Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report Template
Reporting Period: January 1, 2018 – June 30, 2018

June 26, 2018

Table of Contents

Table of Contents 2

Semi-Annual Report Information and Submission Instructions 3

ACH Contact Information 7

Section 1: Required Milestones for Demonstration Year (DY) 2, Quarter 2 8

A. Milestone 1: Assessment of Current State Capacity 8

B. Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment) 16

C. Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations 21

D. Milestone 4: Identification of Partnering Providers 38

Section 2: Standard Reporting Requirements 40

ACH-Level Reporting Requirements 40

A. ACH Organizational Updates 40

B. Tribal Engagement and Collaboration 41

Project Reporting Requirements 48

C. Project Status Update 48

Portfolio-Level Reporting Requirements 50

D. Partnering Provider Engagement 50

E. Community Engagement 55

F. Health Equity Activities 68

G. Budget and Funds Flow 70

Attachment: Semi-Annual Report Workbook

Semi-Annual Report Information and Submission Instructions

Purpose and Objectives of ACH Semi-Annual Reporting

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

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

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

Reporting Requirements

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

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

- The ACH as an organization,
- The ACH's Partnering Providers, or
- Both the ACH and its Partnering Providers.

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

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	**Sub-Section Description**
Section 1. Required Toolkit Milestones (DY 2, Q2)	Milestone 1: Assessment of Current State Capacity
	Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)
	Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations
	Milestone 4: Identification of Partnering Providers
Section 2. Standard Reporting Requirements	ACH Organizational Updates
	Tribal Engagement and Collaboration
	Project Status Update
	Partnering Provider Engagement
	Community Engagement
	Health Equity Activities
	Budget and Funds Flow

Key Terms

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

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

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

Semi-Annual Report Submission Instructions

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

File Format

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

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

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

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

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

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

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

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

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

Semi-Annual Report Submission and Assessment Timeline

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

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

Contact Information

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

ACH Contact Information

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

ACH Name:	Better Health Together
Primary Contact Name **Phone Number** **E-mail Address**	Hadley Morrow (509) 954 - 0831 hadley@betterhealthtogether.org
Secondary Contact Name **Phone Number** **E-mail Address**	Alison Poulsen (509) 499-0482 alison@betterhealthtogether.org

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

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

A. Milestone 1: Assessment of Current State Capacity

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

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

Yes	No
x	

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

   ACH Response:

   Not Applicable

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

   ACH Response:

   BHT conducted two 'current state assessments' in the spring of 2018: 1) a broad Medicaid Transformation Project (MTP) Capacity Assessment with primary care and behavioral health Partnering Providers; and 2) a fully integrated managed care (FIMC) readiness assessment with behavioral health agencies, using Qualis Health's Behavioral Health Agency Billing Survey tool. The 2018 assessment efforts were designed to build on previous data collection and input processes with BHT region stakeholders, including Health System and Care Coordination partner inventories (HSI and CCI) conducted in 2017 and described in BHT's November 2017 Project Plan submission. The table below shows the key differences between these assessments:

	HSI and CCI	FIMC Readiness Assess.	MTP Capacity Assessment
Timing	Summer 2017	Mar-Apr 2018	Mar-Apr 2018
OBJECTIVE	Gauge interest in MTP projects and related transformation	Help BH providers assess readiness for MCO contracts; inform regional FIMC transition strategy	Identify capacity & needs related to BHT's selected MTP projects, including information requested by HCA
PARTICIPANTS	All potential ACH partners	BH agencies who have made the commitment to transition to FIMC	PC and BH providers / partners who have committed to participating in BHT's Collaboratives
TOOL	BHT-designed form	Healthier WA Practice Transformation Support Hub BHA Billing Self-Assessment	BHT-designed form drawing from existing surveys
LEVEL OF INFORMATION	Organizational	Organizational	**Clinic/practice level**
MODE	Fillable PDF / Emailed form	Online survey; will generate a PDF copy for BH agencies	Online survey with option for facilitated process for selected HSI respondents

Response rate for both the MTP Capacity and FIMC Readiness Assessments was very high. For the MTP Capacity Assessment, BHT received 65 responses from 45 organizations, representing about 96% of primary care and behavioral health providers who signed a Memorandum of Understanding to participate in Transformation planning with BHT and its six county-based Collaboratives. 100% of the 31 Behavioral Health partners who completed the FIMC letter of commitment also completed the assessment.

Key findings by project area. BHT's MTP Capacity Assessment contained a range of questions related to the four Medicaid Transformation projects selected by BHT (bi-directional integration; care coordination; chronic disease management; and opioid-related services) as well as questions about HIT/HIE, value-based payment, and to a lesser extent, practice transformation and workforce. Assessment findings related to Domain 1 are described under Question B.3; more detailed results for all items can be found at: http://www.betterhealthtogether.org/bold-solutions-content/assessment-results.

Integration. Many BHT region providers are starting to move toward delivering more integrated care but use of best practices is somewhat uneven. For example, when asked about their use of best practice elements from the Collaborative Care Model and Bree Collaborative Recommendations, more than 60% of respondents reported that they have individual treatment plans including patient goals and clinical targets for 'most or all' of their patients but only about 15% reported that physical and behavioral health providers have shared care plans for 'most or all' patients.[2] Clinics that already provide *both* primary care (PC) and behavioral health (BH) were more likely than others to use most Bree and Collaborative Care Model elements

[2] For context, data from WA DSHS suggests that approximately 25% of BHT region Medicaid enrollees have a co-occurring condition (either a mental health or substance use disorder diagnosis and at least one chronic disease).

consistently. (Clinics were asked to report whether they used each element with: 1 = None of their patients; 2 = Some of their patients; 3 = Most/all of their patients. The average score across eight elements was 2.4 for BH-PC clinics, versus 2.1 or 1.9 for BH-only and PC-only clinics, respectively).

When asked about collaboration across types of care, 85% of PC-only clinics responded that they collaborated at least occasionally with mental health but only 57% had any collaboration with substance abuse disorder (SUD) treatment providers. Among BH providers, all mental health clinics and about 85% of SUD providers reported at least occasional collaboration with PC.

Following directions from the October 2017 MTP Toolkit, BHT asked providers to locate themselves on the six levels of SAMHSA's integrated care framework. However, less than half of the respondents indicated that their clinic fell cleanly into one level or another, even when levels were collapsed into the three broader categories of coordinated, co-located, or integrated. These findings suggest that the SAMHSA categories and/or the progression they imply may not accurately reflect providers' on-the-ground experiences.

For BHT region providers, barriers to integrated care are primarily but not exclusively operational and technical, rather than a lack of familiarity with or support for the concept. The most commonly cited barriers were: payment or financing mechanisms (mentioned by 72% of respondents) and workforce availability (69%, although somewhat more frequently mentioned by PC-only providers than others). Other issues cited by at least 40% of respondents included HIT or HIE capacity, data availability, and partnerships.

Mitigation strategies: BHT hosted and recorded a series of topical webinars in June 2018 to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For bi-directional integration of care, Anne Shields of the University of Washington AIMS Center was the featured presenter.

BHT is still considering the range of technical assistance and supports that it will provide to Collaboratives and Partnering Providers as Medicaid Transformation project Implementation begins. But in preparation for fully integrated managed care (FIMC) beginning in 2019, BHT is offering these resources to behavioral health Partnering Providers in particular:

- A two-part training led by Qualis/the WA Practice Transformation Support Hub on value-based payment and integrated managed care
- Technical assistance and project management via an external vendor to help agencies transition their billing and/or IT systems and implement new functions/procedures necessary to successfully bill Managed Care Organizations.

In addition, BHT hosted and recorded a series of topical webinars in June 2018 to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For bi-directional integration of care, Anne Shields of the University of Washington AIMS Center was the featured presenter.

Additionally, from our six-county Collaborative's Transformation Plans we have identified a shared need for additional technical assistance in the form of education and training around:

- Health Equity activities, especially around trauma-informed care and ACEs
- Telehealth
- Building powerful relationships with social determinants organizations
- HIPAA and 42 CFR for information sharing between primary care and behavioral health organizations
- CDSMP (Stanford Self-management program), with a need for someone to organize training for leaders and support identifying and recruiting participants
- How to define and manage a complex care population
- How to organize around the Pathways approach, technology platform, and resource sharing to support Care Coordination strategies at the clinic/provider level
- Mental health first aid training with a feeling all clinic staff, small and large, should be trained in this.
- Treatment and prescribing protocols for opioid/substance use disorder

Care Coordination. More than three-quarters of clinics reported that they use care coordination personnel (either within the practice or as an adjunct) to monitor and manage care for patients who need that support. A similar proportion reported that they prioritize specific patient groups for care coordination, but the groups prioritized vary widely. Some examples include: Medicare beneficiaries; people with diabetes; people with mental health, SUD, or co-occurring disorders; high utilizers of various definitions, or people with social risk factors (e.g. child protective services involvement).

In addition to asking PC and BH providers about their collaboration with each other, BHT also asked about collaboration with other medical and social services providers/agencies. The assessment specified that collaboration should mean "joint work, conversations, or information exchange between providers or agencies, not general referrals without follow-up."

Collaboration with acute care (hospitals or EDs) and with social services was most common: 47% of respondents reported 'extensive' collaboration with transportation providers, and roughly 40% had extensive collaboration with housing providers and acute care (hospital and/or ED). With some variation by clinic type and geography, collaboration was considerably less common with EMS systems and oral health providers (39% and 36% of respondents reported no collaboration with those two sectors, respectively).

Mitigation strategies: BHT is still considering the range of technical assistance that it will provide to Collaboratives and Partnering Providers as Medicaid Transformation project Implementation begins. Support strategies will be informed by the activities and resource requests received in Transformation Plans from both Partnering Providers and Collaboratives in summer 2018. Within each County Collaborative, BHT as The Pathways Community Hub anticipates:

- Providing project management, training, and support of the Pathways platform, Coordinated Care Systems
- Identifying referral partners and resources for the target population within the

Collaborative

- Developing contracts with care coordination agencies for care coordination services
- Working with each Collaborative to review data, gaps in services, and priorities
- Working with all Pathways evaluation teams to review data and develop quality improvement plans

Chronic Disease Management. BHT asked providers about their use of best practices from the Chronic Care Model and, similar to findings for integrated care, the responses were mixed. Almost half of clinics reported tailoring their approach or offering targeted interventions for particular groups of patients (e.g. high utilizers, or patients with diabetes) and 45% said they offered team-based care. Only about a quarter—and less in rural counties—offered culturally specific care programs or initiatives. Clinics that already provided *both* primary care and behavioral health services reported greater use of Chronic Care Model elements than other clinics, and PC-only practices generally reported employing more CCM strategies than BH-only practices.

Because BHT has prioritized diabetes and asthma (especially among children) as focus areas for chronic disease work, the assessment asked about self-management supports for these conditions. Roughly a third of clinics reported offering asthma education and a small number reported offering programs like the Stanford Chronic Disease Self-Management Program or National Diabetes Prevention Program (NDPP) classes.

Mitigation strategies: In June 2018, BHT hosted and recorded a series of topical webinars to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For chronic disease, Dr. Ron Stock was the featured presenter. Dr. Stock is a primary care physician who formerly directed the Transformation Center at the Oregon Health Authority.

BHT is still considering the range of technical assistance that it will provide to Collaboratives and Partnering Providers as Medicaid Transformation project Implementation begins. Support strategies will be informed by the activities and resource requests received in Transformation Plans from both Partnering Providers and Collaboratives in summer 2018.

Opioids. BHT asked PC and BH partners about opioid prescribing practices and about the availability of OUD treatment. In general, it appears that prescribing guidelines have been broadly adopted and that clinic-based opioid use disorder prevention efforts might be better focused on adoption of systems to support those guidelines and on expanding access to OUD treatment.

About 23 clinics prescribe opioids for chronic pain. Among those, all but three report that 'all or almost all' prescribing providers have been trained on opioid prescribing guidelines (a P4R measure). But only six (26%) have clinical decision supports for opioid prescribing built into EHRs (another P4R measure). 21 of 23 clinics report that they are enrolled in the Prescription Monitoring Program (PMP) but it is not clear how regularly PMP data are used or whether provider access the PMP via a direct interface with the clinic's EHR system or through a more manual process. Nine of the 23 (roughly 40%) said that difficulty accessing PMP records is a

barrier for them in implementing safe opioid prescribing practices. According to BHT partners, the most significant ongoing barrier to reducing opioid prescribing is patient expectations and a shortage of viable treatment alternatives for chronic pain, especially in rural areas. Nineteen of the 23 prescribing clinics reported that patient resistance to prescribing guidelines constituted a barrier for full Implementation of prescribing guidelines.

