Medicaid Transformation
Accountable Communities of Health (ACH)

Implementation Plan Template:
Work Plan Instructions & Portfolio Narrative

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ACH CONTACT INFORMATION

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SUBMISSION INSTRUCTIONS

Building upon Phase I and Phase II Certification and Project Plan submissions, the Implementation Plan provides a further detailed roadmap on Medicaid Transformation project implementation activities. The Implementation Plan contains two components:

- *Project work plans.* Work plans are a key component of the Implementation Plan. ACHs must detail key milestones, work steps to achieve those milestones, deliverables, accountable ACH staff and partnering provider organizations, and timelines from DY2, Q3 to DY5.

- *Portfolio narrative.* ACHs must respond to a set of questions, included in these instructions, which detail implementation approach and activities with partnering providers and coordination with health systems and community capacity building and other initiatives across their portfolio of projects between DY2, Q3 through DY3, Q4. The intent of describing roles and activities for a narrow timeframe is to capture concrete examples of implementation steps as they get underway, while not overly burdening ACHs to report on the full timeframe of Medicaid Transformation, or the full scope of work by partnering providers.

ACHs will be asked to report against progress in the Implementation Plan, and project risks and mitigation strategies in future Semi-annual Reports. Successful completion of the Implementation Plan is a key P4R deliverable and an opportunity for ACHs to earn incentive payments in DY 2.

Work Plan Template. The Implementation Plan Work Plan Template (Excel workbook) provided by HCA is for use by ACHs in completing the Work Plan component of the Implementation Plan. ACHs may submit an alternative work plan format; however, ACHs

must meet the minimum requirements outlined below, and provide complete responses to all questions in the Portfolio Narrative section.

File Format and Naming Convention. ACH submissions will be comprised of at least two documents: the Work Plan (in Microsoft Excel or Word, or Adobe Acrobat) and Portfolio Narrative (in Microsoft Word). Use the following naming convention:

- Work Plan(s): ACH Name.IP.Work Plan.Project Identifier.10.1.18.
  - o Depending on the approach, ACHs may choose to submit separate work plan documents by project area(s). Please indicate in the work plan naming convention the project areas included in the Work Plan.
- Portfolio Narrative: ACH Name.IP.Portfolio Narrative.10.1.18

Submission. Submissions are to be made through the Washington Collaboration, Performance, and Analytics System (WA CPAS), found in the folder path "ACH Directory/Implementation Plan."

Deadline. Submissions must be uploaded no later than 3:00 pm PT on October 1, 2018. Late submissions will not be accepted.

Questions. Questions regarding the Implementation Plan Template and the application process should be directed to WADSRIP@mslc.com.

REQUIRED PORTFOLIO NARRATIVE

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

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

ACHs should read each prompt carefully before responding.

Partnering Provider Project Roles

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

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

In total, examples must reflect:
- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.[1]
- All projects in the ACH's portfolio.

ACH Response

Responses must cover the following:

Whole Person Care Collaborative Project:

- *What is the name of the partnering provider organization?*
  - Mid-Valley Clinic

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

- *What type of entity is the partnering provider organization?*
  - Outpatient clinic based out of Mid-Valley hospital

- *In which project/project(s) is the partnering provider organization involved?*
  - All, though primarily bi-directional integration and chronic disease

- *What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?*
  - This provider will submit a change plan outlining roadmap for process improvements, as well as quarterly progress reports outlining status of change ideas, successes, challenges, next steps, and quantitative measures.

- *What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?*
  - Test and refine workflow and process improvements through Plan Do Study Act (PDSA) cycles, with assistance from coaches and learning activities.
    - This may involve hiring of staff and various relevant trainings. A core team from their outpatient clinic already participated in our Foundations of Motivational Interviewing and Introduction to Quality Improvement workshops.
  - Migrating to a new EHR that promotes improved measure reporting and population health management functionalities.
  - Recruiting an integrated behavioral/mental health professional who will work closely with medical provider team in clinic.
  - Learning to optimize use of PreManage, an HIT tool that ensures outpatient clinics receive real-time notifications when their patients are admitted to or discharged from acute care. This technology also assists clinics with patient risk identification. This is important for purposes of acute care follow-up and care coordination.

