped up to apply for a design grant and served as the initial backbone organization. The health district took on a leadership role in reaching out to stakeholders and getting people from across the four-county region to convene. Backbone staff have continued to work on broadening community engagement and getting diverse representatives to participate in the ACH. As stated in their designation proposal, “There is a diversity of opinion in North Central Washington about health care reform, but one common principle informs [the ACH’s] work: major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process.”

Community-based organization backbones. Three ACHs have selected community-based organizations to serve as their backbones. These organizations have a history of promoting community health improvement and fostering partnerships between stakeholders. Some backbone staff from these ACHs specifically identified their organization’s history as a collaboration agent in the region as a helpful factor because past leadership on collaborative projects or existing relationships across the region helped stakeholders trust the backbone and the emerging ACH.

For the **Greater Columbia ACH** the Benton-Franklin Community Health Alliance (BFCHA) is the community-based organization serving as the ACH’s backbone. BFCHA has been promoting community wellness and accessible health care in the Tri-Cities area for many years and has experience taking a collaborative approach. BFCHA supported stakeholders from across the ten-county region in successfully developing an ACH that includes both existing partners and new colleagues representing a range of cross-sector interests. The backbone is facilitating a governance structure that is focused on regional identity, and intentionally does not include individual county councils because “we are stronger by working together as a region.”

Single non-profit with a dual-role. Two of the regions have a single, existing non-profit organization that provides their backbone support and is also identified as the ACH. In these instances, there is not a separate backbone organization, but instead the operational support is provided by some of the organization’s staff who in essence serves as the backbone. The non-profit’s board is the decision making body for both the existing nonprofit and the ACH. A few other ACHs are considering becoming independent non-profits as well and took this potential pathway into consideration when building their bylaws.

Better Health Together (BHT) – the ACH for the region spanning Adams, Ferry, Lincoln, Pend Oreille, Stevens, and Spokane counties – is an established nonprofit organization that includes both the backbone organization and the ACH’s decision-making board. BHT decided to leverage its existing governance structure and collaborative relationships across the region as a foundation to build the ACH upon. BHT states this approach to ACH development lets the backbone organization’s work be fully aligned with the priorities of the ACH, as well as leveraging additional backbone resources and broader investment for programmatic development.

Backbone contributions to the ACH. Some backbone staff focused on facilitation as a key contribution; bringing people together and helping them feel heard was essential. A few talked about the backbone’s role in promoting decision-making. As one staff member commented, “Everyone is still willing *not* to be pressed hard on decisions; they can continue talking about it forever. It is our obligation to press that. Backbone staff can get push-back when they try to move [things] forward.” A few also noted their responsibility for coordinating resources, such as hiring external consultants when needed. ACHs differed on the level of visibility, leadership, and neutrality that backbones have in the ACH work.

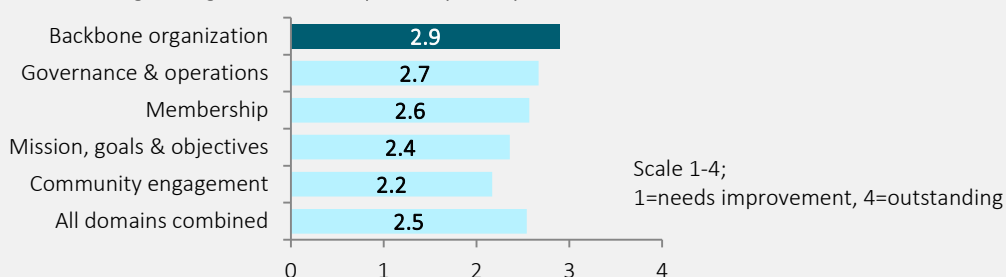
As the backbone, we don’t have an agenda going in. We are open to changing to what [the ACH participants] want.

Although the types of backbone organizations and their roles vary across regions, ACH participants overall are pleased with the performance of their backbones (see survey results below), suggesting that most ACHs have developed a backbone infrastructure that is responsive to their needs and expectations.

ACH participant survey responses: Assessment of backbone support

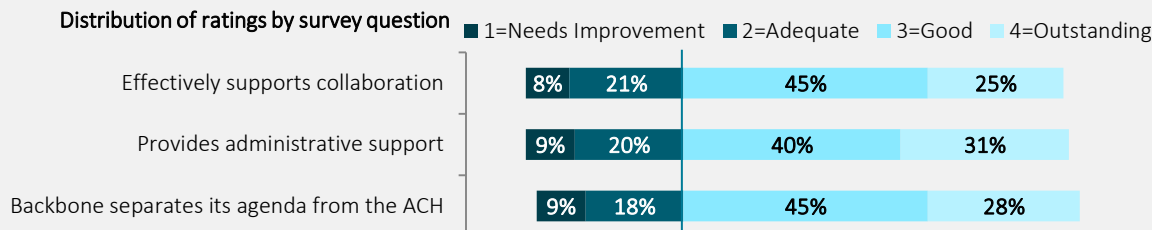
Survey respondents rated the backbone organization domain highest overall out of five survey domains, with a statewide average rating of 2.9, which corresponds to a score of *good* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).

Average ratings of ACH development by survey domain



Over two-thirds of respondents also rated their backbones as *outstanding* or *good* in providing ACH support.

Distribution of ratings by survey question



Developing a sustainability pathway

Healthier Washington envisions ACHs continuing their regional collaboration beyond the initial financial investment provided by the SIM grant funds, which continue through early 2019. Designation criteria required a description of the pathway for sustainability under development by each ACH, including current community support as well as future potential resources.

Current community support. All of the ACHs are receiving in-kind support, primarily from the backbone organization or ACH participants that are playing key roles such as fiscal agent or administrative support. Over half the ACHs described specific grant funds or philanthropy partners that support ACH work, with a wide variation from a few thousand dollars to several hundred thousand dollars per year. Many ACHs also reported receiving financial contributions from some of their participants, but only one ACH currently requires board member dues/contributions.

Future potential resources. Overall, ACHs are in the early stages of developing their sustainability pathways and level of initial detail in the plans varied widely. Ideas for future resources for sustainability included: increasing local community financial support, seeking grant funds, developing fees for services, exploring methods for capturing savings or developing social impact bonds. A few ACHs are exploring requiring participant dues, but one ACH described this as difficult given the variation in financial resources their partner organizations bring to the table. ACHs are also struggling with essential questions such as, “How will health care savings really be reinvested into the community?” as they think about future finances.

A set of pathways is developed that envisions a balanced funding model, braiding together resources contributed by funders from various sectors, sustaining the engagement of stakeholders, and undertaking meaningful work that results in real progress being made on our region’s shared health priorities.

– ACH designation proposal

ACH participant survey responses: Sustainability planning

Many survey respondents (36%) indicated their ACHs *need improvement* with regards to executing a sustainability strategy. Another quarter (26%) rated their ACH’s performance on this item as *adequate*. Less than one-third (30%) of respondents said their ACH’s sustainability strategy was *good*.

Sustainability requires demonstrating ACH value. Many ACHs talked about the need to demonstrate their value as an ACH before they could ask the community or partner organizations to increase support at this early stage. Often this discussion was tied to the need to secure funding for their ACH project, expected to launch in 2016. Projects are seen as a way to demonstrate ACHs’ value. Some ACHs described the challenge of key stakeholders who are waiting to see where the effort goes and if the state is committed to it long-term before committing additional resources to the effort.

The push for sustainability is premature, because what are we sustaining? We haven’t had a chance to mature and produce something.