Twenty clinics report that they provide treatment & recovery services for opioid use disorder (a P4R measure). The same number currently provide medication assisted treatment (MAT)—mostly buprenorphine and naltrexone—and another 17 refer patients to external providers for MAT. However, several of the assessment participants noted that demand for MAT exceeds the capacity of certified providers in their services area(s).

Mitigation strategies: In June 2018, BHT hosted and recorded a series of topical webinars to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For opioids, Dr. R. Corey Waller was the featured presenter. Dr. Waller is an addiction, pain, and emergency medicine specialist and a nationally recognized expert on strategies to address the opioid crisis.
BHT is still considering the range of technical assistance that it will provide to Collaboratives and Partnering Providers as Medicaid Transformation project Implementation begins. Support strategies will be informed by the activities and resource requests received in Transformation Plans from both Partnering Providers and Collaboratives in summer 2018.

Summary. Overall, MTP capacity assessment results suggest that many practices have made a good start on integration, care coordination, chronic disease management, and preventing or addressing opioid addiction. PC-only, BH-only, and combined PC-BH practices appear to have different strengths and gaps and will likely have different paths towards Transformation.

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

ACH Response:

BHT does not intend to add or drop projects as a result of assessment findings. However, the findings are being used inform project planning, Implementation design, and year 2-5 incentive payment financial modelling, including setting expectations and direction for Partnering Providers and helping BHT prioritize ideas for resources and technical support. We do not expect to finalize this work until after September 5, when Transformation Plans submitted by Partnering Providers in primary care and behavioral health have been reviewed.

Currently, BHT's Collaboratives and Partnering Providers are using the assessment results to inform their individual Transformation Plans. Collaborative and Partnering Provider Transformation Plans are due to BHT this summer and will be incorporated into BHT's region-wide Implementation Plan for HCA in the fall. BHT made the assessment information available to partners in a variety of products:

- A June webinar provided overall results with some comparisons across clinic type

- Each Collaborative received a summary of their county-specific results; Tribal providers received a similar summary
- A rural summary outlined findings across BHT's five rural counties
- Key contacts at each participating practice received a PDF copy of their clinic's responses
- A web page containing downloadable results summaries plus links to the webinar

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

ACH Response:

Our region benefits from a spirit of collaboration. Because so many of our partners intersect through various coalitions and existing projects, we see great opportunities to leverage shared learning from partners with bright spots in health equity.

Responses to the MTP Capacity assessment suggest that about a quarter of BHT-region primary care and behavioral health providers offer culturally-specific chronic disease management or care coordination programs. Examples include: a diabetes prevention & management program for American Indians, initiatives for LGBTQIA+ patients, and use of Community Health Workers who share cultural backgrounds or life experiences with the individuals they serve.

As noted under question A.3., more than three-quarters of BHT-region primary care and behavioral health providers prioritize specific populations for care coordination. Some groups are defined by utilization patterns (e.g. frequent ED visits) or source of coverage (Medicare beneficiaries) but other priority groups are those who experience health disparities. Examples include: Marshallese Islanders, individuals with serious & persistent mental illness, Russian-speaking populations, and homeless youth.

Work conducted in 2016 to identify and map connections between organizations that impact health in BHT's region[3] catalogued 112 entities operating in the health, social services, government, business, and education sectors. The study found that a number of organizations focused their service efforts on groups who experience health disparities. Target populations represented among the responding organizations included:

- Racial or ethnic minorities (23% of respondents reported this as one of their organization's target populations)
- LGBTQIA+ populations (22%)
- Foster youth (21%)
- Refugees or immigrants (19% and 16% respectively)
- Veterans (18%)
- Tribal members (16%)
- Individuals with a history of incarceration or criminal activity (13%)

[3] Spokane Regional Health District Data Center (2017). Community Linkage Mapping: General Report. An assessment of the regional population and social determinants of health systems. See: https://goo.gl/1WDBpo

Many of the organizations represented in the regional network mapping are already connected to BHT through participation on ACH governance and advisory committees and BHT will leverage their programmatic assets and expertise to support its health equity goals.

BHT has been working closely with Upstream Foundation, who's work training clinics in evidence-based practices directly supports one of our ACH priorities of preventing unintended pregnancies. 35% of pregnancies in the BHT region are unintended, and we believe increasing access to birth control through strategies like One Key Question will support Medicaid women in becoming pregnant when they are informed and ready. We benefit from a close relationship with Upstream's leadership and expect some of our Partnering Providers to participate in their trainings. We view this as an equity asset in preventing unintended Medicaid births, which will can delay the risk of kids being born into poverty and the financial impact to low-income families.

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

ACH Response:

We devoted the entire May Leadership Council and part of our annual BHT Board retreat to a conversation around health equity. After a set of presentations and discussions, we asked the group to recommend one activity they would suggest BHT sponsor to accelerate health equity in the region. Three themes emerged from these recommendations:

1) Offering trainings, or perhaps a conference, workshopping health equity related activities, including some examples such as trauma informed care, hiring a diverse workforce, using and collecting data with an equity lens, and stigma-reduction, among many other. One group suggested we look to https://www.racialequityalliance.org/ for resources.

2) Playing a convening role for policy advocacy when the ACH comes up against systemic or policy barriers impacting health outcomes.

3) Requiring Partnering Providers to address health equity in their plans and tying some incentive dollars to completion of identified activities.

The first two suggestions are in the planning phase, and the third has been put into practice as previously mentioned. Our Partnering Providers in primary care and behavioral health are currently working on their Transformation Plans, in which they are required to provide an overall health equity statement as well as plans to address equity for each area of Transformation, bi-directional integration, chronic disease management and addressing the opioid use crisis). BHT will assess and synthesize responses from Partnering Providers in these plans to build a set of recommended activities to accelerate health equity across the region. We will draw on the expertise of our Community Voices Council, Provider Champions Council, and

Tribal Partner Leadership Council to review and adapt these recommendations, and then put forth to the Waiver Finance committee to explore allocating incentive dollars to completion of the activities.

One topic that has been commonly identified recently is around the roadblocks providers come up against when trying to access what are often labeled as "alternative" or "non-traditional" services, actually deeply rooted in tradition and history, with an evidence base pointing to success. These include services such as acupuncture, sweat, peer-based, and faith-based methods for personal recovery, wellness, and prevention. As an example, acupuncture is not a wildly recognized or billable treatment for SUD, however it can treat the pain that often leads to opioid addiction. A lot of work has been done to destigmatize these services, and more is needed. We have heard behavioral health and Tribal providers voice a fear that the medical model of the primary care world will not support or validate these time-tested programs. In response to these concerns, BHT intends to explore opportunities to educate our partnering Providers about these services and their merit, and support advocacy to reduce the barriers to accessing these services.

The BHT Board is working to expand its understanding and actions related to the strategic role that BHT should be playing to move this from discussion into specific actions. BHT Board agrees to continue to work to further understand and define actionable efforts to support reducing health inequities. It is the expectation of the Board that we are regularly engaging in both deepening our knowledge and shared agreements on health equity.

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

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

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

Yes	No
x	

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

   ACH Response:

   Not Applicable

3. Describe progress the ACH has made during the reporting period to identify potential strategies for each Domain 1 focus area that will support the ACH's project portfolio and specific projects, where applicable.

ACH Response:

As a step in identifying potential strategies for Domain 1 focus areas, BHT included a number of questions related to HIT/HIE, value-based payment, workforce, and current participation in practice transformation in the two current state assessments conducted in spring 2018 (see Question A.3). Key findings are summarized by topic below.

HIT and HIE. Clinical providers in BHT's region have varying levels of Health Information Technology (HIT) capacity. Looking across both assessments, about 85% of primary care and behavioral health practices report having an EHR, in most cases a certified product. Behavioral health only and Tribal clinics are heavily represented in the group without EHRs but more than half of BH practices reported plans to make IT system upgrades or changes before 2019.

Primary care only and combination PC-BH practices reported using IT tools for a number of clinical care functions such as: basics (e.g. recording patient history, problem lists, and medications); sending & receiving labs or prescriptions; quality controls (e.g. built-in clinical guidelines or drug interaction warnings); patient engagement (e.g. e-visit summaries) and population management (e.g. identifying and tracking certain groups of patients). As a group, behavioral health only practices reported doing many basic functions electronically but frequently indicated that some of the other functions listed were not relevant to their practice.

Reported electronic Health Information Exchange (HIE) was fairly low across all clinic types. Clinics participating in the MTP Capacity Assessment reported that they do exchange information with a variety of medical and social care providers, but that information exchange is typically not electronic, as shown in the table below:

	Clinics exchanging info with this provider type	At least some of the info exchange is electronic
Primary care	95% (61)	38% (24)
Hospitals and/or EDs	92% (59)	24% (15)
Mental health	95% (61)	23% (15)
Substance use disorder	89% (57)	23% (15)
Oral health	61% (39)	16% (10)
Long-term care	78% (50)	5% (3)
Community-based organizations	88% (56)	8% (5)

Commonly reported barriers to increased use of HIT and HIE included: lack of interoperability of different systems (55% noted this as a barrier); cost (48%); technical issues with hosting or performance (44%); workflow constraints and privacy/confidentiality concerns (42% each). Thirteen clinics, all in rural counties, noted insufficient broadband capacity as a barrier.

Value-based Payment. Across the primary care and behavioral health clinics that participated in the MTP Capacity assessment, self-reported participation in value-based payment (VBP) for any/all lines of business was approximately 40%. Twenty two (33%) reported at least some of their Medicaid revenue was part of a value-based contract. For context, 6 of the 15 (about 40%) of BHT-region providers who participated in HCA's 2017 Provider VBP survey reported some Medicaid VBP revenue in categories 2C-4B, but the survey questions are not directly comparable.

When asking about barriers to VBP, BHT used many of the response options from HCA's Provider VBP survey and received fairly consistent feedback. The top five barriers cited in the two surveys were:

BHT MTP Capacity Assessment (2018; 64 respondents)	HCA VBP Provider Survey (2017; 15 respondents)
1. Lack of timely cost data 2. Misaligned quality measures 3. Lack of interoperable data systems 4. Lack data on patient populations 5. Inability to analyze payment models	1. Lack of comprehensive data on patient populations 2. Lack of availability of timely patient/population cost data to assist with financial management 3. Lack of interoperable data systems 4. Misaligned incentives & contract requirements 5. Insufficient volume by payer to take on clinical risk

Workforce and Practice Transformation. Workforce development was not a direct focus of either the MTP Capacity or FIMC Readiness Assessments. Nevertheless, workforce availability and training were mentioned as challenges in a number of different contexts, including:

- Ability to offer integrated care – Primary care only clinics in particular cited insufficient workforce as a barrier in this area (examples included social workers and psychiatrists but also physicians and nurses)
- OUD treatment and MAT – a number of participants noted that the number of practitioners certified to provide MAT is insufficient to meet demand
- Greater adoption of HIT and HIE – Respondents across both assessments commented that adopting new technology or transitioning between systems can be burdensome or intimidating for staff
- Rural settings – some respondents noted that default expectations for coordination or team-based care were not always a good fit for rural locations where one behavioral

health provider may serve an entire county, or that increasing use of IT tools would be particularly challenging in very small rural practices that lack staff with IT expertise

- Pharmacy – BHT sees opportunities to better leverage pharmacies as a key touch point in community health
- Peer based care – how to recruit, train, and integrate Community Health Workers and Peer-to-Peer Counselors in care teams
- Behavioral Health Workforce shortage – Partnering Providers have discussed how commonly providers get "poached" from one practice to another, and desire a shared strategy for recruiting more behavioral health workforce in the face of extreme shortages

Some of BHT's primary care and behavioral health partners have substantial experience with practice transformation. Fifteen of the 67 clinics who participated in the MTP Capacity Assessment reported that they are NCQA certified Patient-Centered Medical Homes and a small number hold other certifications from The Joint Commission or CARF (Commission on Accreditation of Rehabilitation Facilities). Between 10 and 15 clinics have participated in Washington's Mental Health Integration Program (MHIP) or TCPI, the pediatric Transforming Clinical Practice Initiative.

4. Provide information as to whether the ACH has adjusted Domain 1 strategies as originally proposed in its Project Plan based on ongoing assessment.

ACH Response:

We have evolved our anticipated workforce development activities related to our Care Coordination strategy. Originally, we expected to build out a Pathways Hub and large community health work (CHW) workforce, but we have now shifted more towards building a robust care coordination infrastructure across the region. It is evident that many of our partners have already hired staff to support care coordination, patient navigations, or social workers. It is not a viable strategy to think that all care coordination would run through a hub, rather it makes more sense to align efforts around a shared ability to develop care plans, share patient information and do a better job of managing community assets. At this time, it appears that a patient's ability to access service is luck of the draw, meaning seasoned care coordinators have a better way to connect patients to services, while the recent graduate of EWU's social work program relies on a google group to connect a patient to services. We note that this is not an equitable way to ensure fair distribution of services.