Transitional Care and Diversion Interventions:

- *What is the name of the partnering provider organization?*
  - Columbia Basin Hospital

- *What type of entity is the partnering provider organization?*
  - Columbia Basin Hospital is a 25 bed local Critical Access Hospital. It is located in one of our rural communities (Ephrata, WA: population 7,664). In addition, Columbia Basin Hospital operates Columbia Basin Family Medicine, an outpatient clinic that serves the patients in and near Ephrata. This clinic is also

participating in the Medicaid Transformation Project through the whole person care collaborative learning community

- *In which project/project(s) is the partnering provider organization involved?*
    - o Transitional Care
    - o Diversion Interventions
- *What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?*
    - o Columbia Basin Hospital will submit an application by September 28th, 2018 (DY2, Q3), which includes the specific projects that Columbia Basin Hospital will participate in, such as:
        - ▪ Developing a Transitional Care Management program in their hospital that is applicable to their hospital size.
        - ▪ Select from the following options of Emergency Department tactics:
            - – Integrating Emergency Department Information Exchange (EDie) more efficiently into Emergency Department Workflow and EMR.
            - – Enhancing referral processes to primary care upon discharge from Emergency Department.
            - – Working with local partners to more effectively and efficiently refer patients to the appropriate level of care for their healthcare needs.
    - o Columbia Basin Hospital is required to submit semi-annual reports that outline their progress on process improvement efforts in their organization and that also demonstrate documentation of progress toward previously specified metrics. Columbia Basin Hospital is responsible for ensuring all necessary internal processes are established and functional so that the organization is able to report on all assigned metrics. This includes providing all applicable training needs to its staff and ensuring the organization has adopted the policies and procedures to sustain process changes. The organization will partner with the NCACH and assigned vendors (i.e. Collective Medical Technology and Confluence Health) to ensure all training for staff is completed by DY3 Q4.
- *What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?*
    - o Transitional Care
        - ▪ Train staff on the Transitional Care Management model and assign a designated Transitional Care Management nurse to complete call back processes. This could include assigning a current nurse and training under the aforementioned model or hiring a new staff member.

- - Utilize the Transitional Care Management Toolkit to develop processes and procedures that will be adopted by the organization internally.
    - Implement the model and have patients receive a follow up phone call from a transitional care nurse
    - Participate in trainings regionally to continue improving implementation of the model in the organization.
    - Receive a completed site visit by contracted vendor to provide a review of organization's program and provide recommendations for additional quality improvements opportunities.
  - Diversion Interventions (Emergency Department Diversion)
    - Develop policies and procedures in the Emergency Department that streamlines staff's ability to refer to appropriate setting for care and to educate patients on the appropriate utilization of care.
    - Ensure that staff are fully trained on selected care models and that internal review is conducted on the efficacy of the approach.
    - If EDie integration into EMR is part of work, assign IT staff to partner with vendor and develop business plan to complete work and trainings.

Community Based Care Coordination:

- *What is the name of the partnering provider organization?*
  - Community Choice, dba, Action Health Partners

- *What type of entity is the partnering provider organization?*
  - Community-Based Organization

- *In which project/project(s) is the partnering provider organization involved?*
  - Community Based Care Coordination (Pathways Community HUB)
  - Participates in the Whole Person Care Collaborative Workgroup and the Transitional Care and Diversion Interventions but is not a funded partner in those projects.

- *What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?*
  - The organization will serve as the Pathways Community HUB lead agency.
  - The organization will successfully launch the Pathways Hub model with Care Coordination Agencies in North Central Washington

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

- As the Pathways Community HUB lead agency, Community Choice, dba, Action Health Partners will perform all necessary tasks to build a successful HUB in North Central Washington. Key steps include:
  - Develop policies and procedures.
  - Convene a Pathways Community HUB Advisory Board.
  - Hire and train a Pathways HUB Operations Manager and a Care Coordination Network Director.
  - Develop and carry out a Quality Improvement strategy and system.
  - Launch the Pathways Community HUB.
  - Contract for, customize, and utilize Care Coordination IT platform.
  - Develop a plan for and work toward long term sustainability beyond the Medicaid Transformation Project period.