Table 1. ACH governance at-a-glance

ACH	Counties	Designation	Backbone	Governance (decision-making group in bold)
Better Health Together (BHT) website	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	Nov. 2015	Better Health Together <i>Non-profit with dual role</i>	15-member Board of Directors that governs both ACH and BHT programs. 62 regional organizations participate in an ACH Leadership Council. Rural county coalitions are emerging for local activation.
Cascade Pacific Action Alliance (CPAA) website	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	July 2015 <i>Pilot ACH</i>	CHOICE Regional Health Network <i>Community organization</i>	44-member Regional Coordinating Council which uses a consensus decision-making model. Seven county level forums convene local stakeholders.
Greater Columbia (GC ACH)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	Jan. 2016	Benton-Franklin Community Health Alliance <i>Community organization</i>	17-member Board of Directors (hospital & business representatives vacant). An open-participation Leadership Council that regularly includes 30-50 regional participants.
King County website	King	Nov. 2015	Public Health-Seattle & King County <i>Public Health</i>	23-member Interim Leadership Council with an Interim Steering Committee. Workgroups include Council and community members.
North Central (NCACH)	Chelan, Douglas, Grant, Okanogan	Jan. 2016	Chelan-Douglas Health District <i>Public Health</i>	17-member Governing Board and an Executive Committee. A regional Leadership Council and three county-level Coalitions for Health Improvement (CHIs) convene local stakeholders.
North Sound (NSACH) website Facebook	Island, San Juan, Skagit, Snohomish, Whatcom	July 2015 <i>Pilot ACH</i>	Whatcom Alliance for Health Advancement <i>Community organization</i>	29-member Governing Body that includes regional stakeholders. A Steering Committee.
Olympic Community of Health (OCH) website	Clallam, Jefferson, Kitsap	Dec. 2015	Kitsap Public Health District <i>Public Health</i>	16-member Interim Leadership Council. An open-participation Community of Health stakeholder group also meets and includes 40-50 regional participants.
Pierce County website	Pierce	Jan. 2016	Tacoma-Pierce County Health Department <i>Public Health</i>	23-member Board of Trustees , to be finalized in 2016. 30-40 stakeholders engage in the Pierce Health Innovation Partnership.
Southwest Washington Regional Health Alliance (SWWA RHA)	Clark, Skamania	Dec. 2015	Southwest Washington RHA <i>Non-profit with dual role</i>	22-member Board of Directors that governs both ACH and Early Adopter Behavioral Health activities. A Community Advisory Council includes 13 Medicaid members.

Regional collaboration for health improvement

ACHs took clear steps towards building regional collaborations to improve the health of their regions, including engaging a variety of sectors and the broader community. ACHs also started to develop the key components of a Regional Health Improvement Plan. The next step will be selecting and implementing specific health improvement projects.

Building multi-sector collaboration

A key area of success and challenge for ACH development in 2015 was engaging ACH participants to form coalitions that reflected balanced, multi-sector engagement.

Many sectors at the table. Since HCA left this definition to each region, there was variation in both how ACHs formally defined “sectors” and how they were included in their bylaws. Many sectors were represented in all ACHs although some sectors were more selectively incorporated.

- All ACHs included local public health, some incorporating one representative from each county.
- All ACHs included multiple health system partners, such as hospitals, primary care providers, Medicaid managed care plans, and community health centers with most ACHs including separate seats for provider types. Some ACHs included several representatives from a given sector while others adopted a caucus model with a single representative per sector. All ACHs include behavioral health providers and a few included substance abuse/chemical dependency organizations. A few included oral health providers.
- All ACHs included social services or human services organizations. Many specifically included seats for housing, with a few calling out food systems and transportation. Many include local Area Agency on Aging or other long term care representatives. Some also included first responders.
- Most ACHs included education, although this sometimes meant school districts and other times college systems.
- Over half of the ACHs included employers or business, but not all of these seats were filled.
- Over half included at least one local government representative and several included local philanthropy organizations.
- Most of the ACHs also were actively working to engage Tribes as ACH participants but only a few currently have representatives engaged with the ACH.

Figure 6. Multi-sector engagement requirements

At a minimum, balanced engagement refers to the participation of key community partners that represent systems that influence health; public health, the health care system, and systems that influence the social determinants of health (SDOH), with the recognition that this includes different spheres of influence.

We are trying to build this from the ground up and getting people working together who haven't before.

The established relationship helped us get going. We also already had trust built-in, which made it easier to establish trust with new people to loop in.

- About half of the ACHs specifically included a space on the decision-making body for at least one consumer representative, although not all of these spaces were filled.
- Individual ACHs included a variety of other partners: labor, faith-based organizations, workforce development, criminal justice, rural health organizations, existing coalitions that work on equity, and specifically the Hispanic community.

Successes and challenges in building collaboration. Building a collaborative structure was portrayed by ACH backbones as being the most time intensive and challenging aspect of the year. Many ACHs described seeing progress, including examples of new sectors that are now committed, passionate participants. They described consistent attendance at meetings and collaborative discussions as indicators of success. Most describe the benefit of creating a forum for disparate stakeholders to figure out the interconnections that are being missed in their region. One ACH specifically described seeing more cross-sector communication around topics that would otherwise not happen. A few pointed to the ability of ACHs to create space around the table for voices that are often missing, such as consumers.

All of the ACHs described how difficult it is to build these new multi-sectoral coalitions. Some described tension around engaging stakeholders at the table while there was still significant ambiguity about what ACHs would be doing in the region. As one ACH said, “it’s hard to have those stakeholders stay engaged when they don’t know what they’re signing up for.”

Many ACHs described significant challenges of building trust and a shared sense of purpose among new sectors and counties that did not have a history of working together. Some ACHs highlighted the challenge of getting the necessary decision-makers to the table so the ACH participants could make decisions on behalf of their organizations. As one ACH said, “I know a big challenge is just getting the right people in the room at the right time.” ACHs pointed to different learning curves for participants as they learned about each other’s sectors. Educating new participants can be time consuming and resource intensive.

Many ACHs talked about how “we have to prove our value proposition” if they are to keep participants engaged. Some ACHs described this to mean elevating the social determinants of health and health equity issues, while some see it as a need to focus on demonstrating their ability to show cost savings or control health care costs.

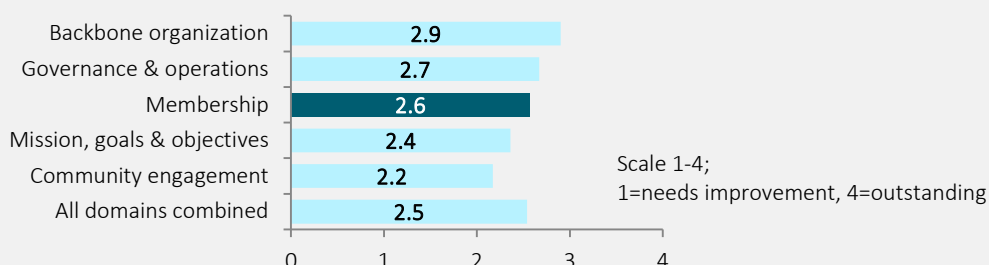
We’re still trying to make sure we don’t fall into token engagement for community outreach... it’s important to us, but we don’t have resources right now.

What is the value proposition we are going to use to get stakeholders involved? ...Creating a community voice is a project – it’s fragile, we are only in the middle of it, agreeing to sit together and work on common goals.