Through our Hub Council and Community Health Transformation Collaboratives, BHT is convening and aligning the set of partners needed to fulfill community-based care coordination needs with a vision for a shared technology platform, shared community resources, and standardize best practice training across agencies. This strategy will allow us to create a more centralized approach with room for localized innovation. We have limited the number of individuals we intend to serve with our Care Coordination Pathways project due to concerns around negotiating MCO payments for outcomes. This approach will give us the opportunity to develop and prove the model.

We originally expected to conduct a detailed workforce development assessment from our partners but have decided to delay this until after our Partnering Providers complete their Transformation Plans to inform the picture of how much workforce it will take to complete Transformation goals. We still expect to work with the Workforce Development Council and Community Colleges of Spokane to conduct this assessment. In the meantime, BHT is working with other ACHs to identify statewide strategies to address behavioral health shortages through policy changes around licensing and credentialing.

BHT is excited to see leadership from IGT contributors UW and WAPHDA around a statewide infrastructure investment for telehealth and workforce credentialing for increasing the behavioral health work force that would dramatically expand access for BH and PC utilization in our rural counties. There is great risk that without legislative investment and intervention the free market will drive the expansion, and much like broadband, our rural communities will be penalized.

Additionally, we are encouraged about the work that WSU School of Medicine is doing to increase a lens of health equity in the training of the next generation of primary care and family physicians. This will have a profound impact on the workforce for our region.

Additionally, three hospitals in our region, including Odessa, Lincoln, and East Adams, have signed on to the Caravan ACO, and BHT sees a great opportunity to align with these efforts around our Domain 1 strategies.

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

ACH Response:

We continue to find that lack of safe and affordable housing stock is a big barrier to improved health in our region. We hope to see growing partnerships within the region that seize on opportunities for funding from the Department of Commerce and support HUD initiatives to increase availability of housing, local jurisdictions, and private philanthropy. There are interesting opportunities for social impact bonds and other creative financing options that would require unprecedented local and state cooperation.

We also see areas where policy barriers are impacting our workforce. Our Provider Champions Council has begun to identify policy barriers related to reimbursement and licensure that contribute to constricted service availability. We hope for a streamlining of the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring. Department of Health would be a valued partner in revisiting scope of practice for behavioral health, oral, and primary care workforce. We also see opportunities for continued growth and alignment with DOH for chronic disease management and care coordination related activities.

We will need to work very close with Providers, MCOs, and HCA to ensure better access to and use of patient population data if we'll ever achieve success in VBP. BHT is intrigued by an

example in our region where an MCO provided data to a hospital regarding how much it cost to care for their most expensive patients. This data showed discrepancies between billing practices and costs, where providers were missing the opportunity to bill for certain services. Being informed with this data created the opportunity for them to make changes to work more efficiently and generate more revenue, while also more aggressively managing the care coordination of their patient. This resulted in the opportunity for overall cost savings and improved health. This sort of relationship between MCOs and providers has to exist first to get the data on total cost of care. They can't take risk or bend the cost care if they don't know where their baselines are.

BHT would like HCA to join the conversation in support of a strategy that would enable our multi-sector partners to evaluate the cost of patient care with billing practices thereby establishing the opportunity to generate revenue beyond DSRIP incentives. This could include financial resources for technical assistance or funding needed resources to evaluate billing practices.

We intend to align our ACH VBP metrics with MCO contracts as much as possible, however our role in supporting the shift to VBP feels hampered by lack of clarity from HCA on what success looks like. There is risk our investments will not be fully leveraged later down the road, if we do not know how HCA will measure VBP success for MCOs, and where the risk will be taken. Our approach will evolve as we learn more, but it is important to note that lack of shared vision can often disrupt alignment.

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

For this milestone, the ACH should either:

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

  Or,

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

1. Medicaid Transformation Approaches and Strategies

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

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

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

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

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

2. Target Populations

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

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

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

3. Expansion or Scaling of Transformation Strategies and Approaches

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

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
Project 2A: Bi-directional Integration of Physical and Behavioral Health	
1. Transformation Strategies and Approaches	The BHT ACH bi-directional integration project is designed to improve whole-person care and health outcomes by encouraging and facilitating evidence-based models of care for high-needs populations, while also building on existing physical and behavioral health integration activities. BHT made the decision to support Partnering Providers in the Implementation of either evidence-based model identified in the Medicaid Transformation Demonstration (MTD) Project toolkit: the Bree Collaborative or the Collaborative Care Model. The region will also leverage Health Information Technology and care coordination infrastructure to launch our integration efforts. BHT has developed a two-step process for the development of specific project strategies: **Collaborative Transformation Plans** and **Partnering Provider Transformation Plans.** The Collaborative Transformation Plans were developed by all Partnering Providers within each Collaborative. The idea is for these Plans to provide a framework for county-based goals and activities. Collaborative Transformation Plans were developed by each of the six county Collaboratives in the region (Spokane, Ferry, Pend Oreille, Stevens, Lincoln, and Adams) and submitted to BHT on June 30th. Each Collaborative successfully developed an initial framework for collaboration across all of the areas of Transformation, but additional work will be needed to further operationalize these Plans. Collaboratives will revisit and build on their Collaborative Transformation Plans in September, after Partnering Provider Transformation Plans have been submitted and reviewed by BHT. Partnering Provider Transformation Plans will be submitted by primary care and behavioral health Partnering Providers by August 1st. These Plans require providers to submit detailed plans, including strategies/activities, goals, timeline, and budget for activities within the project areas of bi-directional integration, chronic disease, and opioids, as well as make commitments to support and participate in regional community-based care pilots. It is intended that the Partnering Provider Plans will be driven by the framework established in their Collaborative's Plan. BHT hosted and recorded a series of topical webinars in June 2018 to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For bi-directional integration of care, Anne Shields of the University of Washington AIMS Center was the featured presenter.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
2. Target Populations	The Medicaid Demonstration Toolkit suggests an overall target population of all the Medicaid enrollees in the region, approximately 197,985 individuals in the BHT region. 2A's ultimate project goal for the demonstration is full Implementation of integrated care for all Medicaid beneficiaries. We are proposing to scale up to full Implementation, starting with a high-risk population of Medicaid enrollees with co-morbid conditions, in order to be successful in achieving expected project outcomes. More than 44,000 BHT ACH Medicaid members have been diagnosed with a mental illness, and the prevalence of mental illness is 29.5% in the BHT ACH region, higher than the statewide level. Approximately 20,000 clients in the BHT ACH region have a substance abuse treatment need, equating to a prevalence of 11.2%. Finally, and perhaps most concerning: about 36,000 have a mental health ***or*** substance abuse condition ***and*** 1 or more chronic disease, indicating a high level of need for bi- directional care integration to provide whole-person care and navigate the many obstacles that arise for patients suffering from these conditions. An estimated 36,000 Medicaid beneficiaries in the BHT region have a mental health or substance use disorder and one or more chronic diseases. However, there are a few subpopulations within the broader BHT Medicaid population that are at higher risk of suffering from substance use disorder (SUD), mental health (MH) conditions, and chronic diseases, or a combination thereof. As shown in Table 1 below, disabled clients and newly eligible (Medicaid expansion) adults in the Medicaid population have a higher rate of co-occurring disorders than the traditional Medicaid population. Rates are also higher than expected in Pend Oreille and Spokane counties.[4] In the BHT ACH region, people with an MH and SUD diagnosis are almost 5 times as likely to have 3+ ED visits in a year as general BHT ACH area Medicaid beneficiaries.[5]

[4] HCA Co-occurring disorder tables, See:
https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519
[5] RDA Measure Decomposition files released 10-27-17. See:
https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/41072598437

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	Table 1: Co-occurring conditions by Medicaid eligibility group in the BHT ACH region:

Coverage group	SUD	MH condition	Chronic Disease	SUD or MH and CD
Disabled	27.7%	60.6%	24.6%	58.8%
New adults (Medicaid Expansion)	20.3%	32.1%	24.2%	29.4%
Traditional Medicaid	5.5%	20.4%	27.2%	13.4%

3. Expansion or Scaling of Transformation Strategies and Approaches	We are proposing to scale up to full Implementation, starting with a high-risk population of Medicaid enrollees with co-morbid conditions of behavioral health and chronic disease, in order to be successful in achieving expected project outcomes. Primary care and behavioral health Partnering Providers have been asked to submit detailed information about plans for expansion and scaling of their Transformation projects. BHT will review and assess these Plans in August and work with Partnering Providers in the fall to develop detailed regional scale and expansion plans.
Project 2B: Care Coordination	
1. Transformation Strategies and Approaches	BHT will implement the Community-Based Care Coordination project as an anchor strategy (along with bi-directional integration of care) to connect the portfolio of projects in the Medicaid Transformation and to develop accountable linkages between clinically-based health care services with the community-based services that play an integral role in improving health outcomes. The Pathways model offers the BHT ACH the opportunity to better connect the community-based social determinant of health system with the clinical delivery system, to support at-risk individuals and address the range of clinical and social factors impacting their health. In 2017, Spokane County was awarded a nearly $1 million grant from the Department of Justice to utilize the Pathways model as the anchor strategy for a local initiative to reform the local criminal justice system. In partnership with BHT, the County criminal justice, is working on plans to launch the Pathways Community Hub in November 2018. This funding came in addition to a $1.75 million grant from the MacArthur Foundation in April 2016 to help reduce the jail population

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	by 21% by 2019. Funds from the MacArthur Foundation grant is being used to implement a newly developed risk assessment tool in the county's Pre-Trial Services Department, as well as a new racial equity toolkit. Earlier this year, BHT launched the *Community-Based Care Coordination Advisory Council (Hub Council)* to develop an RFP for care coordination agencies and complete the environmental scan work. This council includes representatives from the Tribal Partner Leaders Council, the Community Voices Council, MCOs, Social Determinant of Health Providers, and Health Care Providers. This group also confirmed the target populations for Pathways. BHT will issue an RFP process August 2018 to select two care coordination agencies (CCA) September 2018. The CCAs will each employ at minimum one full-time community health worker and part-time supervisor who will all receive training on the Pathways model and supporting platform, Care Coordination Systems (CCS). The CCAs through the Hub will work with referring partners at the County to streamline the referral process using the specified screening-in criteria. In addition to the work of the Hub Council, each of the region's six county Collaboratives were asked to indicate whether or not the Collaborative intended to move forward with a community-based care coordination Pathways proof of concept pilot in the Collaborative Transformation Plans submitted to BHT this summer. All of the Collaboratives are moving forward with a Pathways proof of concept pilot with one or both of the target populations identified by BHT (high risk Medicaid pregnant women and people transitioning out of jail population). Rural Resources Community Action (RRCA) has an active Care Coordination Agreement established with the Better Health Together "Hub". RRCA has been working with BHT in Ferry County to pilot the Pathways model for people transitioning out of jail. BHT has developed the necessary infrastructure to pilot the Pathways model throughout the region. To date, RRCA is delivering "Pathways" in Ferry County and will likely expand their role to the other rural county collaboratives. The Spokane Collaborative will RFP Care Coordination opportunities out in September 2018. BHT hosted and recorded a series of topical webinars in June 2018 to assist Collaboratives and Partnering Providers in creating their Transformation Plans. Subject matter experts provided background information and guidance for each Medicaid Transformation project area. For community-based care coordination, Jenny Slagle, who directs BHT's Pathways work, led the webinar.
2. Target Populations	The Pathways Community Hub model offers the BHT ACH the opportunity to better connect the community-based social determinant of health system with the clinical delivery system to support at-risk individuals to address the range of clinical and social factors impacting their health. The BHT ACH will implement the Pathways model with an initial focus on two populations: High-risk pregnant Medicaid women and people transitioning out of jail. These two high risk