Regional Opioid Workgroup

- *What is the name of the partnering provider organization?*
  - Methow Valley School District
- *What type of entity is the partnering provider organization?*
  - K-12 Public School District
- *In which project/project(s) is the partnering provider organization involved?*
  - Opioid Project
- *What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?*
  - The school district will adopt an integrated K-12, evidence-based approach to preventing substance use.
- *What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?*
  - Assign a temporary program coordinator
  - Conduct student, district staff, and community focus groups to collect input and build support for district efforts
  - Compile available data
  - Review and select evidence-based programs for district to review
  - Select and acquire curriculum
  - Conduct teacher training
  - Begin curriculum integration in grades 6-9

> o   Evaluate outcomes and revise as necessary

Partnering Provider Engagement

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

ACH Response

Responses must cover the following:

- *What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?*
  - o   NCACH developed a comprehensive change plan template for participating primary care and outpatient behavioral health providers to outline their practice transformation road map. The change plan structure is based on the IHI model for improvement. This structured and actionable tool includes measures, drivers, and tactics that will help providers accomplish aims across all projects in our portfolio. It will also serve as a foundation for reporting.
  - o   NCACH is in the process of developing a robust network of practice transformation coaches to support our providers 1-on-1 when challenges are identified or additional assistance is needed to accomplish transformation goals.
  - o   NCACH offers learning activities to WPCC members. These activities are formed around a specific topic, such as Behavioral Health Integration. Standing webcasts promote peer sharing and allow for faculty who are subject matter experts to provide content. WPCC members are encouraged to commit to actions they intend to execute in-between webcasts.
  - o   NCACH offers skills-based workshops to WPCC members. These sessions are customized based on the results from a pre-survey of likely participants. Future skills-based workshops will build upon foundational workshop topics
  - o   NCACH shares additional training opportunities with providers (ie. Department of Health Buprenorphine Waiver Trainings) through the WPCC Learning Community portal using the Healthcare Communities platform. This is a password-protected platform that NCACH is using to centralize communication and resources specific to the regional Medicaid Transformation projects.
  - o   NCACH is contracted with consultants from Foundation for Healthy Generations, Pathways Community HUB Institute, and Care Coordination Systems (CCS) to provide technical assistance and consultation during the pre-launch phase of Pathways Community HUB planning. NCACH expects this

contracted relationship to continue post-launch, though this contract has not yet been established.

- o NCACH is in the process of contracting with regional hospital, Confluence Health, to provide onsite training of Transitional Care Management nurses prior to program implementation, monthly TA sessions to review progress, and onsite visits of each organization to evaluate implementation progress.

- o NCACH works with Collective Medical Technologies (CMT) to help Emergency Departments integrate the EDie into their electronic medical records. This will involve training staff on integrating EDie utilization into their department's workflow. NCACH will also work with CMT to expand the number of outpatient clinics using PreManage effectively.

- o NCACH partners with the North Central Emergency Care Council (NCECC), a regional non-profit corporation focused on working with the state and regional healthcare partners to ensure the continuation of Emergency medical Services and trauma care in Community,   o provide clinical documentation training, patient care record training, and protocol development to enhance data collection and consistency across all Emergency Medical Services (EMS) transport partners.

- *How is training and/or technical assistance resources being delivered within that timeframe?*

  - o NCACH initiated a Change Plan Learning and Action Network in May 2018 with the goal of helping primary care and behavioral health organizations in the WPCC Learning Community develop a plan that captures their vision and transformation tactics.