ACH participant survey responses: Reflections on stakeholder engagement

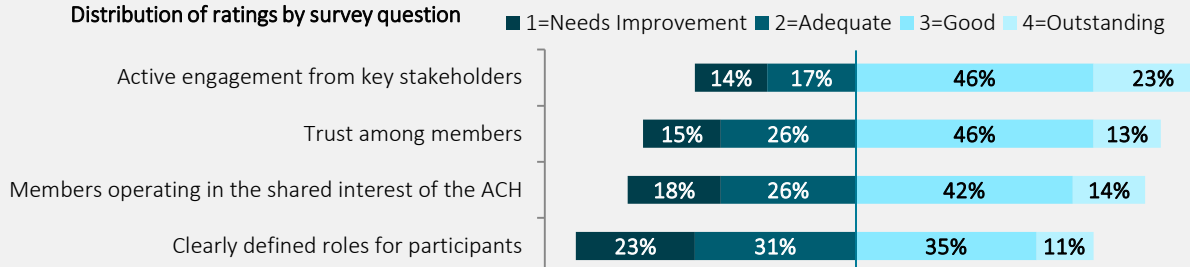
Survey respondents rated the ACH membership third out of the five survey domains, with a statewide average rating of 2.6, which corresponds to a score split between *good* and *adequate* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).

Average ratings of ACH development by survey domain



Over two-thirds of respondents indicated the active engagement from key stakeholders in their ACHs was *outstanding* or *good*. Respondents also rated their ACHs highly in having trust among participants and participants who operate in the shared interest of the ACH.

Distribution of ratings by survey question



Building community engagement

Demonstrating that community engagement activities are underway and that additional activities are planned was an ACH designation criterion. These activities are in addition to the engagement that is already occurring through their governing body.

ACHs described a strong commitment to community engagement, but acknowledged that they are still developing methods to achieve this goal. This was seen as an opportunity for improvement in the participant survey. Several ACHs described the challenge of implementing community engagement strategies under resource constraints.

Most of the ACHs include methods for the public to add their voice to ACH meetings, that can be loosely grouped into three main categories: 1) board meetings that are open to the public and contain public comment periods, 2) frequent ACH regional meetings that are open to public participation, or 3) county-level groups that are designed to collect input for the regional body. Some ACHs adopt multiple methods. Currently there is no requirement for ACHs to adopt a single method for public input.

The **Olympic Community of Health (OCH)** has an Interim Leadership Council as their decision-making body, but also holds open participation stakeholder group meetings for broader community engagement (40-50). These meetings give a broad range of regional stakeholders the opportunity to participate in the ACH's development. Activities have included: informational presentations with Q&A; small group discussions; regional assets, needs, and priorities brainstorming; and relationship building.

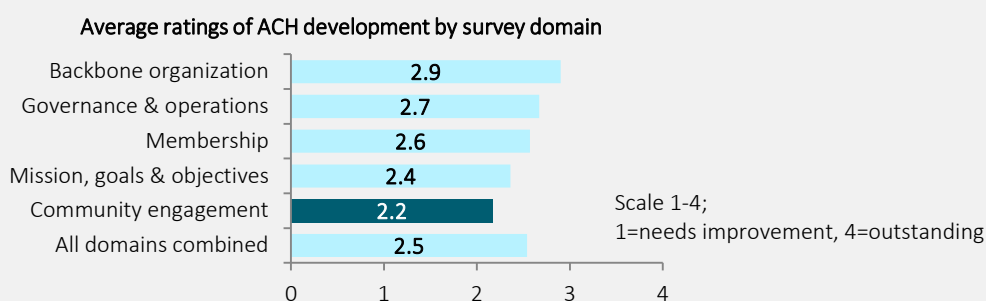
In addition, most of the ACHs deliberately leverage existing coalitions that have relationships with key populations as a way to bring more voices to the ACH table. One ACH described how focusing on organizations was the first step and that, “Increasing engagement of hard-to-reach, underserved, and underrepresented populations who are not traditionally at the decision making table is a priority for upcoming work.”

All of the ACHs have internal and public communications plans that are at varying levels of implementation. Almost all of the ACHs described frequent presentations to local organizations and community groups as significant time commitments last year. Many of the ACHs conducted one or more public forums last year and are planning to continue that work in coming years. Two thirds of the ACHs have an active web presence, but the content varies from including detailed ACH materials (e.g. designation proposals, board minutes) to simply describing the ACH vision or event dates. A few ACHs regularly distribute newsletters or targeted communication to their broader stakeholder lists.

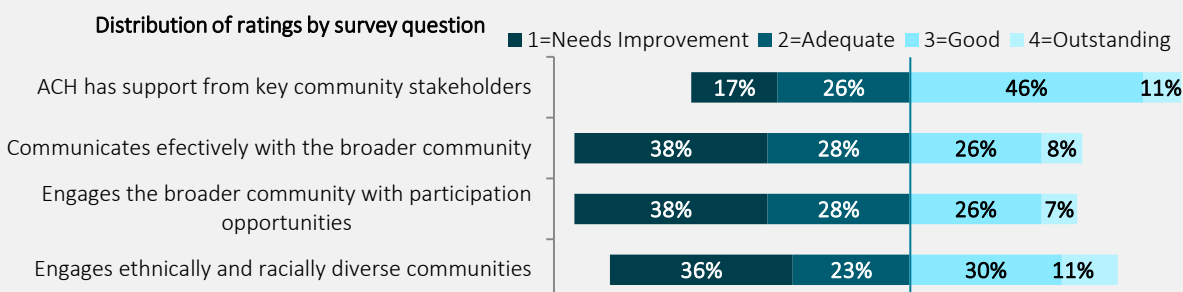
Our local community forums are an important venue for interaction with the broader community in each county. They intentionally build on existing community health improvement planning processes and other existing community structures that facilitate cross-sector communication.

ACH participant survey responses: Feedback on community engagement

Survey respondents rated community engagement the lowest out of five survey domains, with a statewide average rating of 2.2, which corresponds to a score of *adequate* on the survey rating scale (1=needs improvement; 2=adequate; 3=good; 4=outstanding).



Respondents rated their ACHs well for getting support from key community stakeholders. However, more than one-third of respondents indicated their ACHs *need improvement* with regards to communicating effectively with the broader community, engaging the community with participation opportunities, and engaging ethnically and racially diverse communities in the ACH.



Focusing ACH work: Health planning and priority setting

To obtain designation, ACHs were required to develop a Regional Health Needs Inventory (RHNI) that reflected their entire regional service area and demonstrate planning for a regional health improvement plan.

Needs and asset assessment. All of the ACHs leveraged multiple existing data inventories, including recent hospital and public health district community health needs assessments, to identify health priorities or service gaps. Several multi-county ACHs looked at various county-level assessments to identify common priorities across the region.

A few ACHs talked about how time consuming it is to create a regional look at health. In particular, they described the challenge of using health needs assessments created by a variety of local entities or counties since each employed a different methodology and conducted them on different timelines. After this initial process, one ACH began working to align the assessment structure so that they would be better able to think and plan as a region in the future.

All of the ACHs recognized a need to move beyond existing data and conducted some type of asset inventory to identify existing programs, services or initiatives related to regional health priorities or advancing the Triple Aim. They saw this as a first step in alignment of local efforts.

We know the priorities across all the counties, we've vetted them with stakeholders, and cross-walked them to get a clear idea of regional priorities. But regional work is a bit of a challenge because a lot of the work is going on locally. I'm not sure how that will work.