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	populations will individually benefit from the intervention and we expect to demonstrate cross-sector savings. The Medicaid Project Toolkit suggests a number of potential target populations for the community-based care coordination project: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization). Looking closely at regional data and through our HSI, these two key populations emerged as most likely to benefit from increased community-based care coordination and will be the initial target populations for this project as well as demonstrate opportunities for cross sector shared savings and reinvestment. To this end, BHT will be focused on a maximum number of enrollees for each target population of 60 in the rural county per year and 200 for Spokane County for year. This ensures that we have enough enrollees to prove the concept but not too large a financial contribution for MCOs and the ACH Medicaid Waiver dollar. Each the region's six county Collaboratives were asked to indicate whether or not the Collaborative intended to move forward with a community-based care coordination pilot in the Collaborative Transformation Plans submitted to BHT this summer. As indicated below, all of the Collaboratives are moving forward with a Pathways pilot with one or both of the target populations identified by BHT (high risk Medicaid pregnant women and people transitioning out of jail population). • **Adams:** pregnant women and people transitioning out of jail • **Ferry:** people transitioning out of jail • **Lincoln:** people transitioning out of jail • **Pend Oreille:** people transitioning out of jail • **Stevens:** people transitioning out of jail • **Spokane:** pregnant women and people transitioning out of jail
3. Expansion or Scaling of Transformation Strategies and Approaches	We will focus on initial target populations to establish a strong foundation and proof of concept for the model in the region. By doing so, the project will offer a sustainable model that can be deployed to other target populations in the region. This will support the region's shift to value-based payment and provide a more sustainable model for care coordinating organizations than the traditional model of having to rely on grants. Additionally, it's the belief of BHT that the infrastructure developed to support Pathways, a shared care coordination technology platform and better utilization and updating of community resources.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	The Pathways Community Hub model is central to our MTD efforts and the region's efforts to move to value-based care. The Pathways Community Hub model offers a scalable opportunity to link care coordination and to improve health outcomes through a sustainable model of care beyond typical philanthropic/government contracts. By implementing the Pathways Model, we will demonstrate the value of better linking efforts to address social determinants with clinical efforts to improve health outcomes. Other states have implemented the Pathways model and found success in developing long term contracts with funders (not limited to MCOs). This will result in improved community capacity to link health social determinant of health support with at-risk patients that will last beyond the MTD period.
Project 2C: Transitional Care	
1. Transformation Strategies and Approaches	Not Applicable
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 2D: Diversion Interventions	
1. Transformation Strategies and Approaches	Not Applicable

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 3A: Addressing the Opioid Use Public Health Crisis	
1. Transformation Strategies and Approaches	Better Health Together Accountable Community of Health (BHT ACH) will align community efforts to promote prevention, access to treatment, overdose prevention, and recovery for area residents, focusing specifically on adults and youth enrolled in Medicaid. As mentioned above for project 2A, BHT has developed a two-step process for the development of specific project strategies: Collaborative Transformation Plans and Partnering Provider Transformation Plans. The Collaborative Transformation Plans were developed by all Partnering Providers within each Collaborative. The idea is for these Plans to help provide a framework of county goals and activities. Collaborative Transformation Plans were developed by each of the six county Collaboratives in the region (Spokane, Ferry, Pend Oreille, Stevens, Lincoln, and Adams) and submitted to BHT on June 30th. Each Collaborative successfully developed an initial framework for collaboration across all of the areas of Transformation, but additional work will be needed to further operationalize these Plans. Collaboratives will revisit and build on their Collaborative Transformation Plans in September, after Partnering Provider Transformation Plans have been submitted and reviewed by BHT. Partnering Provider Transformation Plans will be submitted by primary care and behavioral health Partnering Providers and are due on August 1st. These Plans require these providers to submit detailed plans, including strategies/activities, goals, timeline, and budget for activities within the project areas of bi-directional integration, chronic disease, and opioids, as well as make commitments to support and participate in regional community-based care pilots. It is intended

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	that the Partnering Provider Plans will be driven by the framework established in their Collaborative's Plan The Collaborative Transformation Plans developed by both the Rural and Spokane County Collaboratives identify a framework for how Partnering Providers will work together to address the crisis, beyond their individual Transformation Plans. Community education has been identified as a key area for collaboration in the region, including outreach to homeless individuals, schools (educators and parents), employers, first responders, and prescribers. The focus of this education will include recognizing the side effects of prescribed medication, detecting abuse, and means for accessing support. Our region has many projects in place, and we are choosing to focus on strengths and build on what is happening in the community. Additionally, via our ACH Leadership Council, Provider Champions Council, Community Voices Council, and Tribal Partner Leaders Council, BHT is working to align other community efforts related to opioid prevention, such as ARCORA's effort to support an oral health local impact network with a focus on reducing opioid use disorder. This strategy will assist us in building a robust network of dental practices who are a key source of opioid prescribing, and involvement and leadership from the dental community which will be a key success factor for establishing a more coordinated response to addressing opioids. Additionally, BHT is working on an inventory of community-based teams currently convening in response to the opioid epidemic. We know that Molina, Premera, the Spokane County Medical Society and Spokane Regional Health District (SRHD), have convened groups, and hope to build out this directory to prevent duplication and maximize alignment. We expect this list will expand beyond just our Transformation partners. BHT has been an active task force participant of SRHD Opioid Taskforce Workgroup, which has currently been exploring use of the Hub and Spoke model. A number of our Partnering Providers applied for the Hub and Spoke grant, and should any of them be grantees, we look forward to aligning those efforts. Through our Collaborative Transformation Plans, we were excited to see that our Lincoln County Collaborative is interested in exploring a syringe exchange program, and that rural public health partners in Stevens county are taking an active role in expanding MAT. BHT also convened partners for an opioid discussion, featuring subject matter expert Dr. Caleb Green. Partners discussed aligning with statewide initiatives, opportunities to expand MAT, evidence-based practice and current trends.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
2. Target Populations	The opioid crisis has skyrocketed in Washington and the BHT ACH region, and it is affecting the Medicaid population. According to the University of Washington Alcohol and Drug Abuse Institute, three counties in the BHT ACH (Ferry, Lincoln and Pend Oreille) each had a rate of publicly funded admissions for opioids of between 90 and 180 per 1,000 residents between 2011 and 2013. Spokane and Stevens Counties each had 180-360 admissions per 1,000 residents in this same period. Opioid related treatment and deaths increased across the state over the past decade, mirroring a growing problem nationally. Across the BHT ACH region, 17.4% of Medicaid enrollees are opioid users. This rate is high compared to the overall Washington rate of 13.5% of all Medicaid enrollees, and all counties in the region except Adams has a higher rate of opioid use than the state as a whole. While not all opioid users are dependent, over 7,000 people (3.6% of Medicaid enrollees) meet the CDC definition of heavy opioid users, and 3.9% of the population has used opioids for over 30 days. Over 6,000 people (3.2% of Medicaid enrollees in the region) are opioid dependent or abusing, based on ICD9 and ICD10 codes over a two-year claims period. The target population is adult and youth Medicaid beneficiaries who use, misuse, or abuse prescription opioids or heroin. This target population will include approximately 7,688 individuals in the BHT ACH region who have used opioids for more than 30 days.[6] Providing special assistance to populations for whom opioid misuse has immediate and systemic impacts (e.g. pregnant women) will be a priority. Among Medicaid beneficiaries in the region and state, women are somewhat more likely to be heavy opioid users than are men (in the BHT ACH catchment area, women make up 58% of heavy opioid users despite being only 51% of overall enrollment).
3. Expansion or Scaling of Transformation Strategies and Approaches	Further detailed plans on scaling and expansion are forthcoming in the Partnering Provider Transformation Plans; however, BHT anticipates that the Rural and Spokane County Collaboratives will play a key role in expanding best practices across the region. As mentioned above, BHT will provide special emphasis in its initial efforts on pregnant women, given the immediate and systemic impact of opioid use by this population. Efforts will continue to be scaled and expanded to address the region-wide population over the next four years.
Project 3B: Reproductive and Maternal/Child Health	

[6] Washington Prescription Drug Monitoring Program, see: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP/CountyProfiles

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
1. Transformation Strategies and Approaches	Not Applicable
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 3C: Access to Oral Health Services	
1. Transformation Strategies and Approaches	Not Applicable
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 3D: Chronic Disease Prevention and Control	

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
1. **Transformation Strategies and Approaches**	Since the inception of the BHT ACH, prevention has been a cornerstone of efforts to improve community health. The BHT ACH selected the Chronic Disease Prevention and Control Medicaid Transformation Project (MTP) to accelerate our efforts to improve health, with an initial focus on control and prevention of Type 2 diabetes. The project strategies include: increasing access to care; educating consumers and their families; identifying risk earlier; increasing coordination of services that link clinical providers and services to social supports and other service needs; and working with the state to support healthy choices for Washington residents. BHT strategies will focus on utilization of all elements of the Chronic Care Model. Rural and Spokane County Collaboratives will align of the model with their providers, Medicaid population and other factors influencing care in the area. This alignment includes, but is not limited to, the Community Guide, Stanford Chronic Disease Self-Management Program, and CDC-recognized National Diabetes Prevention Programs as well as supporting where possible, Implementation of diabetes programs specific to Tribal Health Providers. We expect that each Collaborative will also develop a regional approach to Community Paramedicine, as these locally-designed, community-based solutions could extend the reach of chronic disease management through the utilization of the skills of paramedics and emergency medical services (EMS) systems to address gaps that are identified through community level needs assessment. Additionally, we see evidence of increased interest by our BH providers to expand their scope of work to include chronic disease efforts. Most efforts to tackle chronic disease are aimed at responding to the symptoms and negative consequences of those diseases. The BHT ACH seeks to work upstream, to help people avoid chronic diseases. The MTD project will include a focus on early detection and intervention for individuals at-risk for diabetes, and on reinforcing healthy lifestyle habits early in life. This project will also align with the bi-directional integration efforts to integrate health system and community approaches to improve chronic disease management and control for high priority populations. Projects were selected to support delivery system transformation efforts aimed at developing a sustainable business model for investment in prevention, management, and linking of health care to social determinants of health. The MTD project for chronic disease will prepare the region to thrive in a value-based payment environment and support long term sustainability for prevention efforts. As mentioned above for projects 2A and 3A, BHT has developed a two-step process for the development of specific project strategies: **Collaborative Transformation Plans** and **Partnering Provider Transformation Plans.**

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	The Collaborative Transformation Plans were developed by all Partnering Providers within each Collaborative. The idea is for these Plans to help provide a framework of sub-regional goals and activities. Collaborative Transformation Plans were developed by each of the six county-level Collaboratives in the region (Spokane, Ferry, Pend Oreille, Stevens, Lincoln, and Adams) and submitted to BHT on June 30th. Each Collaborative successfully developed an initial framework for collaboration across all of the areas of Transformation, but additional work will be needed to further operationalize these Plans. Collaboratives will revisit and build on their Collaborative Transformation Plans in September, after Partnering Provider Transformation Plans have been submitted and reviewed by BHT. Partnering Provider Transformation Plans will be submitted by primary care and behavioral health Partnering Providers and are due on August 1st. These Plans require these providers to submit detailed plans, including strategies/activities, goals, timeline, and budget for activities within the project areas of bi-directional integration, chronic disease, and opioids, as well as make commitments to support and participate in regional community-based care pilots. It is intended that the Partnering Provider Plans will be driven by the framework established in their Collaborative's Plan.
2. **Target Populations**	BHT has identified Medicaid beneficiaries with co-morbid behavioral health and two or more chronic diseases as a priority target population across the Transformation project portfolio. Type 2 Diabetes was selected as a priority condition for the chronic disease project because of the physical and financial burden it represents for individuals and the health care system. Stakeholders in the BHT ACH region highlighted obesity and diabetes in early community conversations and health system partners commonly cited Type 2 Diabetes as a condition where improved integration and coordination of care could lead to better health and financial outcomes.
3. **Expansion or Scaling of Transformation Strategies and Approaches**	Individuals with Type 2 diabetes are the initial target population for the chronic disease prevention and control project, this group provides a promising focus to build systems to improve access, care, and outcomes for all individuals with chronic disease in the region. Each Collaborative will develop an integrated plan to address the target population. Based on data from individual counties. We anticipate an additional emphasis on individuals with co-morbidity of behavioral health and Diabetes. We see an additional opportunity for engagement with individuals with behavioral health needs for the population targeted in the bi-directional integration MTD project. To proceed with this deepened focus, we will analyze data to assess the overlap between diabetes and depression among BHT's Medicaid population. Potential efforts may include flagging individuals at appointments to ensure that they are assessed and treated for unmanaged diabetes and presenting behavioral health symptoms.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	The Center for Outcomes and Research and Evaluation (CORE) estimates that between 5,800 and 7,500 Medicaid-covered adults in the region have Diabetes. The low-end estimate is based on individuals with 24 months of continuous eligibility, which is probably an undercount given the number of people who cycle on and off Medicaid over a two-year period.[7] The estimated prevalence rate of diabetes among BHT area Medicaid beneficiaries overall is 3% but varies slightly between 3% and 4% among BHT's counties and among different race and ethnicity groups. Individuals who identify their preferred language as Russian have a slightly higher rate of 5%. (Note that the numerator inclusion criteria for all of these estimates require at least one inpatient or two outpatient claims with a diagnosis of diabetes in the last year, so diabetics who are not in care are not captured.)[8]

[7] Varying estimates based on HCA Behavioral Health and Chronic Conditions files 9-29-17 (https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/39866406519) and Healthier Washington Data Dashboard, which use different continuous enrollment criteria.