  - o Two concurrent Learning and Action Networks (LANs) will be offered in Oct-Dec of 2018 that cover the essential tasks involved in setting up a successful integrated care program:

    - *Integrating Primary Care into a Behavioral Health Settings* – This LAN will detail essential tasks involved in setting up an integrated care program that successfully monitors physical health outcomes in a behavioral health setting. It will include an initial orientation call with each organization, a series of five webinars, and one coaching call with each organization. Each webinar will be followed by structured activities reinforcing the learning of the essential tasks. The pace of the training series will be relatively brisk to help maintain focus on these forward-looking tasks amid the pressures of everyday work. LAN faculty will facilitate the sharing of progress and solutions across the behavioral health agencies in the region.

    - *Foundations of Behavioral Health Integration (BHI) into Primary Care* - This LAN is geared toward primary care teams beginning their journey to integrate behavioral health services or who need assistance in

implementing foundational elements of integration. These sessions will incorporate concepts that are essential in a value-based care environment. Each participating team will be asked to choose one segment of its patient population and one evidence-based practice to focus on as its "BHI Project". The teams will then utilize the skills from each session to advance the planning for their selected BHI Projects.

- o Additional learning activities are scheduled for 2019; some will introduce new concepts and others will build off of foundational LANs offered previously (i.e. *Integrating Primary Care into a Behavioral Health Settings*). In the next year we expect to offer the following learning activities:
  - Empanelment Sprint (3 months) - Confirmed
  - Cardiovascular Sprint (4 months) - Confirmed
  - Chronic Pain and Opioid Prescribing ECHO (12 months) - Tentative
  - Behavioral Health Access LAN (3 months) - Tentative
  - Primary Care Access LAN (3 months) - Tentative
  - Population Health Breakthrough Series (9 months) - Tentative
  - Team care Sprint (2 months) - Tentative

- o Three coaches provided support based on providers' initial pass/fail change plans, with a focus on identifying opportunities for improvement and fine-tuning measures and targets.

- o Two Foundations of Motivational Interviewing Workshops were offered: one in August and one in September. Due to substantial community-wide interest, NCACH intends to offer these workshops throughout 2019 by building local capacity through a train-the-trainer model.

- o A pair of Introduction to Quality Improvement Workshops are being offered this fall: one in September and one in October. The Introduction to Quality Improvement workshop is highly interactive and introduces the fundamentals of quality improvement (QI) for participants in the Whole Person Care Collaborative. Quality Improvement trainings are based on the Institute for Healthcare Improvement (IHI) model for improvement, a simple and practical model offering health care practices a consistent framework, common language, and structured approach to process improvement.

- o Additional workshops will be offered in 2019 that offer advanced skill-building opportunities and capitalize on foundational workshops (e.g. Motivational Interviewing Intermediate, a Motivational Interviewing train-the trainer track, and Intermediate Quality Improvement).

- o Initial training for Transitional Care Management Nurses will occur onsite at Confluence Health during the initial months of the timeframe. Monthly meetings will occur via webinar to provide ongoing training and support

throughout DY3, and site visits will occur at each hospital organization from DY3 Q2 – DY3 Q3

- EDie training will occur both in a web-interface session for basic group trainings and directly to the organization (via web or in person) to address specific organizational needs. Training schedule will be set by DY2 Q4.

- Certified documentation and patient care record trainings, as well as protocol development, will occur with EMS partners throughout 2019. These efforts will be led by the North Central Emergency Care Council.

- NCACH is providing support and technical assistance to the Pathways Community HUB lead agency in following ways:
  - Project management support
  - Participation in weekly consultant calls on the Pathways Community HUB development
  - Participation in weekly HUB staff huddles
  - Support in key milestones (e.g. development of 5 year HUB budget projections)

- NCACH partners have participated in Pathways Community HUB Community Health Worker trainings offered by: Foundation for Healthy Generations, Care Coordination Systems, and Pathways Community HUB Institute. Six Pathways Community HUB staff and supervisors completed the HUB Managers and Supervisors training; three care coordinators are in the process of completing the Pathways Community HUB Community Health Worker training. NCACH, which provides funding for travel and accommodations when necessary, will support additional training opportunities in the future.