"To foster collaboration and to avoid duplication, **North Sound ACH** reached out to local health jurisdictions and hospitals to invite them to participate in a **Regional Health Needs Inventory Work Group**." Together this group looked across existing local Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs) to better understand the region's needs. The workgroup also expanded existing inventories of programs, tasked staff with interviewing health leaders and service providers. This work has led to the selection of two projects that align with their region's shared goals and will be early ACH wins: 1) care coordination via emergency medical services and 2) prevention of unintended pregnancies through education for primary care providers on long-acting reversible contraception.

Priority setting. At the time of this report, about half of the ACHs had established formal priorities that were clearly driving their ACH efforts; the other half had done some prioritizing, but had not formally finalized their list. On average, ACHs had identified five regional priorities; the most common ones (each identified by 6-7 ACHs) were access to care, behavioral health (including behavioral health integration), care coordination, and social determinants of health or health equity. Three of the ACHs selected chronic disease prevention and/or management as a priority and three additional ACHs identified diabetes prevention and/or management specifically. A few ACHs identified housing, oral health care, substance abuse, and adverse childhood experiences (ACEs) as priorities.

Part of the overall vision is to just develop a better understanding of what process it will take to do engagement on [our priorities]. What does it take to develop a collaborative approach for an initiative like this?

ACH participant survey responses: Assessing progress toward regional health priorities

Survey respondents were split in rating their ACHs' progress towards regional health priorities. About half (55%) of respondents rated their ACHs *good* or *outstanding* for agreeing on health priorities based on identified regional health needs. The other half (45%) of respondents rated their ACHs as *adequate* or *needs improvement*.

Early wins: Developing regional projects

ACHs are expected to implement at least one regional health improvement project designed to create measurable progress toward a regional health improvement goal. Many of the ACHs discussed the importance of moving forward with a project as a mechanism from maintaining partner involvement and demonstrating the value of the ACH. As one ACH backbone staff member stated, "The planning phase is encountering impatience because they want to be done and start doing something."

While ACHs are in different stages of project selection, several have developed a formal process that uses criteria and ranking to explore possibilities, engage participants, facilitate discussion and decision making. Some ACHs saw project selection and implementation as an opportunity to build trust and strengthen collaboration. They also recognized the difficulty in getting partners to work effectively across sectors and move away from thinking about their sectors in silos, which keep organizations from aligning.

Both of the pilot ACHs – North Sound and Cascade Pacific Cascade Alliance (CPAA) – selected initial projects and have moved forward with implementation. North Sound selected and is in the planning phase for two regional projects – a care coordination project targeting high utilizers of emergency medical system and emergency departments and a prevention project partnering with primary care providers to increase awareness and accessibility of long-acting reversible contraception. CPAA also implemented two projects, both targeting youth – a pilot project responding to adverse childhood experiences (ACEs) in six local schools (see below) and a youth marijuana prevention and education project.

I think we have a good understanding of the key issues, but I think it's going to be a challenge when we start talking about breaking down silos and barriers. We need to find small projects where they can collaborate and build trust more.

Cascade Pacific Action Alliance (CPAA) – In January 2015, CPAA launched the Youth Behavioral Health Coordination Pilot project to identify children with behavioral health challenges as early as possible and connect at-risk children with community-based intervention and treatment services. Six schools (including elementary, middle and high schools) in four counties were selected as pilot test sites.

An initial work group consisting of representatives from school districts, social services organizations and health care providers selected behavioral health screening tools, identified treatment resources within the region, discussed the roles of school staff and treatment providers, and mapped how these roles would be coordinated on behalf of the children. Then multi-sector work groups in each of the four counties (Cowlitz, Mason, Thurston and Wahkiakum) worked to customize project work flows to be responsive to local conditions.

By January 2016, implementation had begun in Cowlitz County and 25 students had been served by a cross-disciplinary intervention team led by a Registered Nurse care coordinator who works closely with various partners including school staff members, school district nurses, local pharmacies, county youth services, law enforcement, child protective services, and physical and oral health providers.

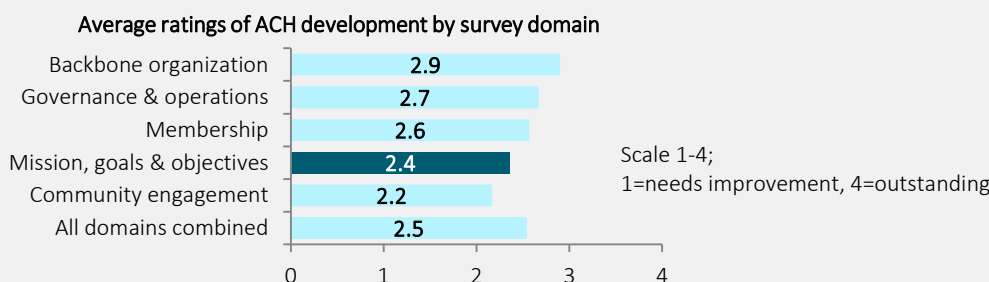
It is anticipated that all ACHs will submit project proposals to HCA for review and approval in early 2016. However, most ACHs have already expressed strong concerns about insufficient funding to conduct the level or type of projects necessary to improve or transform population health in their region. In addition, they are concerned projects with more limited scope will produce smaller changes, which will not demonstrate the ACH's value to stakeholders and keep them at the ACH table.

ACHs see insufficient funding as both a short term problem for launching projects and a long term problem for developing sustainably and achieving regional change. As one ACH said about the current level of funding, "Realistically we can only do small things now, on the margins." Another said, "There isn't serious money in the system for population health improvement that goes beyond health care delivery...A disconnect between the reality and the accountability rhetoric."

The projects are deliberately cross-sectoral and are seeking to demonstrate what can be achieved through mutually supportive and aligned actions of diverse stakeholders within our region.

ACH participant survey responses: Feedback on regional projects

Survey respondents across the state gave the mission, goals & objectives domain an average rating of 2.4, which corresponds to a split between an *adequate* and *good* rating on the survey scale (1=needs improvement; 2=adequate; 3=good; 4=outstanding). Within the mission, goals & objectives domain are three survey questions about ACHs developing regional projects.



More than half of respondents rated their ACHs as *adequate* or *needs improvement* on survey questions related to project development.