[8] Healthier Washington Data Dashboard, CY 2016 data. See: https://www.hca.wa.gov/about-hca/healthierwashington/data-dashboard

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

ACH Response:

BHT ACH is currently working to identify a handful of "transformative" metrics to drive the incentive payments for our region. We have stated consistently for Partnering Providers that how the region earns dollars will be different than how individual partners will earn incentive payments. We intend to develop our Top 10 Transformative metrics during fall of 2018. The Transformative metrics will be informed by our Collaborative, Partnering Provider Plans and the state's P4P and P4R metrics. Additionally, it is our intent to work with our MCO partners to identify key metrics that will be included in VBP contracts as well as key process improvements that will be necessary for whole-person, value-based care. The recommendations will be generated by BHT staff and then run through our Technical Councils, Collaboratives, and MCOs for feedback and refinement before ultimately being presented to the Board for final approval. BHT has identified four priority areas around 1) increasing behavioral health access, 2) reducing unintended pregnancies, 3) reducing jail recidivism, and 4) improving oral health. While we have not identified specific metrics related to these goals as of yet. They were selected because they align with activities in our selected projects, and because of existing community momentum to effect change in these areas. Movement towards these goals is part of our vision for successful Transformation. We have included strategies to increase access to Long Acting Reversible Contraceptive (LARC) in primary care settings to support our goal of reducing unintended pregnancies, and strategies to increase access to fluoride varnish in primary care to both support our goal of improving oral health, and bi-directional integration of care activities.
Each Community Health Transformation Collaborative will have the opportunity to select a few of their own metrics, to guide what local Transformation means for their county. We believe Partnering Providers will be more connected to our vision if they see their own goals as a part of it.
The BHT Board hosted a retreat in June and identified some strategic priorities for the direction of BHT, which we see being deeply embedded in our Transformation activities. Although still in draft form, they currently include:

- **Empower providers to integrate health equity as a fundamental element of all work, through incentivizing and coordinating best practice activities to accelerate health equity.**

- **Create and support robust access and linkages between health care and social determinants of health efforts to improve community health**

- **Support integration and Transformation of physical, behavioral, and oral health delivery systems for whole-person care.**

- **Coordinate and support cross-region, cross-sector efforts to improve population health and address inequities**

- **Develop a community led effort to increase funding and innovations for social determinants, prevention, and reduction of health inequities**

These goals support the vision of a transformed system, and position BHT to play a supporting and connecting role in building out the partnerships and expertise necessary to be successful in meeting our Transformation goals. BHT intends to embed health equity activities in how we structure Medicaid Transformation. It will be necessary to break down silos between sectors to build a whole-person care system in which patients can fluidly access the whole spectrum of services they need.

BHT intends for the county-level Collaborative structure to be a lasting mechanism for cross-sector collaboration in the region and sub-regions. We believe investing in these Collaboratives will be the region's best shot of sustaining these activities over the long-term amount of time that it will take to see the outcomes of a transformed system. The first round of Collaborative planning demonstrates a commitment to developing the right set of partnerships that are necessary to support Transformation efforts beyond the life of the Medicaid Transformation.

All of the project in the BHT ACH Project portfolio make use of the anchor strategies of integration of care, and expanding care coordination efforts to connect disparate systems. The BHT Community Care Coordination Hub will support best practice care coordination and information sharing across the region's community-based organizations and health systems. The Pathways technology platform provides real-time data to identify resource gaps and monitors the effectiveness of best practice interventions as well as the quality of the care coordination agencies implementing them. This will be a powerful tool to support a data-driven case for alignment of community investments, especially around major resource gaps in safe and affordable housing, jobs in rural counties, and transportation throughout the region.

BHT ACH will withhold 10% of all Transformation dollars to invest in a Community Resiliency Fund. The fund will align with ACH community priorities to strengthen the linkages between the health care systems and providers who focus on social determinants of health. It is the intent of the BHT ACH to leverage these dollars to influence increased, targeted investment in population and community health improvement, including aligning nonprofit hospital community benefit dollars, philanthropic funders, and shared savings investment models based on data. It is expected that late in 2018, BHT will launch the first round of funding.

D. Milestone 4: Identification of Partnering Providers

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

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

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

Section 2: Standard Reporting Requirements

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

ACH-Level Reporting Requirements

A. ACH Organizational Updates

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

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

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

   ACH Response:

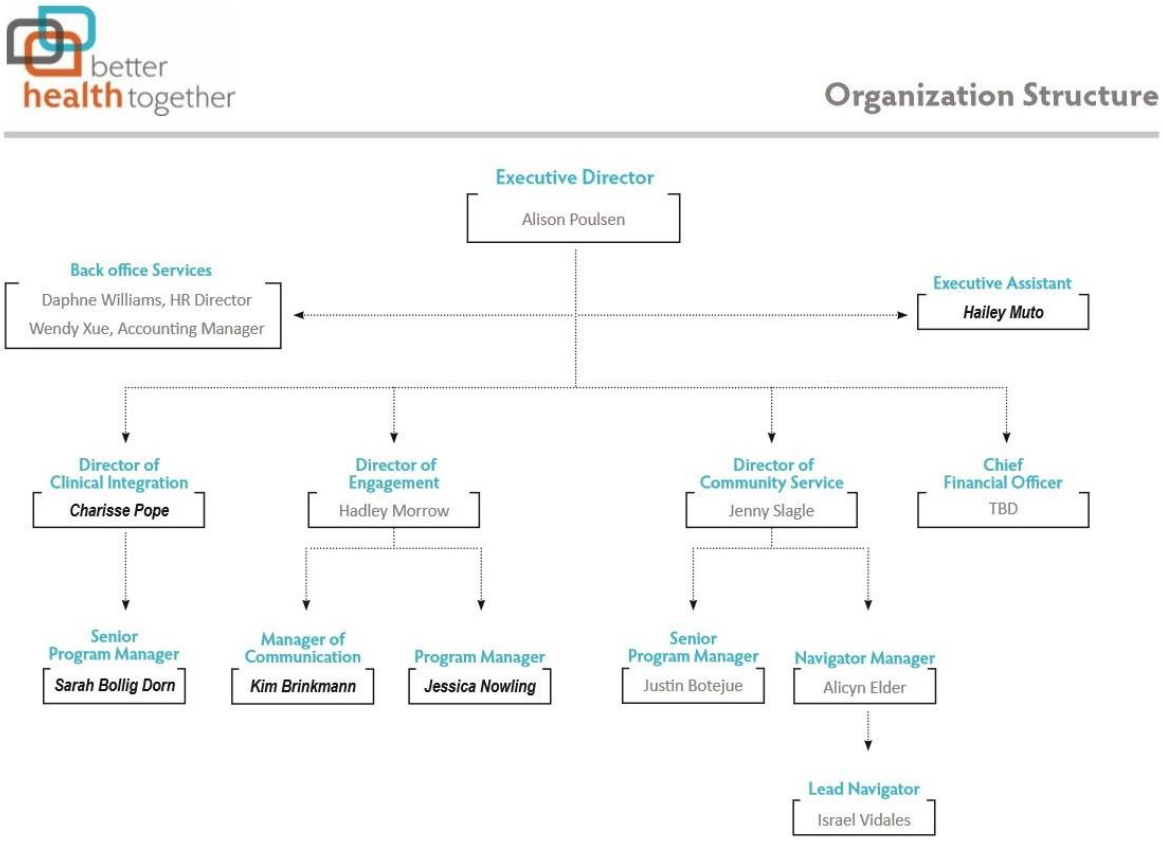
   Not Applicable

3. **Key Staff Position Changes**: Provide a current organizational chart for the ACH. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the

reporting period. Place an "X" in the appropriate box below.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

Insert or Include as an Attachment: Organizational Chart



B. Tribal Engagement and Collaboration

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

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
Tribal Partners Leadership Council	1/4/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	The NATIVE Project, American Indian Community Center, Kalispel Tribe, Lake Roosevelt Community Health Center	Discussion and overview of Collaboratives by county, update of Technical Councils	Monthly Meeting
Tribal Partners Leadership Council	2/1/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	Colville Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe IHS, Lake Roosevelt Community Health Center, Kalispel Tribe, Empire Health Foundation	Conversation around Collaboratives and Transformation planning.	Monthly Meeting
Lake Roosevelt - BHT Call	2/15/18	Lake Roosevelt Community Health Clinic	Lake Roosevelt Community Health Clinic	Discuss and advise on behavioral health Transformation planning, specific to opioid activities.	Continued engagement

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
Spokane Tribe of Indians - BHT meeting	2/22/18	Spokane Tribe of Indians	Spokane Tribe of Indians	Waiver, BHT ACH, Collaboratives overview.	Continued engagement
Kalispel-BHT meeting	2/27/18	Kalispel Tribe	Kalispel Tribe	Check-in on Collaborative work and Transformation planning and needs.	Continued engagement
Tribal Partners Leadership Council	3/1/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	American Indian Community Center, The NATIVE Project, Spokane Tribe, Kalispel Tribe, Colville Tribe, Lake Roosevelt Community Health Center	Technical council updates and TPLC appointees: Colville Tribe to Provider Champions Council; The NATIVE Project to Community Voices Council; The NATIVE Project and American Indian Community Center to Community-based Care Coordination Council; and Kalispel Tribe and The NATIVE Project to remain in the Waiver Finance Work Group.	Monthly Meeting
BHT Community-Based Care Coordination Advisory Council	3/5/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community	American Indian Community Center, The NATIVE Project	First meeting of the Hub Council working toward a regional community-based care coordination plan.	Monthly Meeting

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project			
American Indian Community Center - BHT Meeting	3/8/18	American Indian Community Center	American Indian Community Center	Regular monthly check-in meeting to offer support in Transformation planning.	Continued engagement
Waiver Finance Work Group meeting	3/14/18	Kalispel Tribe, The NATIVE Project		Monthly meeting providing strategic planning of funds flow.	Monthly Meeting
Spokane Collaborative Meeting	3/21/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe, The Healing Lodge of Seven Nations	The NATIVE Project, American Indian Community Center	Forming the Spokane Collaborative charter and workgroups	Active participation in developing Spokane Collaborative Charter
Spokane Tribe of Indians - BHT meeting	4/5/18	Spokane Tribe of Indians	Spokane Tribe of Indians	Overview of Collaborative and Transformation plan	Continued engagement
Tribal Partners Leadership Council	4/5/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center,	The NATIVE Project, Kalispel Tribe, American Indian Community Center, Spokane Tribe, Colville Tribe	Technical council updates, Collaborative development plans and Transformation planning activities. Collected input of project areas of focus.	Monthly Meeting

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project			
Spokane Collaborative Meeting	4/10/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe, The Healing Lodge of Seven Nations	The NATIVE Project, American Indian Community Center	Forming the Spokane Collaborative charter and workgroups	Continued participation in forming Collaborative Charter and governance structure
AICC-BHT Call	4/12/18	American Indian Community Center	American Indian Community Center	Regular monthly check-in meeting to offer support in Transformation planning.	Continued Engagement
BHT Community-Based Care Coordination Advisory Council	4/16/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	American Indian Community Center, The NATIVE Project	Hub Council working toward a regional community-based care coordination plan. Reviewed Pathways model	Monthly Meeting
Kalispel-BHT meeting	4/18/18	Kalispel Tribe	Kalispel Tribe	Check-in on Collaborative work and Transformation	Continued engagement

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
				planning and needs.	
Spokane Collaborative Meeting	4/26/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe, The Healing Lodge of Seven Nations	The NATIVE Project, American Indian Community Center, Kalispel Tribe	Forming the Spokane Collaborative charter and workgroups	Active participation in development of governance structure
Tribal-HCA-Tribal Liaison meeting	4/27/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe, The Healing Lodge of Seven Nations	Kalispel Tribe, American Indian Community Center	Although not a BHT meeting, BHT offered to pay travel expenses for our Tribal partners to attend this meeting in person and also attend the behavioral health billing training immediately following.	Continued engagement and alignment
Tribal Partners Leadership Council	5/3/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	The NATIVE Project, Kalispel Tribe, American Indian Community Center, Spokane Tribe, Colville Tribe, Lake Roosevelt Community Health Center	Provided input of the community resiliency fund to include violence, untreated trauma, and housing issues and the types of funding needed to address it in the native communities.	Monthly Meeting