- *How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?*
  - The NCACH has engaged all 17 primary care and outpatient behavioral health providers who have a minimum of 300 Medicaid encounters annually. We recognize that each provider will have unique capacity to implement Transformation efforts as well as unique barriers that will need to be addressed. NCACH staff are currently developing a coaching network to provide short and long-term support for providers on process improvements, practice transformation, and sustainability. Coaches will be available to all providers, but particularly for smaller providers with limited capacity that require additional assistance in practice transformation.

  - NCACH developed a funding framework for the Whole Person Care Collaborative that consists of base funding as well as funding incentives for active participation in learning activities. Base funding is determined by rankings based on the number of Medicaid encounters annually; incentive funding is scaled based on the number of learning activities in which an

organization participates. The latter funding enables smaller providers the opportunity to engage in more transformation activities geared toward capacity building that may otherwise be cost-prohibitive.

- o Several of NCACH's smaller WPCC providers do not have the organizational capacity to join learning and action networks, and/or are not as experienced in change management. NCACH WPCC staff have scheduled individuals meetings with these organizations to review their specific change plans in order to assess for adequacy. These meetings will also result in recommendations for internal process improvement efforts as part of the Transformation Project. In some instances, NCACH staff are meeting individually with key staff members to help them learn more about the goals of the Transformation project and the details of the WPCC change plan as well as provide tailored guidance on next steps.

- o Specific to Fully Integrated Managed Care (FIMC), NCACH identified and worked with providers who did not have IT capacity or managed care contracting experience. NCACH contracted with Xpio Health (IT consultant) and Feldesman Tucker Leifer Fidell LLP (contracting consultant) to help behavioral health providers prepare their IT systems and contracts to be successful through FIMC. These services provided key resources that were not normally available to these providers due to cost.

- o NCACH developed a Rapid Cycle Opioid Application to engage community-based organizations in the Transformation work. This application was specifically developed with the support of the Opioid Workgroup to be accessible to community-based agencies with less capacity. The application called for organizations to apply for up to $10,000 to implement "shovel-ready" opioid initiatives over a 6-month time period.

- *What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)?*

NCACH has worked with other ACHs across the state to reduce the administrative burden of providers in the following ways:

- o To support collaboration statewide, NCACH has participated in multiple executive director and staff meetings to discuss the current progress of ACH contracts with Pathways Community HUB vendors, including the Care Coordination Systems) platform, and program evaluation options for the Pathways Community HUB statewide. These key strategic meetings will ensure providers operating in multiple ACH regions will interact with a similar platform and process no matter which ACH implements the model. Pathways Community HUB is a standardized model that minimizes cross-ACH variation.

- o NCACH's Pathways Community HUB lead agency, Community Choice, dba, Action Health Partners, also operates in the Better Health Together (BHT)

region. This is beneficial because their director has maintained a strong working relationship with both ACHs and is therefore able to align the regions' approaches to the Pathways Community HUB and the current Health Homes programs. NCACH and Community Choice intend to continue to fully participate in cross-ACH Pathway HUB calls and in-person meetings.

o NCACH has been a mid-adopter in three of four counties (Chelan, Douglas, and Grant) and has collaborated with ACHs that are in the process of moving toward FIMC. NCACH held individual calls with these ACHs, a majority of which have elected to implement the process that NCACH developed and used in 2018.

o NCACH holds monthly FIMC calls with Better Health Together (BHT) on Integrated Managed Care activities to ensure a smooth transition for Okanogan County which is changing from the Spokane BHO to the North Central ACH as of January 1, 2019.