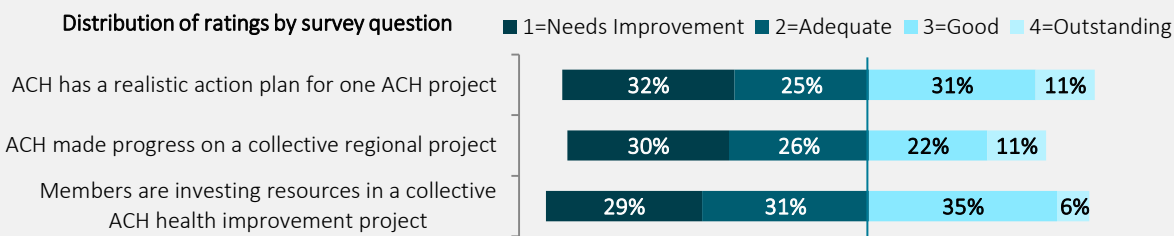


Table 2. ACH regional priorities at-a-glance

ACH	Counties	Regional Priorities (as of January 2016, may be interim)
Better Health Together (BHT) website	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	<ul style="list-style-type: none"> • Access to oral health care • Community-based care coordination • Linkages in housing, food security & income stability systems • Obesity reduction & prevention • Whole-person care; integration of physical, behavioral & oral health care
Cascade Pacific Action Alliance (CPAA) website	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	<ul style="list-style-type: none"> • Access to care & provider capacity • Adverse childhood experiences (ACEs) prevention & mitigation • Chronic disease prevention & management • Economic & educational opportunities • Health integration & care coordination
Greater Columbia (GC ACH)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	<ul style="list-style-type: none"> • Behavioral health • Care coordination • Healthy youth & equitable communities • Obesity/diabetes • Oral health – primary caries prevention
King County website	King	<ul style="list-style-type: none"> • Physical/behavioral health integration • Care coordination for complex needs • Health equity • Housing-Health intersections • Prevention – chronic disease & social determinants of health
North Central (NCACH)	Chelan, Douglas, Grant, Okanogan	<ul style="list-style-type: none"> • Diabetes prevention and management • Health care transformation
North Sound (NSACH) website Facebook	Island, San Juan, Skagit, Snohomish, Whatcom	<ul style="list-style-type: none"> • Behavioral health integration & access • Care coordination • Dental & primary care access • Health disparities • Housing • Prevention
Olympic Community of Health (OCH) website	Clallam, Jefferson, Kitsap	<i>Regional priorities not selected. Broad areas of focus include:</i> <ul style="list-style-type: none"> • Access to care (coverage & capacity) • Population health improvements • Access to “Whole person” support (clinical coordination & integration) • Data management & infrastructure
Pierce County website	Pierce	<ul style="list-style-type: none"> • Access to care • Behavioral health • Chronic disease • Health equity & social determinants of health
Southwest Washington Regional Health Alliance (SWWA RHA)	Clark, Skamania	<ul style="list-style-type: none"> • Access to care • Behavioral health integration • Care coordination

ACHs and the Healthier Washington initiative

ACHs are an essential component of Washington’s Health Innovation Plan, known as “Healthier Washington,” which aims to transform the health system in the state to bring better health, better care, and lower costs to Washington residents. By 2019, the five-year Healthier Washington plan, funded through a federal \$65 million State Innovation Models (SIM) grant, has goals to:

- See improvements in health for 80% of Washington residents and communities.
- Achieve improved health outcomes and lower costs for Medicaid clients with physical and behavioral health co-morbidities.
- Limit annual state-purchased health care cost growth to 2 percent less than the national health expenditure trend.

As described by Washington state, Healthier Washington “is guided by the principle that no one individual or organization alone can make it happen. Working together, we can achieve better health and better care at lower cost for Washington’s residents.” Although it is clear that ACHs will play a key role in realizing this vision, very little detail on how this will be operationalized is clear thus far. Initial statements describe ACHs as the regional forum for alignment between local activities and the broader Healthier Washington strategies, including potential implementation activities. This uncertainty has significant implications for Washington’s model since the goal is for regional ACH and state-level Healthier Washington work to be complementary and synergistic.

Figure 7. Healthier Washington



Examples of early ACH involvement

One of the more visible examples of ACH involvement in the broader Healthier Washington initiatives is the nomination of a subset of backbone staff, representatives from the Greater Columbia, King County, and North Sound ACHs, to represent the statewide group in conversations on broader measurement initiatives. These representatives have regularly provided input on Healthier Washington’s data and analytics initiative (Analytics, Interoperability and Measurement (AIM)). This representative approach also empowered one ACH representative to provide public testimony to the Performance Measures Coordinating Committee that represented the collective needs of ACHs across the state.

HCA staff also routinely bring Healthier Washington initiatives to regular cross-ACH meetings to foster closer collaboration during both development

and implementation phases. All of the ACHs have representatives participating in the Plan for Improving Population Health’s external advisory board, which is being led by Washington’s Department of Health. ACHs have also hosted or participated in several of the Practice Transformation Support Hub Listening Sessions.

Southwest Washington is the first region in the state to adopt fully-integrated managed care, and in April 2016, people covered by Medicaid in Clark and Skamania counties will receive comprehensive physical and behavioral health services through the managed care plan of their choosing. As a partner in this effort, **Southwest Washington Regional Health Alliance** will be “participating in the development and monitoring of an ‘early warning system’ designed to provide an early alert to local health and community system issues, including access to services.” This system is likely to monitor for a wide range of issues from spikes in emergency department and jail use to drops in Medicaid enrollees seeking treatment.

ACH feedback on participating in Healthier Washington

Feedback from ACHs on perceived benefits and challenges of partnering with HCA and participating in the Healthier Washington initiative was gathered throughout the first year and shared with HCA.

The Health Care Authority is seen as engaged and responsive. Overall, all the ACHs had positive feedback about working with the HCA, describing that regular communication mechanisms were an example of HCA “getting it right.” These regular touchpoints provide a venue for the HCA team and their Healthier Washington partners to provide information and solicit feedback. As one ACH commented, “It seems like the HCA is trying to live the learning model.”

ACHs want to be seen as partners and co-creators of this new model. ACHs appreciated HCA’s efforts to partner in the development of the new model Washington is pioneering, but continue to ask for clarity as new aspects of the role emerge. One of the strongest themes was frustration with abrupt changes in direction or timeline concerning issues that significantly impact ACH development. As one ACH said, “surprises are just bad for building trust.”

Funding levels are a key concern for ACHs. Most ACHs expressed strong concerns about the overall level of funding to build and sustain ACHs in their region. They see the role of ACHs as becoming more central to Healthier Washington’s overall success than originally anticipated, but the funding levels have not increased accordingly. They believe the HCA is not “resourcing in line with what they want to be improved.”

“Giving guidance and allowing for flexibility don’t need to be mutually exclusive.” Most ACHs talked about the desire for individual ACH flexibility while simultaneously asking for more HCA guidance in developing these complex collaboratives. Many have strong concerns about HCA deciding to impose rigid requirements on ACH function or development, but some also

The Healthier Washington group is creative, energetic, and enthusiastic. It’s been great to work with them.

I’ve never seen a government agency doing anything close to this adaptive leadership. But they are falling victim to the same things we are – the train is moving so fast.

said the lack of guidance meant each ACH had to start from scratch for development of fundamental ACH functions. The ACHs see an opportunity to gain efficiency if the state can provide more direction on how to tackle some complex tasks.

There is confusion about the ACH role in broader Healthier Washington activities. ACHs had many questions about other aspects of Healthier Washington and report confusion about the goals, structure, and expected ACH role in those efforts. Several ACHs experienced situations where the state agencies leading the different Healthier Washington activities were not aligning on their plans or communication strategies. Most ACHs were concerned about their capacity to participate in these other Healthier Washington efforts in addition to the work to launch and develop their ACHs.

They (the State) have a big enough challenge of showing they have the credibility to do this in the communities, and that's without them tripping over themselves...So it seems a little tone-deaf.

Long-term ACH impact: Achieving the Triple Aim

Over the next few years, ACHs will begin their regional health improvement work in earnest. The long term impact of this work is to improve regional health and well-being, advance health equity and achieve the Triple Aim of better health, better care, and lower costs.

The Common Measure Set. The Washington State Health Care Authority has adopted a set of 52 common measures as a standard way to measure the impact of the Healthier Washington initiative (see Table 3 and Appendix E).

As part of this alignment, the Common Measures are being incorporated into other state contracts, including those with health plans and providers, with the expectation that adoption of these measures will grow over time. As stated in the first report of these measures for ACH regions, “Gaining multi-organization alignment around the state’s Common Measure Set will clarify our collective understanding of health care value and send a clearer market signal regarding purchaser and payer expectations for performance on key indicators.”