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
The Healing Lodge of Seven Nations - BHT Meeting	5/4/18	The Healing Lodge of Seven Nations	The Healing Lodge of Seven Nations	Overview of ACH partners, Collaborative and Transformation Plan	Continued engagement
American Indian Community Center - BHT Meeting	5/10/18	American Indian Community Center	American Indian Community Center	Regular monthly check-in meeting to offer support in Transformation planning.	Continued engagement
Spokane Collaborative Meeting	5/15/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane Tribe, The Healing Lodge of Seven Nations	The NATIVE Project, American Indian Community Center, Kalispel Tribe	Forming the Spokane Collaborative charter and workgroups	
BHT Community-Based Care Coordination Advisory Council	5/21/18	American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project	American Indian Community Center, The NATIVE Project	Provided input of the community resiliency fund, recommended approval of the Pathways funding model to the Waiver Finance Committee.	Monthly Meeting
Spokane Collaborative Meeting	6/7/18	Kalispel Tribe, The NATIVE Project, American Indian Community Center, Spokane		Collaborative workgroups begin Collaborative Planning Process	Continued Collaborative planning process

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome / Next Steps**
		Tribe, The Healing Lodge of Seven Nations			
American Indian Community Center - BHT Meeting	6/22/18	American Indian Community Center	American Indian Community Center	Regular monthly check-in meeting to offer support in Transformation planning and BBQ.	Continued engagement
Weekly ACH-Tribe Opioid Project call		American Indian Community Center, Colville Tribe, DOH Tribal Liaison Office, Empire Health Foundation, HCA Tribal Liaison Office, Kalispel Tribe, Lake Roosevelt Community Health Center, Spokane Tribe, The Healing Lodge of Seven Nations, The NATIVE Project		Technical support, information sharing, and general information of opioid work that tribes across the state are doing.	Continued engagement and alignment

Project Reporting Requirements

C. Project Status Update

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

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

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

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
The ACH secured Memoranda of Understanding (MOUs) with Partnering Providers to participate in a Community Health Transformation Collaborative	2a, 2b, 3a, 3d	Y	Partnering Providers received a $4000 payment for completion
Partnering Providers in behavioral health and primary care completed current state capacity assessments	2a, 2b, 3a, 3d	Y	BHT staff and consultants analyze responses to build recommendations for regional investment and technical assistance.
Community Health Transformation Collaboratives finalized governance model, and select a Lead Agency, in a signed charter	2a, 2b, 3a, 3d	Y	Collaborative officially begins meeting to work on Transformation Plans.
Community Health Transformation Collaboratives completed	2a, 2b, 3a, 3d	Y	BHT reviews, sends any requests for more information or clarity. Collaboratives will be

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
Collaborative level Transformation Plan			expected to update Plans with information from individual provider Plans
Partnering Providers in behavioral health and primary care complete practice level Transformation Plan, in alignment with Collaborative level Plan	2a, 3a, 3d	Y	These are due to BHT August 1st, BHT will review and send back with any requests for more information or clarity.
BHT hosts webinars with subject matter experts on each of the four project areas	2a, 2b, 3a, 3d	Y	Recorded and posted on website for future use by partners
BHT launches Community-Based Care Coordination Council to guide development of Pathways Hub	2b	Y	Will meet monthly to advise elements of Care Coordination strategy
Finalized target population of Medicaid eligible Jail Transitions and/or High-Risk Pregnant women for Community-Based Care Coordination in each Collaborative.	2b	Y	Individual Partnering Providers working on their Transformation Plans to inform Collaborative strategy
BHT allocated regional infrastructure payment to support Collaboratives in a Pathways Pilot startup	2b	Y	
BHT hosted webinars for Collaborative members to deep dive into each evidence-based model in our selected projects	2a, 2b, 3a, 3d	Y	Collaborative members are watching these recorded webinars to help inform their Transformation Plans.

Portfolio-Level Reporting Requirements

D. Partnering Provider Engagement

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

   ACH Response:

BHT neighbors both the Greater Columbia and North Central ACHs and share a few providers and patients across our borders, as well as medical referral patterns to Spokane. The Confederated Tribes of the Colville reservation also crosses both BHT and NC ACH borders. To support cross ACH Collaboration, BHT has developed strong partnerships with each of our ACH leaders for best practices, learning, and problem solving. Additionally, BHT is working with individual partners to share information, align processes, and support appropriate level of coordination. It's important to note that the design of the ACHs are inherently tied to the counties we serve, but county lines don't necessary facilitate consumer choice and/or natural referral patterns. BHT recently attended, with 10 of our behavioral health providers, NC's IMC overview in Wenatchee. This was a useful learning session for our providers and we expect to build on the experience of our shared partner Children's Home Society of Washington for some shared learning opportunities around their IMC in North Central. We are also working in partnership with the other six ACHs to support Providence's efforts in each region. This work is designed to support, where possible, a multi ACH strategy while recognizing that each ACH has developed their own planning process.

BHT intends to convene North Central ACH and Greater Columbia ACH in September in a conversation about our border providers and how to support them. A central topic will be how to align our reporting strategies, as to not burden providers participating in multiple ACHs. BHT has benefited from a close relationship with the Northwest Rural Health Network, which includes critical access hospitals in GCACH and NCACH. Their connections have helped to bi-directionally influence ACH activities across borders and providers. Leadership in our two organizations talk regularly about opportunities to reduce the burden on these shared partners, and already existing networks.

It has felt too early in the process to align around shared reporting strategy until reporting requirements are clearer and we know who the successful MCOs are after the MCO IMC appeal process is finalized. We are intent to create as much of a coordinated approach as possible. For now, BHT remains an active participant in all ACH partner calls and gatherings and views these as important opportunities to align messaging.

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

ACH Response:

Partnering Providers for the BHT ACH's Transformation projects signed a Community Health Transformation Collaborative MOU that outlined expectations for participation in Transformation Project.

To participate, Partnering Providers must join the Community Health Transformation Collaborative for the counties in which they operate. Each Collaborative has a self-determined governance structure, which varies slightly from county to county, but all include the basic expectation that Partnering Providers stay engaged in the Collaborative by maintaining regular attendance in meetings, supporting completion of the Collaborative Transformation Plan, completing individual Transformation Plans, and following through with Implementation milestones and reporting requirements decided upon by the Collaborative and ACH.

On July 29th, all six of our Collaboratives submitted Collaborative Plans on time. In our Rural Collaborative, all Partnering Providers provided input and sign off on the Plan in order for it to be considered complete. This provided us documentation of engagement and alignment on Collaborative level Plans. Each Collaborative also had to develop a charter, with its own governance and decision-making process. Rural Collaboratives nominated a Collaborative Lead agency who would serve as the fiscal agent for Collaborative funds, be the main point of contact between the Collab and BHT for updates and reporting and serve as project manager for the Collaborative's Transformation Plan. The Spokane Collaborative, being much larger, nominated a 12-member Community Connection Team (CCT) which carries out the Collaborative Lead responsibilities collectively. We believe requiring and incentivizing our partners to establish a shared vision with a network of partners will better prepare them for the kinds of relationships needed in VBP, and as the relationships deepen, be more likely to sustain itself after ACH dollars are expended.

Partnering Providers in primary care and behavioral health are now completing individual *Partnering Provider Transformation Plans*, due August 1. With the recently completed Collaborative Transformation Plan to serve as a framework, individual providers now will complete their own Plans, including detailed project Plans, activities, milestones and AIM statements for projects across all areas of Transformation, partners, equity Plans, anticipated challenges and technical assistance needs, and detailed budgets for ACH projects.

BHT has made it an expectation that these Plans include evidence of an intent to partner with other organizations in their Collaborative to support projects, especially with social determinants. Once complete, BHT will review, give feedback to providers, and then facilitate discussion with all Partnering Providers to align Transformation Plan activities and roles across the county-based Collaborative. We expect Plans to be finalize in early September, to support completion of BHT's Implementation Plan due to HCA on October 1.

Partnering Provides who serve on our Technical Councils have had an additional role in supporting Transformation activities, through the development of recommendations that lay the foundation for the requirements and expectations for earning Medicaid waiver dollars. For example, the Provider Champions Council created the setting requirements that outline the minimum expectations for Partnering Providers taking on MTPs. For each of the evidence-based models within the four projects our ACH developed, these council members set a recommendation that then went to the Board for approval. These setting recommendations have served as the framework for the Transformation Plans our Partnering Providers in behavioral health and primary care are currently working on. We are confident that because actual practicing providers in our region have set these recommendations, they reflect practical and actionable activities for our region.

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

ACH Response:

For year one, we have worked hard to create an engagement and incentive structure that rewards providers for participation, launching our efforts to keep them engaged throughout the process. We are proud that 100% of the providers we identified as critical to influencing the Medicaid market have joined in, representing our highest Medicaid billers.
At this point, we have been able to sustain the right set of partners to launch our planning process. There is ongoing concern that the time needed to work collaboratively across sectors—with a variety of partners—and develop individual partner Plans for the amount of investment that can and will be earned, will be challenging. As we move through our incentive payment process it will be important to note the amount of time it will take to actually implement these activities on top of daily operations.

We allocated most of our year 1 incentive payments with recognition that, whether you are a high-volume partner or specialty provider, there is a set amount of work necessary to complete the planning process. Though we did include a small equity and volume payment, in general volume and geographic reach was not discriminating in dollars eligible to be earned.
The cornerstone of BHT's engagement structure are our Technical Councils, based around sectors critical to success in Transformation.

The primary mechanism for our engagement with providers is through our Provider Champions Council. Made up of primary care, behavioral health, and social service providers, this council has set the recommendations for which evidence-based approaches to select from the toolkit, and will help review Transformation Plans. This council meets monthly in the evenings, and holds prep calls at 7am, to meet the scheduling needs of the many actively practicing providers serving Medicaid patients during normal working hours. All meetings are available by webinar and phone call-in as well. This group ensures providers always have a voice in any decision making relevant to clinical Transformation that goes before the BHT Board.

The Tribal Partners Leadership Council (TPLC) meets monthly and includes membership from six of the seven Medicaid serving Indian health organizations in our region. This council ensures that Tribal partners have a voice in our decision-making and creates opportunities for alignment. Similarly, to PCC, this group reviews recommendations that are going before the Board, to give input from the native perspective and insures there are no unintended consequences from our decision making.

Jenny Slagle, who serves as BHTs Tribal Liaison, continues to have regular meetings to check in with Tribal partners to ensure alignment with BHT projects as well as with the state-wide Tribal work. The open communication afforded by this relationship has helped BHT to be flexible and responsive to the meeting what tribes need to engage. For example, using knowledge of Tribal government operations and timelines, we have worked with our Tribal partners to allow time for them to bring a decision forward to Tribal Council first. Additionally, we've worked to align our Partnering Provider Plans and will attempt to align any of our shared metrics with the statewide Tribal work together whenever possible recognizing the fact the tribes are being tasked with a set of work and are not exclusively funded through state Medicaid dollars, but also the complex environment of the federal Indian Health System.

The Waiver Finance workgroup includes representation from primary care, behavioral health, native health, social services, and county government. This group sets recommendations for use and allocation of earned incentive dollars from Project Funds and Integrate Managed Care

benefits. It was important that this council have representation from all sectors to ensure alignment and engagement in waiver funding decisions.

Additional, Partnering Providers are engaging through their Community Health Transformation Collaboratives. The Collaborative partners are developing the necessary partnerships to ensure our Transformation efforts effectively link together behavioral health, primary care, and social determinant of health partners. While the emphasis is heavily centered around preparing Transformation Plans and building relationships necessary to succeed, BHT staff participate to support project development and deliver needed information and updates to our partners. Each Partnering Provider has a BHT staff member assigned to them who is responsible for monthly check-ins and serves as a dedicated point of contact for the agency. In addition, we have private web pages for our Collaborative members, which hold all of the documents, meeting schedules, and information they would need to stay up to speed. We aim to be accessible and give all of our partners a clear and direct channel to get their questions answered.

BHT has two Program Managers who make, at minimum, monthly trips to each of BHT ACH's rural counties. This includes attendance at all of the monthly Rural Health Coalition meetings, as well as calls and visits when requested for check-ins or technical assistance with various partners. Their long history of superb attendance at these meetings have helped positioned BHT staff as trusted members in the network of partners that make up each rural counties' Collaborative.

Recognizing the many barriers to providers in taking on an extra workload for Transformation, especially with a workforce shortage, and lagging technology and access to data, BHT's Year 1 funding structure is designed to reward for participation and timely completion of milestones, and reward for these activities in incentive payments to offset the work. We expect these dollars help providers find more capacity to stay engaged.