NCACH encourages providers (including those that cross ACH boundaries) to focus on their local priorities as they advance the goals of the Medicaid Transformation and has focused on a number of processes in our region to reduce the administrative burden on our providers. These include:

o NCACH staff and consultants developed a comprehensive change plan template for participating providers to outline their practice transformation road map. This structured and actionable tool includes measures, drivers and tactics that will help providers accomplish aims across all of the projects in our portfolio. This allowed providers to focus on *how* they want to implement practice transformation rather than spending time trying to understand various approaches and writing lengthy narratives.

o NCACH is facilitating and planning training opportunities for partnering providers, which minimized the need for providers to coordinate their own training activities.

o NCACH's contracts with Xpio Health and Feldesman Tucker Leifer Fidell LLP help behavioral health providers prepare their IT systems and contracts, rather than transferring funds to each provider and then requiring them to contract independently with the consultants. Similarly, NCACH is contracting a coaching network for providers, rather than asking each provider to contract with a coach.

o To provide a single point of contact for partners, NCACH manages all MOUs with one staff member. Payments are all submitted through the Washington State Financial Executor portal with a NCACH staff lead ensuring that any partner issues with payments are addressed by the Financial Executor in a timely manner. To ensure confusion does not occur when payments are made,

NCACH notifies each organization when to expect a payment and the reason for that payment.

- o All expected deliverables are clearly stated in an MOU between NCACH and the partner. Each project utilizes a similar MOU template to ensure partners have consistency across contracted work notwithstanding the variability of deliverables across projects.

- *How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?*
  - o The NCACH region includes a small number of participating providers that have multiple sites in different ACHs; no large health systems cross over into any other ACH boundaries. NCACH encourages providers (including those that cross ACH boundaries) to focus on their local priorities as they advance the goals of the Medicaid Transformation. The processes NCACH is developing in the region may be distinct (for example the change plan process), but partnering providers are able to leverage this process at any of their sites in other ACH regions. NCACH has made it clear that it does not expect sites outside of NCACH to engage in these specific processes unless partners decide they will add value to their organization.
  - o To ensure each ACH is aware of partner engagement strategies, NCACH is sharing updates at biweekly ACH leads calls as well as weekly and monthly executive director meetings. NCACH also shared the change plan template for outpatient providers and its corresponding portal (Healthcare Communities) with the other ACHs. Several ACHs have adopted or are considering adopting this portal, which would allow providers who cross ACHs to utilize one system to report their progress on Transformation Projects. NCACH staff recently met with BHT staff to discuss overlap and differences in our partner engagement and change plan strategies. As we continue these efforts to coordinate with other ACHs, we plan on inviting GCACH staff to join future discussions, given that our 3 collective ACHs cover the entire Eastern Washington (where some of our partners cross ACH boundaries.)
  - o NCACH collaborates across ACHs to find alignment in Domain 1 initiatives for all partnering providers. NCACH participated in the Statewide Shared Domain 1 Investment meetings that included other ACHs, Association of Public Hospital Districts, and the University of Washington. These meetings focused on identifying key efforts each region is willing to collaborate on to better achieve the goals of the Transformation Project statewide. NCACH expects to be part of these efforts moving forward, which include:
    - ▪ Addressing scope-of-practice, financing, and regulatory barriers to provide whole person care in mental health and physical health care settings.

- Identifying and participating in common training opportunities such as trauma-informed care, health equity, and historical trauma.
- Identifying a shared definition of team-based care and using this definition to influence state level actions that support team-based care (e.g. Medicaid-MCO contracts and RFPs/grants to communities).
- Supporting the development of a state-level Community Health Worker (CHW) association and statewide training programs for CHWs by CHWs.
- Supporting expanded site of service and scope of practice requirements for telehealth.