Table 3. Areas of focus in the Common Measure Set

Prevention	Acute Care	Chronic Illness
Adult screening(s)	Avoidance of overuse/ potentially avoidable care	Appropriate use of medications
Childhood: early and adolescent	Behavioral health	Asthma
Immunizations	Cardiac	Depression
Obesity/ Nutrition/ Physical activity	Readmissions	Diabetes
Oral health	Obstetrics	Hypertension and cardiovascular disease
Tobacco cessation	Patient safety	
Unintended pregnancy	Stroke	
Cross cutting: Patient experience		

Focus on the social determinants of health. Many ACHs cite a focus on social determinants of health as part of their ACH’s mission and a key reason that stakeholders beyond traditional health partners are participating. Due to the focus on the Common Measure Set, these ACHs have consistently expressed concern that broader stakeholders will not see the impact of their work

I’m worried about the impact on our stakeholders if you push those clinical measures.

reflected in those clinically focused measures and clinical stakeholders will not be encouraged to think about health more broadly. One key concern is how progress on social determinants will be measured. The committee responsible for developing the Common Measure Set recently added behavioral health measures being pursued by the ACHs.

The **King County Accountable Community of Health** established a Data/Performance Work Group aimed at supporting data sharing and integration in the ACH environment. The King County ACH has placed a high priority on clarifying and building the ACH's data and information functions, which it sees as the underpinning to successfully measuring the impacts of ACH-led cross-sector initiatives. Work ranges from building relationships between regional IT leaders and state agencies to developing a successful grant proposal that supports the integration of housing and health data, in partnership with local housing authorities.

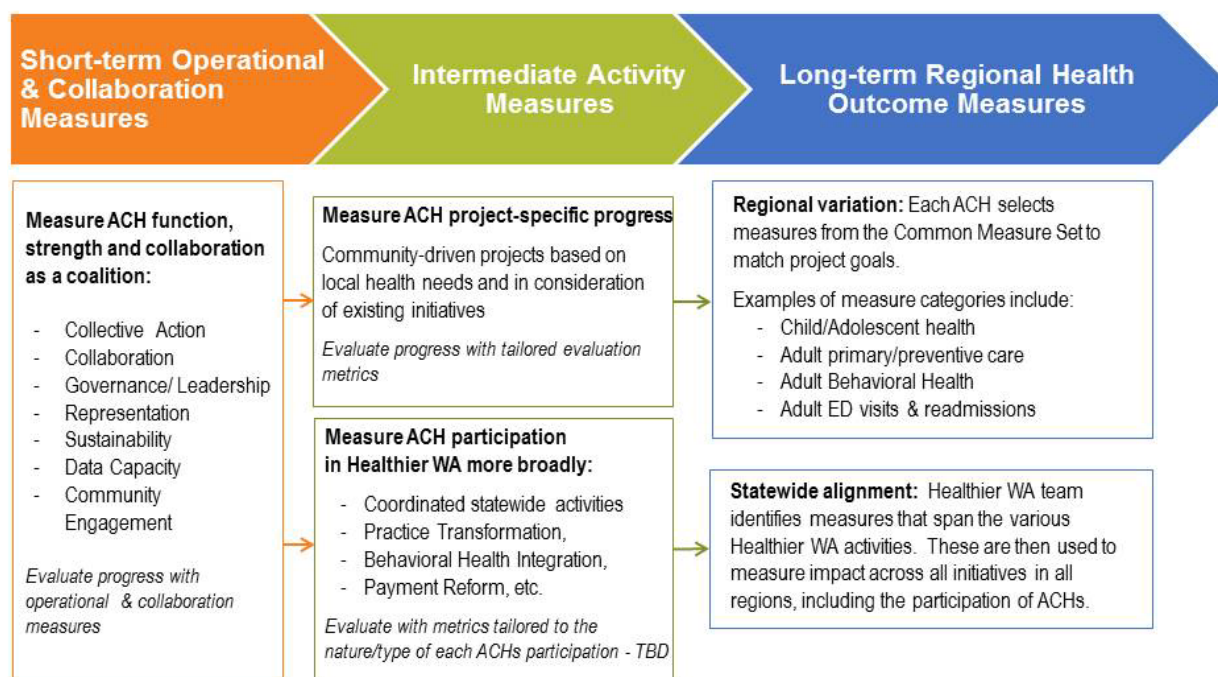
Measuring long-term ACH outcomes

A key task of the evaluation is to develop a measurement framework that can document the long-term regional impact of ACHs on key Triple Aim measures. Measuring these regional impacts is challenging given the short time frame of the initiative, the limited scope of ACH health improvement projects, and the numerous existing regional efforts and other Healthier Washington activities occurring simultaneously, which makes it difficult to directly attribute long term health improvements to the ACHs.

CCHE addresses the challenge of attribution using a logic model framework (labeled a “chain of impact” model) that attributes longer-term changes in outcomes to ACHs only if there are corresponding short- and intermediate-term outcomes aligned with those longer term changes. The diagram (Figure 8), which draws on our Theory of Change (see above p.5), illustrates how this approach works.

On the left side, the chain starts with the development of the ACHs as functioning coalitions promoting collaboration among key regional organizations. The next step in the chain is to create regional health improvement projects and participate in Healthier Washington activities that ultimately lead to the spread of health-promoting programs, policies and practices. If the changes brought about are significant enough, we can expect to see movement in some of the longer-term regional health outcomes measures (panel on the right). The evaluation is developing measures for each step in the chain to assess whether ACHs are having their intended impact.

Figure 8. ACH chain of impact



Conclusion and recommendations

ACHs met their major development goals during the first year of Healthier Washington. All nine regions successfully completed the criteria required to be officially designated as Accountable Communities of Health. They engaged a wide range of regional stakeholders, developed formal governance structures to guide their collaboration, took steps forward in health improvement project planning development, and began the conversation about sustainability. While there were many similarities in progress and approach, there was also significant variation across regions, reflecting the visions of the local leaders. While it is too early to draw any conclusions, over time the natural experiment provided by the variations in regional models will provide rich insight on how differences in approaches impact ACHs ability to improve regional health.

ACHs are well aware that a challenging year lies ahead as they turn their attention from building a strong foundation to active collaboration on local health improvement projects. The next year is also likely to bring more involvement in broader Healthier Washington strategies as those programs become better defined. These more action-oriented steps will provide ACHs an opportunity to demonstrate their value propositions to both regional and statewide stakeholders.

The following are recommendations that emerged from CCHE's evaluation findings, for consideration by the Health Care Authority as the initiative begins its second year.

- Continue to support ACH development and cross-ACH learning through effective, regular communication channels. Leverage the understanding that can be gained by ACHs working on challenges together.

The potential of the ACH is immense and transformational - it's important to keep that bigger picture in mind.

- Better define the ACH role in broader Healthier Washington activities, in consultation with the ACHs themselves. Allow ACHs to weigh in on key considerations during their development. Take into consideration the multiple Healthier Washington requests of ACHs and coordinate internally to minimize burden.
- When possible, look for timely opportunities to offer guidance to ACHs to help them be successful in ACH development and their broader role in Healthier Washington. For example, provide clear and concrete guidance on what constitutes an ACH “health improvement project”.
- Be consistent and clear about where there is flexibility and where there is a requirement, keeping in mind the tension between these two.
- Continue to develop and refine a common language and definitions for describing ACH structure and activities. For example, developing a common definition for what constitutes a “sector” may help facilitate stakeholder understanding and involvement.
- Examine the funding levels for ACHs and their projects and determine if this model will allow ACHs to impact population health in their region in the given timeframe.
- Continue to explore inclusion of broader social determinants of health measures as part of the Common Measure Set or other statewide measurement efforts, such as Washington’s Plan for Improving Population Health. Include ACHs in this discussion.