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

ACH Response:

BHT invited all of our BHO contracted behavioral health providers, as well as Tribal behavioral health providers, to complete the Quails Billing and Information Technology Self-Assessment and offered incentive dollars for completing it and sharing results with BHT. Throughout this time, BHT staff members were available for one-on-one support with the assessment. We offered $20,000 for currently contracted BHO and Tribal behavioral health providers to take the assessment, with these funds earned intended to be directed toward offsetting costs associated with IMC transition. These assessments were recently completed, and BHT is currently reviewing the results to assess opportunities to support behavioral health providers.

We are currently hosting three workgroups specific to IMC transition:

1. **Early Warning System:** Develop recommendations for an Early Warning System that allows a feedback loop and triage process to identify and resolve system issues as they arise.

2. **IT/EHR:** Identify and resolve IT/EHR issues including but not limited to MCO/ASO billing capacity, EHR compatibility, provider data reporting requirements, technical assistance needed by providers.

3. **Communications:** Provide recommendations and work to engage the consumer sector in system change efforts related in integrated managed care. Ensure that consumers maintain confidence and continuity in the care they are receiving. Ensure smooth transition to IMC through the development of clear communication materials, client notifications, and transparent transition processes.

BHT staff meets monthly with BHO director and key staff to ensure open communication and alignment through the winddown, and to help make this transition as smooth as possible.

E. Community Engagement

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

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

Community Engagement Activities for the Reporting Period						
Activity Description	**Date**	**Objective**	**Target Audience**	**Associated Project Areas**	**Brief Description of Outcome**	**Attendance Incentives Offered? (Y/N)**
Stevens County Healthcare Roundtable (Colville, WA)	1/5/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Spokane Alliance Introduction (Spokane, WA)	1/5/18	Introductory meeting to align health equity related work	Spokane Alliance members	Community-Based Care Coordination, Opioid Response,	Spokane Alliance invited to participate on BHT's Technical Councils	N

				Chronic Disease, Bi-Directional Integration		
Healthy Ferry County Coalition (Republic, WA)	1/9/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Pend Oreille Health Coalition (Usk, WA)	1/11/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
EW Community Health Worker Network (Spokane, WA)	1/11/18	Sharing BHT ACH updates, offering TA to help local objectives	Community Health Workers, Social Service Providers	Community-Based Care Coordination	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Integrated Services Pilot	1/16/18	BHT asked to be Pathways subject matter expert in discussion for an integrated services pilot	Spokane County based organizations working to impact homelessness	Community-Based Care Coordination	Group to explore using Pathways for their pilot	N
BHT ACH Leadership Council	1/16/18	Shared learning from Ann Monroe, NY DSRIP	All partners related to ACH work: regional partners in county government, healthcare, social services,	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Learning about upcoming steps in the ACH work according to an expert from a state two years ahead in the process	N

			community members			
Winterfest (Republic, WA)	1/20/18	Community Health Needs Assessment Survey Implementation	Ferry County residents		Soliciting responses for county-wide community heath needs assessment to support Health Ferry County Coalition work	N
BHT Board Meeting - Community Comment Hour (Spokane, WA)	1/24/18	Engaging with ACH region community members interested in issuing comments to the BHT ACH Board	BHT ACH Region Community Members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Continued engagement with BHT ACH region community members	N
Presentation on Community-Based Care Coordination to Spokane Fire Department CARES Team (Spokane, WA)	1/25/18	Presentation to Spokane Fire Department Community Assistance Response Team	MSW / BSW students, Spokane Fire Department personnel	Community-Based Care Coordination	Awareness of BHT ACH community-based care coordination objectives	N
Opioid Issue Awareness Meeting with WA-Eastern Region U.S. Attorney's Office (Spokane, WA)	1/25/18	Sharing BHT ACH updates, offering TA to help local objectives	U.S. Attorney's Office staff	Opioid Response	Connecting U.S. Attorney's Office to county-based groups regarding opioid crisis	N
Invest Health Meeting (Spokane, WA)	1/26/18	Sharing BHT ACH updates, offering TA to help local objectives	Spokane County social service providers, City of Spokane, community members	Community-Based Care Coordination	Supporting local efforts to reduce admission rates of children into foster care	N

State-wide Conference Call on Community Health Workers (Conference Call)	1/26/18	Shared learning on state-wide CHW legislative concerns	Community Health Workers, Social Service Providers, State Legislators	Community-Based Care Coordination	Supporting local CHWs in legislative efforts	N
MCO Briefing	1/30/18	MCO Briefing on BHTs Collaborative and Funds Flow	MCO representatives	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Group updated on BHTs intended planning process and funds flow.	N
Meeting with potential community partner	1/30/18	Sharing BHT ACH goals and mission to find opportunities for collaboration	Community partner working with Native youth	Bi-Directional Integration; Opioid Response	Connected this individual with the appropriate Technical Councils for ongoing feedback	N
NAMI Spokane	1/31/18	Discuss opportunity for NAMI programs to support project goals	NAMI Leadership	Opioid Response, Bi-Directional Integration, Community-Based Care Coordination	NAMI working towards value-proposition for their services	N
Meeting with social services provider	1/31/18	Sharing opportunities for engagement with a partner who does not provide direct Medicaid services	Social service provider looking in ACH work	Opioid Response	Connected this individual with the appropriate Technical Councils for ongoing feedback	N
"Making Mental Health Essential" Convention (Spokane, WA)	1/31/18	Engaging greater region on Mental Health / Substance Use Disorder awareness	Community members, health care organizations, government	Opioid Response	Continued engagement with BHT ACH region community members	N

Poverty Round Table	2/23/18	Discussion on poverty in the BHT region to inform legislative policy	Sen. Patty Murray staff	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	ACH efforts and priorities clearly laid out for Senators staff to support allignment	N
Pend Oreille Health Coalition (Newport, WA)	2/1/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
West Plains Support Network Meeting	2/7/18	Sharing BHT ACH updates	Local government, social services providers, educators, religious institutions, community members	Community-Based Care Coordination	Awareness of BHT activities, community programs, flagged issues for prioritization	N
Community Voices Council Check-In	2/8/18	Meeting with Technical Council co-chairs and MCO partners on how to build Medicaid beneficiary engagement into council	Board member, MCO representatives, public health representative, community partners	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Laid groundwork for following meetings and building participation from Medicaid beneficiaries	N
Healthy Ferry County Coalition (Republic, WA)	2/13/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N

Adventist Community Services (Spokane, WA)	2/14/18	Sharing BHT ACH updates, offering TA to help local objectives	Faith-based community-based organization	Community-Based Care Coordination	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Leadership Council Webinar	2/20/18	Funds Flow Update from Alison Poulsen	All partners related to ACH work: regional partners in county government, healthcare, social services, community members	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Walkthrough of the most up-to-date funds flow planning for Year 2	N
BHT Board Meeting - Community Comment Hour (Spokane, WA)	2/21/18	Engaging with ACH region community members interested in issuing comments to the BHT ACH Board	BHT ACH Region Community Members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Continued engagement with BHT ACH region community members	N
Spokane Regional Transportation Council (Spokane, WA)	2/26/18	Keeping up to date on local transportation initiatives and raising awareness of MTP Planning	Local government, transportation advocates, regional planners	Community-Based Care Coordination	Connecting social determinants of health to the health systems	N
ARCORA	3/13/17	Meeting to align efforts related to Oral Health	ARCORA and Smile Spokane Staff	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Opportunities to align efforts related to projects identified	N

Pend Oreille Health Coalition (Newport, WA)	3/1/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Stevens County Healthcare Roundtable (Colville, WA)	3/2/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Community Voices Council Meeting	3/6/18	First meeting with Medicaid beneficiaries with overview of ACH work and role of CVC	Board member, MCO representatives, public health representative, community partners, Medicaid beneficiaries	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Developed a plan for targeted recruitment for council, building engagement across all regional demographics	Y
West Plains Support Network	3/7/18	Sharing BHT ACH updates	Local government, social services providers, educators, religious institutions, community members	Community-Based Care Coordination	Awareness of BHT activities, community programs, flagged issues for prioritization	N
Eastern WA CHW Network Meeting	3/8/18	Sharing BHT ACH updates, offering TA to help local objectives	Community Health Workers, Social Service Providers	Community-Based Care Coordination	Awareness of BHT ACH community-based care coordination objectives	N
Healthy Ferry County Coalition (Republic, WA)	3/13/18	Sharing BHT ACH updates, offering TA to	County government, social service	Community-Based Care Coordination,	Awareness of BHT ACH activities,	N

		help local objectives	providers, healthcare organizations, community members	Opioid Response, Chronic Disease, Bi-Directional Integration	community programs, flagged issues for prioritization	
Prevention First Leadership Team Meeting	3/14/18	Sharing BHT ACH updates	Public health department and other community partners working on the 1422 waiver for Chronic Disease	Chronic Disease	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Healthy People Community Assessment Meeting (Spokane, Wa)	3/19/18	BHT to give input on Community Health Assessment priorities	Community organizations impacting health	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Suicide selected as a priority issue	N
Spokesman Review Healthcare Forum (Spokane, WA)	3/20/18	Shared learning of community opinion and questions on healthcare in Spokane County	Community members, faith-based organizations	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Continued engagement with BHT ACH region community members	N
Leadership Council Webinar	3/21/18	A discussion on BHT Regional priority areas	All partners related to ACH work: regional partners in county government, healthcare, social services, community members	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Information for partners and community members on priority areas selected for our region in addition to the four project areas	N

Adventist Community Services (Spokane, WA)	3/22/18	Sharing BHT ACH updates, offering TA to help local objectives	Faith-based community-based organization	Community-Based Care Coordination	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Population Health Panel (Spokane, WA)	3/23/18	Presentation on VBP, health equity, and population health	Current med students	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Rich discussion and engagement with our future workforce	N
Spokane Regional Transportation Council (Spokane, WA)	3/27/18	Keeping up to date on local transportation initiatives and raising awareness of MTP Planning	Local government, transportation advocates, regional planners	Community-Based Care Coordination	Connecting social determinants of health to the health systems	N
BHT Board Meeting - Community Comment Hour (Spokane, WA)	3/28/18	Engaging with ACH region community members interested in issuing comments to the BHT ACH Board	BHT ACH Region Community Members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	N
Department of Health Community of Health Worker Conference (Lynwood, WA)	4/12-13/18	ACH updates, state-wide CHW developments	State-wide Community Health Workers	Community-Based Care Coordination	Cross-state CHW connections, shared learning	N
Prevention First Leadership Team Meeting	4/11/18	Sharing BHT ACH updates	Public health department and other community partners working on the 1422 waiver for	Chronic Disease	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N

			Chronic Disease			
Tri-County Subregional Meeting	4/12/18	Collaborating with Catholic Charities' SNAP Program and tri-county partners on food security and other local issues	Health care providers, social services providers, community partners	Community-Based Care Coordination; Chronic Disease	Opportunities for collaboration between BHT and regional partners and how Transformation work will impact food security	N
Greater Spokane County Meals on Wheels	4/17/18	ACH updates	Meals on Wheels Staff	Community-Based Care Coordination	Connections to ACH activities	N
Leadership Council Meeting	4/18/18	A discussion on embedding health equity into Transformation work across all sectors	All partners related to ACH work: regional partners in county government, healthcare, social services, community members	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Furthered conversation and set partner and community member expectations for how Medicaid Transformation will involve health equity in all aspects of the work	N
EW Community Health Worker Network (Spokane, WA)	4/19/18	Sharing BHT ACH updates, offering TA to help local objectives	Community Health Workers, Social Service Providers	Community-Based Care Coordination	Awareness of BHT ACH community-based care coordination objectives	N
BHT Board Meeting - Community Comment Hour (Spokane, WA)	4/25/18	Engaging with ACH region community members interested in issuing comments to the BHT ACH Board	BHT ACH Region Community Members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	N
Recovery and Integration Forum	4/17/18	BHT participated	Behavioral Health	Community-Based Care	Aired concerns around recovery	Y (Lunch)

		in DSHS Recovery and Integration Forum	providers, with a focus on SUD and Recovery	Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	culture getting lost in integration, discussed strategies	
Stevens County Healthcare Roundtable (Colville, WA)	5/4/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Community Voices Council Meeting	5/7/18	Onboarding for new council members, establishing goals and outcomes for coming months	Board member, MCO representatives, public health representative, community partners, Medicaid beneficiaries	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease; Opioid Response	Engaged three new Medicaid beneficiaries with the Council, established norms and regular meetings times, set scope of work	Y
Healthy Ferry County Coalition (Republic, WA)	5/8/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
EW Community Health Worker Network (Spokane, WA)	5/10/18	Sharing BHT ACH updates, offering TA to help local objectives	Community Health Workers, Social Service Providers	Community-Based Care Coordination	Awareness of BHT ACH community-based care coordination objectives	N
Meeting with Molina representative	5/11/18	Build a relationship and get her established with the work	Molina	Bi-Directional Integration; Community-Based Care Coordination; Chronic Disease;	Familiarized representative with regional work and priorities, connected her	N

		in the BHT region		Opioid Response	with significant partners	
Healthy Youth Summit (Spokane, WA)	5/15/18	Shared learning on school-age pregnancies	Community Members, healthcare providers, schools	Maternal and Child Health	Connections to ACH activities	N
BHT Board Meeting - Community Comment Hour (Spokane, WA)	5/16/18	Engaging with ACH region community members interested in issuing comments to the BHT ACH Board	BHT ACH Region Community Members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	N
Medical Dental Integration	5/23/18	Discuss strategies for fluoride varnish application with oral health experts	Dentists, clinicians, ARCORA foundation	Bi-Directional Integration,	Subject matter expertise identified to support this activity	N
Lincoln County Health Collaborative Meeting	5/23/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Adams County Health Coalition	5/29/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N
Health Equity	5/29/18	Spokane Regional Health District received a significant	BHT and SRHD	Community-Based Care Coordination, Opioid Response,	Shared resources for health equity accelerators	N

		grant to support health equity. Meeting to discuss lessons learned and opportunities to align.		Chronic Disease, Bi-Directional Integration		
Stevens County Healthcare Roundtable (Colville, WA)	6/1/18	Sharing BHT ACH updates, offering TA to help local objectives	County government, social service providers, healthcare organizations, community members	Community-Based Care Coordination, Opioid Response, Chronic Disease, Bi-Directional Integration	Awareness of BHT ACH activities, community programs, flagged issues for prioritization	N

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

   ACH Response:

   Overall, only 6% of BHT's Medicaid population are not primarily English speakers. Half of those are Spanish speakers, predominately located in Adams county.