o NCACH participates in a five-ACH collaborative managed by the Center for Evidence-based Policy at Oregon Health & Science University (OHSU). The OHSU team convenes regular calls and in-person meetings with the participating ACHs. Agendas are developed collectively. The focus of the collaborative is identifying and sharing best practices, pooling resources, providing mutual feedback, developing cooperative strategies, and coordinating efforts wherever possible. Activities have included:
- Joint engagement with vendors to pursue economies of scale and increase effectiveness or impact through coordination.
- A report and crosswalk that distill the funds flow and financial management approaches adopted by all ACHs. The information was derived from Center-led interviews with each of the nine ACHs.
- Compiling and sharing best practices. Topics have included the social determinants of health, consumer/beneficiary engagement, bidirectional integration, contracting with behavioral health providers, internal staffing, evaluation and metrics, investing in the community, and health equity.
- A planned workshop dedicated to better understanding ACH successes and challenges pertaining to stakeholder outreach and engagement, provider payments, target populations, and evaluation. This sharing of information has already been critical in informing the ACHs on best approaches for managing pace, scope, and scaling.
- A planned sustainability workgroup that will bring together the participating ACHs and their regions' Managed Care Organizations (MCO), as well as other potential payers. The goal is to coordinate how the ACHs can establish a shared pathway to future MCO payments based on the identification and performance of key, agreed-upon metrics.
- Development of a shared decision tree for vetting and responding to vendor inquiries, with the goal of coordinating between ACHs whenever there is an advantage to doing so.

Partnering Provider Management

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

ACH Response

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

- *What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?*

NCACH will have signed MOUs with all of its funded partners by the end of 2018 and expects partnering providers that participate in the projects to complete the following general requirements across all projects:

- o Submit data to NCACH that can be used in reporting progress updates to the HCA.

- o Submit data to NCACH that can be utilized in monitoring and tracking progress on selected initiatives.

- o Communicate with partnering providers on how the organization is doing with the implementation of strategies and approaches in a collaborative venue (conference calls, meetings, events) to ensure the ability to spread best practices to all providers.

- o Sign an MOU or contract that outlines the specific requirements the organization needs to achieve based on the project(s) they are completing under Medicaid Transformation. These MOUs contain variable deliverables based on project-specific work. For example, the initial MOU for the WPCC Learning Community partners included the need to complete an initial clinical assessment and to develop a change plan. The Pathways HUB MOU outlined the deliverables that NCACH's lead agency needed to complete for a successful HUB launch.

- o Demonstrate how the work they are completing assists in connecting patients to social service partners in the region that help address social determinants of health.

As partners in each sector engage in specific projects, NCACH defines general guidelines based on the selected evidence-based approaches chosen. Partners are expected to stay within those guidelines to achieve the overall goals of the approach, but each organization is allowed a level of flexibility, so they are able to tailor a specific approach to fit the needs of their organization and local community. All partnering providers understand the goals of the NCACH and are committed to moving toward these goals as a region.

- *What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?*
    - WPCC Learning Community members
        - Change status for drivers (Not Started, Planning, Testing, Limited Implementation, Spread, Fully Implemented, Fully Implemented But With Gaps)
        - Measure reporting (measures dependent on process and outcome measures selected by each organization in their change plans). These measures will be captured via our web-based portal. The CSI Lumen system, which is part of our portal, is designed to accept entry of numerators and denominators for measures that a practice wants to improve. The system calculates the actual measure based on the numerator and denominator and then allows the practice to view graphs of the measure over time so that progress toward improvement can be monitored.
    - Pathways Community HUB Partner
        - Number of contracted care coordination agencies
        - Number of trained care coordinators
        - Budgeted vs. actual revenues and expenses
        - Number of payers secured
        - Metrics reported monthly from the Pathways HUB Care Coordination Systems platform. There are close to 100 metrics developed into this data repository, associated with global demographics, visits and contacts, pregnancy metrics, completed and incomplete pathways, and screening metrics.
    - Transitional Care and Diversion Interventions Partners
        - Transitional Care:
            - Training of Transitional Care Management Nurses completed
            - Model implemented by organization with patient encounter under established model
            - Participation in monthly trainings documented
            - Improvement in quality metrics from baseline
            - Participating providers will report on additional components of the model that were included in initial application and have been implemented during semi-annual reporting.
        - Emergency Department Diversion
            - EDie training completed by staff members (if applicable)

- Process improvements implemented (e.g. referral of patients directly to primary care clinic, education of patient in ED on appropriate level of care for health needs, etc.)
- Improvement in quality metrics from baseline
- Participating providers will report on additional components of the model that were included in the initial application and have been implemented during semi-annual reporting.
- Policy and procedures implemented in organization
- Participation in monthly meetings documented