Appendix A: ACH models nationwide

The ACH model is not unique to Washington state. Although there are no direct equivalents in other states, ACH or Accountable Care Community models that share key characteristics are active or are currently being piloted in some other states. Given the emerging nature of the ACH model and its focus on community-driven design, there are not clear guidelines for Washington's implementation. Examining the similarities/differences and challenges faced by other ACH models can inform the development of Washington's model.

At the heart of these models is the idea that improving population-level health requires collaboration between multi-sector stakeholders that reach beyond traditional health care providers. This inclusion of community-based services and an acknowledgement of the importance of social determinants of health is a hallmark of the model.¹ The various ACH models differ widely on elements such as governance structure, choice of backbone organization, and the scope of work or community impact anticipated. For example, Vermont primarily uses hospitals as the backbone organization for their models, since hospitals were best suited to engage their communities.² This is different from other states, including Washington, which may use existing community organizations or have developed new entities to facilitate ACH activities. Some ACH efforts are more centered in care coordination within clinical settings; however, in Ohio, Accountable Care Communities emphasize leveraging resources outside clinical settings, i.e. social services, public health, and community organizations, an emphasis similar in Washington's model.^{3,4}

Typically, models have targeted health indicators, and are implemented within a defined region or specific population. In many cases, ACHs are implemented in only select communities within a state. Washington, however, has chosen to divide the entire state into regions for ACH implementation at the same time.

In some states the model also incorporates some form of value driven payment. Minnesota also received State Innovation Model funding (SIM) to implement an Accountable Health Model in 15 select communities.⁵ While many of the collaborative aspects are similar to those in Washington, Minnesota's model also requires partnership with an Accountable Care Organization, a model that holds providers accountable for costs and quality of care. While payment model testing is included in Washington's broader Healthier Washington initiative⁶, there are not specific requirements for ACH-level strategy development in that area.

Models such as the Patient-Centered Medical Home, the Accountable Care Organization, and Oregon's Coordinated Care Organizations have explored the integration of clinical services with behavioral health and social services, but the ACH model is one of the first frameworks to purposefully integrate public health strategies that address the community-level factors that shape population health.

– Prevention Institute

As these models are relatively new, limited longitudinal data is available to show significant effects at a population level. Given the emerging nature of the ACH model and its focus on community-driven design, there are not clear guidelines for Washington’s implementation. Under the SIM grant, Washington hopes to learn more about how ACHs can successfully leverage innovation and increase collaboration in local communities.

¹ Prevention Institute (2016), *The Accountable Communities for Health: An Emerging Model for Health System Transformation*. Retrieved from: <http://www.preventioninstitute.org/component/jlibrary/article/id-371/127.html>

² Mikkelsen, L & Haar, W.L. (2015) *Accountable Communities for Health: Opportunities and Recommendations*. Retrieved from Prevention Institute website: <http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html>

³ St. Jean, E. (2015). *Profiles of County Innovations in Health Care Delivery: Accountable Care Communities*. Retrieved from National Association of Counties website: <http://www.naco.org/sites/default/files/documents/Accountable-Care-Communities.pdf>

⁴ Janosky, J.E. & Douglas, F.L. (2012). *Healthier By Design: Creating Accountable Care Communities. A Framework for Engagement and Sustainability (White paper)*. Austen BioInnovation Institute in Akron, Akron, OH. Retrieved from: <http://abiakron-org-si-cloud.com/Data/Sites/1/pdf/accwhitepaper12012v5final.pdf>

⁵ State of Minnesota. (2016). *Minnesota Accountable Health Model – SIM Minnesota*. [Fact sheet]. Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197626

⁶ Washington State Health Care Authority. (2015). *The Plan for a Healthier Washington*. Retrieved January 26, 2016, from <http://www.hca.wa.gov/hw/pages/default.aspx>

Appendix B: Annotated Healthier Washington resources

For more information on **Healthier Washington**, including details on each Strategy and the links to the original Healthier Washington State Innovations Model grant application --

<http://www.hca.wa.gov/hw/pages/default.aspx>

For more information on the **Accountable Communities of Health**, including the Readiness Proposal Criteria, Frequently Asked Questions and updates on their progress -

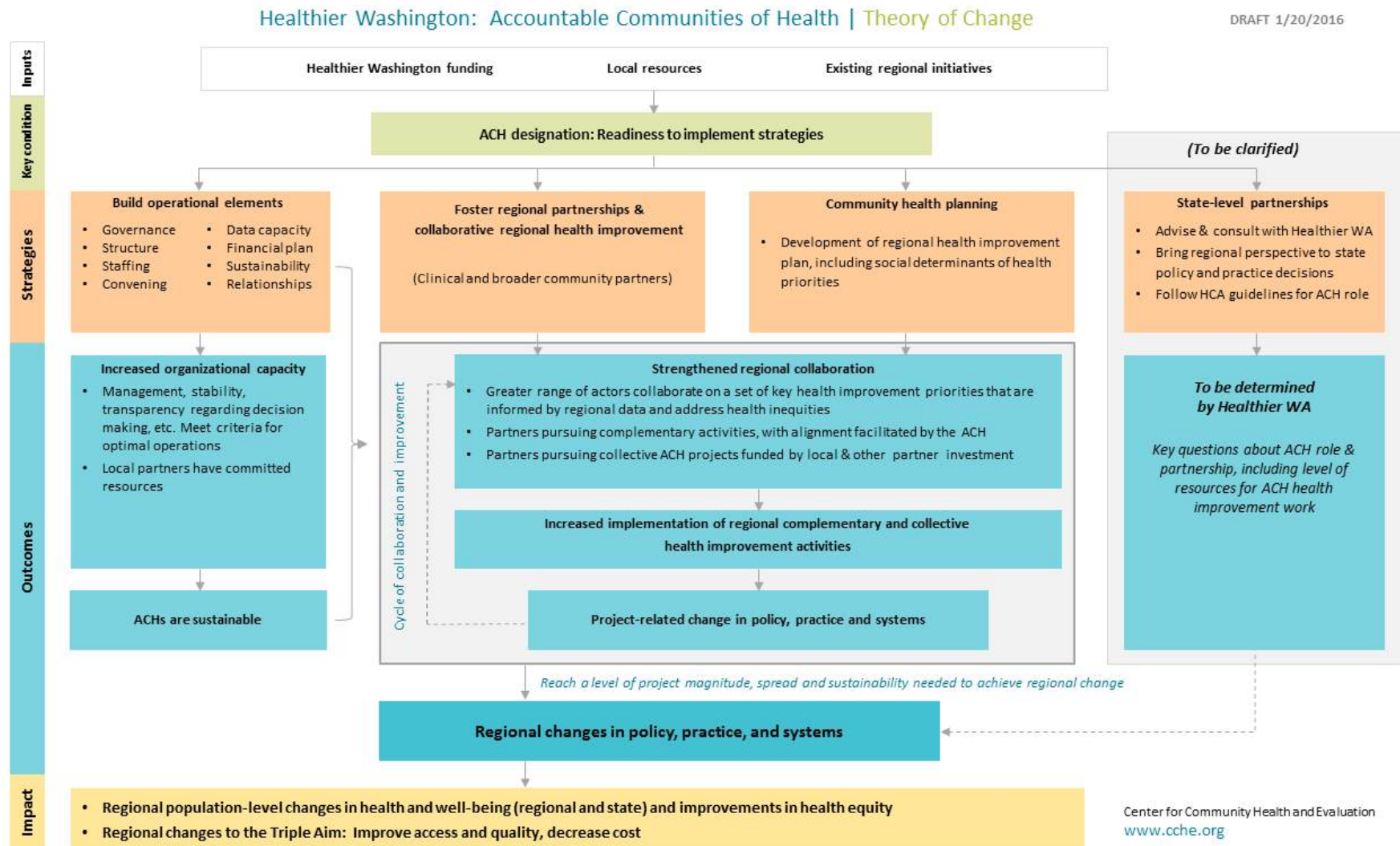
http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

For more information on the **Common Measure Set** for Health Care Quality and Cost –

http://www.hca.wa.gov/hw/Pages/performance_measures.aspx . For ACH specific information, see the **2015 Performance Results for Accountable Communities of Health**.

http://www.hca.wa.gov/hw/Documents/performance_results_achs2015.pdf

Appendix C: ACH theory of change



Appendix D: Evaluation approach & data collection methods

In May 2015, the Health Care Authority (HCA) contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the ACHs.¹ The ACH evaluation closely coordinates with the evaluation the overall Healthier Washington initiative, led by a team at the University of Washington.