   BHT has been working with a Community Health Worker with connections to the COFA islander, Russian, and Spanish communities in the BHT region, that represent the majority of our non-English speakers. This CHW is helping to recruit community members from this population to join our Community Voices Council, to be sure their incorporated in our planning process. BHT has asked Partnering Providers to comment on what health equity resources they offer with in their agency, including translation services, in their Transformation Plan. These are due to

   BHT August 1st, and will help BHT assess how much capacity currently exist to support limited English speakers, and look for opportunities to support providers in this kind of engagement. BHT has experience in working with limited English populations through our work in the Navigator Network, which has run targeted advertising and outreach for health insurance sign-up in Spanish and Russian and works closely with the COFA islander population. Although COFA Islanders are not covered by Medicaid, their children often are, making them a key demographic in Spokane. If our region does reduce Medicaid coverage to 3 MCOs, an estimated 37,000 people will need to change their Plans, and it will be crucial to consider non-English speakers in our communication strategy in order to maintain access.

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

ACH Response:

Our Community Voices Council members likely face the highest levels of barriers to engagement. Representing Medicaid beneficiaries and often marginalized groups from our region, the people on this council face barriers relating to transportation, income, childcare, disability, and more to attend our monthly meeting. We offer a $75 stipend to each (non-MCO) participant, to help offset some of those challenges and to thank them for their time. We let the group make all decisions about where meeting locations should be, and staff aim to accommodate as much as we can. For example, some Spokane-based group members had a hard time commuting to downtown Spokane, so the group discussed and felt north of town would be better and asked us to book either the library or community center up there. We now meet at that library.

With the development of BHT's Community Voices Council, we have been intentional in recruiting membership from underrepresented groups in order to make sure their voice is actively engaged in Transformation. Current demographics represented in this group include members of the LGBTQIA+, disability, formerly incarcerated, Russian speaking, special needs, and foster care community. We are currently holding space on the council to recruit for more rural and Tribal representation, recognizing they are currently underrepresented given our geographic spread.

To support rural community members participating, one rural FQHC offered to donate their office space and conferencing technology for CVC members to use to attend the meeting via webinar. This will help rural community members without access to reliable phone or internet access to have a central place to tune in, and we are currently recruiting other partners to serve as satellites meeting sites in this way.

While Tribes have historically been underrepresented in health care Transformation efforts, BHT believes our work in building deep and trusted relationships with our Tribal partners is demonstrated in six of seven Tribal health organizations in our region signing and MOU to participate. Our Tribal Partners Leadership Council has been the main platform for engagement with Tribal partners and embeds their voice and recommendations into our governance structure.

F. Health Equity Activities

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

1. Provide an example of a decision the ACH and its Partnering Providers have made about project planning or Implementation based on equity considerations.

ACH Response:

A commitment to health equity is reflected in BHT's selection of people transitioning out of jail as a target population for our Community-Based Care Coordination project. As well as our efforts to decrease unintended pregnancy, a key to…..needs lisa's language here Stigma against those with criminal history often creates systemic barriers to key determinants of health, such

as housing and employment. A disproportionate amount of people in the BHT regions jails are black, Hispanic, or Native American, and an overwhelming majority present with a behavioral health issue. A network analysis of collaboration in the BHT regional health system showed that organizations specializing with the returning citizen population were the least common among the specialty demographics we surveyed. With compounding complex needs and social barriers, BHT sees an opportunity to accelerate health equity and demonstrate the value of whole-person care by strengthening community linkages and access to services for this population through our Pathways pilot. We expect to demonstrate, as was done in a Muskegon, Michigan Pathways pilot, that care coordination will reduce recidivism and support an overall reduction in the jail population. We also see this work as an opportunity to increase trauma-informed care services and reduce stigma and barriers in the health system.

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

ACH Response:

Through our assessment and Transformation planning process, BHT has collected information from our Partnering Providers on their biggest barriers to health equity, and most pressing issues.

BHT's Partnering Providers are in the process of completing a Transformation Plan, in which they have been asked to speak to any current health equity activities and priorities in place in their setting, and any plans for future activities or requests for TA. These Plans are due August 1. As described in our response to question A.6., BHT will follow the guidance of our Leadership and Technical Councils in developing a prioritized set of activities to promote health equity, attached with TA and financial incentives.

BHT continues to deploy staff to key community meetings and coalitions, to stay informed of shifting regional priorities and issues and look for opportunities to align efforts. We will also rely on regular conversation with our Community Voices Council, Provider Champions Council, and Tribal Partners Leadership Council members to inform health equity priorities and strategies. Additionally, we expect to have one of our ACH Transformation metrics, through which our Partnering Providers will earn dollars, tied to health equity. Though we have not developed our final Plans, criteria and process for our Community Resiliency Fund, it is anticipated that all funding will be allocated through a lens of accelerating the elimination health disparities.

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

ACH Response:

BHT's health equity related activities will be guided by the Community Voices Council and endorsed and supported by the BHT Board, comprised of both Medicaid beneficiaries and community advocates with lived experience navigating Medicaid and other social services for themselves or others. Members from this council will review Partnering Provider responses to the health equity questions on the Transformation Plans, both to give feedback to providers and

to help recommend a set of health equity activities for BHT to endorse, and potential technical assistance BHT should offer. As the Community Voices Council explores recommendations for these activities, they will also be charged with recommending process measures to monitor adoption of these tools. These recommendations will then go to the Waiver Finance Work Group to explore a possible mechanism for tying incentive dollars to these activities.

Internally, BHT Board and staff have been engaging in strategic conversations and trainings on health equity to deepen our commitment to health equity as a value. The Board recently articulated their desire in their next strategic plan for a specific goal for health equity around increasing the percentage of providers trained in trauma-informed care and developing technical assistance capacity to further expand our region's ability to deliver culturally appropriate care. Another goal centered around increasing opportunities for individual self-determination through greater focus on prevention activities and elimination of health disparities. We intend to convene a BHT Board workgroup to further develop these goals but expect they will be tied to the health equity activities we recommend.

G. Budget and Funds Flow

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

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

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

Yes	No
X	

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

ACH Response:

BHT's financial statements are only audited at the end of each calendar year, and 2017's won't be final for another month as the external auditors are still doing their review. We do not expect to have any findings.

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

ACH Response:

Not applicable

2. Design Funds

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

3. DY 1 Earned Incentives

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

4. Integration Incentives

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

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

ACH Response:

BHT ACH designed our funds flow for Year 1 IMC incentives to distribute earned dollars to behavioral health providers as soon as possible, in a way that rewards for hitting milestones along the path to IMC readiness. The ACH Waiver Finance Work Group, which includes participation from behavioral health providers, the BHO, and county commissioners, recommended a set of milestones related to IMC planning, and allocated incentive dollars for the completion of each milestone. This recommendation went to the BHT Board, which includes representation from county commissioners and behavioral health providers. The following was approved by the BHT Board:

Contracted BHO Providers providing mental health or substance use services will receive a base payment of $50,000 + a technical assistance payment of $20,000.

Letter of Commitment	$25,000
FIMC Readiness Assessment	$20,000
FIMC Implementation Plan	$20,000
FIMC Ready by 12.31	$5,000

Tribal Behavioral Health Providers will receive a base payment of $25,000 + a technical assistance payment of $20,000. FIMC is not required for Native American and Indian Health Providers, many of whom are already integrated, and this payment is to incent Tribal and Native organizations to participate in regional integration activities.

Letter of Commitment	$10,000

FIMC Readiness Assessment	$20,000
FIMC Implementation Plan	$10,000
FIMC Ready by 12.31	$5,000

33 of 36 contracted BHO providers have signed the commitment, as well as 6/7 Tribal behavioral health providers.

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

ACH Response:

BHT has already distributed $1,180,000 of our integration incentives. BHT staff and consultants created a strawman recommendation for a funding model that would reward providers for hitting milestones along the path to IMC readiness. This recommendation was given to the Waiver Finance workgroup to modify and recommend to the BHT Board. The incentives described in the previous question were approved by the BHT Board.

Contracted BHO providers and Indian behavioral health providers were invited to sign an FIMC commitment form to signal their intent to achieve IMC readiness by 2019. All of these providers also signed Collaborative Commitment forms, signaling their commitment to participating in one of our Community Health Transformation Collaboratives and in the five-year Transformation activities. For signing this letter of commitment, partners received a participation payment, intending to give flexible dollars upfront to offset the burden of these activities on top of daily operations.

These providers were then invited to take an IMC readiness assessment, and similarly offered an incentive upon completion. The answers to these assessments will help inform BHT's recommendation for the use of balance of Integration incentive dollars. BHT will utilize provider partnering Plans to inform the next set of funding decisions.

We expect, and have received feedback, that this payment structure is supporting providers through the sets of activities they need to implement to be ready for IMC, and ready to serve Medicaid beneficiaries in 2019.

5. Total Medicaid Transformation Incentives

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

Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report Template
Reporting Period: January 1, 2018 – June 30, 2018

Request for Supplemental Information

Upon review of the ACH's semi-annual report, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification. Please respond within this template. Updates to semi-annual reports are not required and will not be reviewed.

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

No requests for additional information.

Section 2: Standard Reporting Requirements

Item C.1. Provide a status update that highlights Transformation planning progress by listing activities that have occurred during the reporting period in the table.

1. ***Independent Assessor Question:*** In the Project Status Update table, Better Health Together included the following key activity: "Partnering Providers to participate in a Community Health Transformation Collaborative". Additional information was not included about project areas, progress, or next steps. Please confirm whether information was inadvertently omitted, and provide the additional detail.

   ACH Response:

Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Partnering Providers to participate in a Community Health Transformation Collaborative	2a, 2b, 3a, 3d	Y	Collaboratives will meet monthly to drive development, coordination, and implementation of transformation projects.

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

2. ***Independent Assessor Question:*** The response states the following. "A commitment to health equity is reflected in BHT's selection of people transitioning out of jail as a target population for our Community-Based Care Coordination project. As well as our efforts to decrease unintended pregnancy, a key to…..*needs lisa's language here Stigma against those*

with criminal history often creates systemic barriers to key determinants of health, such as housing and employment…" Please review and update to include missing language.

ACH Response:

The missing language was referring to statistics about the disproportionate representation of people of color and people with mental health needs in county jails. For example, Spokane County has reported that Native Americans and African Americans account for 7% and 11% of the county jail population, while representing only 1% and 1.9% of the total population.[i] A 2013 analysis of the statewide jail population estimated that 60% of Washington jail inmates who were enrolled in Medicaid in 2012 or 2013 had a mental health need.[ii] In partnering with counties to improve jail transition services and outcomes, particularly recidivism, BHT aims to reduce some of these disparities.

[i] See: https://www.spokanecounty.org/DocumentCenter/View/16062/1506_Spokane_Intro-to-SJC_Final?bidId

[ii] See: http://sac.ofm.wa.gov/sites/all/themes/wasac/assets/docs/research-11-226a.pdf