CCHE takes a collaborative approach to evaluation and partnered with key stakeholders at HCA to develop a theory of change for ACHs within Healthier Washington (see Appendix C) and a framework for measuring short, intermediate and long-term impact ACHs' work (see p. 27).² These documents, along with input from HCA staff, informed the development of an evaluation plan for three-year initiative focused on four key questions (see Figure 9).

The evaluation plan is expected to adapt over the course of the multi-year project (2015-2019); the evaluation will flex to respond to lessons learned and shifts in ACH activities and the strategic direction of Healthier WA.

CCHE aims to understand the function and contribution of the ACHs—how they form, agree on community health priorities, engage in health improvement activities, contribute to the Healthier Washington initiative, and work towards becoming sustainable coalitions. CCHE will also assess the ACHs' impact at the end of the project. In addition, CCHE provides timely feedback to Healthier Washington and HCA staff through bi-weekly check-in calls with key program staff, regular presentations to key decision makers, and written memos about ACH success factors, challenges, and lessons learned to inform program improvement. This final report includes ACH evaluation findings from the first year of Healthier Washington – February 2015 – January 2016.

Qualitative and quantitative data were collected from multiple sources to understand ACH capacity and progress for this report. CCHE took an opportunistic approach to data collection, leveraging existing structures and convenings of ACH participants to increase understanding of relevant context and minimize burden on the ACHs. This approach generated a rich set of qualitative data, but resulted in some inconsistency in the timing and level of detail of information collected from each individual ACH. All qualitative data gathered is considered confidential and reported in aggregate as themes in this report.

Figure 9. Evaluation questions

1. Have the ACHs been successful in achieving their objectives in:
 - Governance, structure and operational capacity?
 - Developing and implementing effective, collaborative health improvement plans and at least one regional health improvement project?
 - Contributing to broader Healthier Washington activities?
2. What have been the success factors and barriers for achieving the ACH objectives?
3. What lessons have been learned in the process of ACH implementation that can help shape the future direction of the program?
4. To what extent have ACHs advanced the Triple Aim – population health, patient experience and per capita cost?

Site visits to all nine ACH regions to observe ACHs in action including meeting structure, decision making processes, participant engagement, and quality of discussion/collaboration.

Interviews with backbone staff and key ACH participants to understand ACH development, regional ACH activities, and their role in state-level Healthier Washington activities. Interviews were also conducted with key Healthier Washington staff, including technical assistance providers.

Online survey of regional stakeholders engaged in the ACHs to solicit individual ACH participants' opinions and perspectives about how each of the nine ACHs are developing and functioning; 391 participants responded to the survey in Year 1.

Observing meetings where ACH members are convened to discuss both ACH development and the statewide initiative (e.g., weekly conference calls with ACH backbone staff) to document ACHs evolution individually and as participants in Healthier Washington, including reported success factors, challenges, and lessons learned.

Document review of ACH grant applications, designation proposals, and reports submitted to HCA, as well as the broader Healthier Washington initiative materials necessary to understand the context in which the ACHs are developing.

Qualitative data from interviews were analyzed thematically with the aid of Atlas.ti. Quantitative data were compiled and analyzed with Microsoft Excel and STATA where appropriate.

When not otherwise attributed, quotes within this report are from ACH backbone staff and participants or ACH designation applications. When appropriate, descriptions of Healthier Washington, including the ACH initiative goals, purpose and criteria, align as closely as possible with published material such as the ACH Requests for Proposals, Healthier Washington website descriptions and the ACH Frequently Asked Questions document.

¹ Washington State Health Care Authority. (2015). *Accountable Communities of Health*. Retrieved January 26, 2016 from http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

² Current versions of these guiding documents are included in this report. They are subject to changes as the initiative unfolds and more is learned about how the role of ACHs is operationalized.

Appendix E: Washington State Common Measure Set

The Common Measure Set for Health Care Quality and Cost was originally approved December 2014.

Detail available at: http://www.hca.wa.gov/hw/Pages/performance_measures.aspx.

Population Measures	
1. Immunization: Influenza	4. Behavioral health: % of adults reporting 14 or more days of poor mental health
2. Unintended pregnancies	5. Ambulatory care sensitive hospitalizations for COPD
3. Tobacco: % of adults who smoke cigarettes	
Clinical Settings Measures	
Children/Adolescents (Health Plan)	27. Immunizations: Pneumonia (older adults)
6. Access to primary care	28. Avoidance of antibiotics for acute bronchitis
7. Well-child visits in the 3rd, 4th, 5th & 6th years of life	29. Avoidance of imaging for low back pain
8. Youth obesity: BMI assessment/counseling	30. Asthma: Use of appropriate medications
9. Oral health: Primary caries prevention/ intervention	31. Cardiovascular disease: Use of statins
Adults (Health Plan)	32. COPD: Use of spirometry in diagnosis
10. Access to primary care	33. Diabetes: HbA1c testing
11. Adult obesity: BMI assessment/counseling	34. Diabetes: Eye exams
12. Medical assistance with smoking and tobacco use cessation	35. Diabetes: Screening for nephropathy
13. Colorectal cancer screening	36. Depression: Medication management
14. Diabetes care: Blood pressure control	37. Medication adherence: Proportion of days covered
15. Diabetes care: HbA1c poor control	38. Medication safety: Annual monitoring for patients on persistent medications
16. Hypertension: Blood pressure control	39. Medications: Rate of generic prescribing
17. Follow-up after hospitalization for mental illness @ 7 days, 30 days	Additional Measures (Hospitals)
18. 30-day psychiatric inpatient readmission	40. Patient experience: Communication about medications and discharge instructions
Children/Adolescents (Primary Care Medical Groups)	41. 30-day all cause readmissions
19. Immunization: Childhood status	42. Potentially avoidable ED visits
20. Immunizations: Adolescent status	43. Patients w/ 5 or more ED visits <i>without</i> care guidelines
21. Immunizations: HPV vaccine for adolescents	44. C-section NTSV
22. Appropriate testing for children with pharyngitis	45. 30-day mortality: Heart attack
Adults (Primary Care Medical Groups)	46. Catheter-associated urinary tract infection
23. Patient experience: Provider communication	47. Stroke: Thrombolytic therapy
24. Screening: Cervical cancer	48. Falls with injury per patient day
25. Screening: Chlamydia	49. Complications/patient safety composite (11 parts)
26. Screening: Breast cancer	
Health Care Cost Measures	
50. Annual state-purchased health care spending relative to state's GDP	
51. Medicaid spending per enrollee	
52. Public employee and dependent spending per enrollee (include public schools)	