- o Regional Opioid Workgroup Partners
    - Since implementation of funded partner project in the Opioid Project varies widely, a flexible template will be provided to partners to report on implementation progress and outcomes. The report will include:
        - Description of how funds were utilized
        - Milestones achieved
        - Barriers and challenges encountered
        - Lessons learned
        - Successes
        - Identified best practices
        - Report of project specific metric outcomes
        - Site Specific questions for both Clinical and Community Based Organization providers based on proposed project

- *What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?*
    - o WPCC Learning Community members
        - WPCC Learning Community providers will submit quarterly quantitative and qualitative reports that mirror their change plan drivers and tactics. These progress reports will hold providers accountable to reporting their current change status on specific drivers, articulating broader successes and challenges and also submitting process and outcome measure data. This information will be complemented by information gleaned from our coaching network and annual site visits. These various progress indicators will help us understand where providers need additional supports, while also highlighting successes that can be shared across the network to accelerate change.
    - o Pathways Community HUB Partner
        - The Pathways Community HUB lead agency, Community Choice, will be required to submit monthly reports with the metrics identified above.
        - NCACH staff are closely monitoring the planning and implementation of the Pathways Community HUB.

- Pathways Community HUB staff must provide verbal and written monthly report to the NCACH Governing Board.
- Community Choice will continue to convene the Pathways Community HUB Advisory Board that will monitor the Pathways Community HUB progress and provide guidance.
  - o Transitional Care and Diversion Interventions Partners
    - Acute Care providers engaged in Transitional Care Management Programs and ED Diversion Programs will be required to submit Semi-Annual reports that outline their progress towards implementation measures outlined in their applications and quality metrics. These reports will be submitted to NCACH, evaluated, and shared back with partnering providers.
    - ED Diversion staff and Transitional Care management staff will have monthly meetings of partners to share best practice processes and opportunities for improvement. These meetings will include subjective assessments of partner progress, and NCACH staff will follow up with organizations if they identify obstacles to successful project implementation.
    - Transitional Care Management will conduct site visits in DY3 Q2 – Q4 to evaluate how implementation is progressing at each clinic.
  - o Regional Opioid Workgroup Partners
    - Funded partners through the Opioid Project must:
      - Provide one verbal report (approximately 20 minutes) to the NCACH Regional Opioid Stakeholders Workgroup.
      - Provide one verbal report (10-20 minutes) during a partner meeting. A partner meeting is any gathering of partners that includes information sharing.
      - Submit interim and final written reports (template provided by NCACH) outlining activities completed during the implementation period (typically semi-annually or at the end of the 6 month project period).

- *How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?*
  - o NCACH views its role as a coordinator, facilitator, and capacity builder to promote the success of our funded providers. When faced with delays and/or barriers, NCACH will schedule individuals meetings with organizations to discuss challenges and provide recommendations on process improvement efforts the organization can complete as part of the Transformation Project. NCACH will strive to provide tailored guidance on next steps, as well as helpful resources. If a change in timeline does not affect reporting requirements or the implementation of projects across NCACH's portfolio, NCACH will work

with the partner to re-evaluate and adjust the timeline, update MOUs if needed, and ensure completion under the new timeline. If additional technical assistance is needed, NCACH will work with partners to identify consultants or resources that can meet their needs, while also determining whether these could benefit other organizations participating in the project (to take advantage of economies of scale). If a change in timelines does affect project implementation and reporting requirements, NCACH will communicate with both HCA and partners to identify a workable solution.

Alignment with Other Programs

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

ACH Response

NCACH has taken a regional project management approach. This means that the work that all partners complete through the Transformation Project rolls up to a regional workgroup and/or learning community to align with the selected priorities of the region. Those priorities were selected after workgroups reviewed current state assessments of partners and the availability of statewide resources to support implementation. NCACH staff continue to participate in statewide meetings for each project. To facilitate plan adjustment, staff regularly update workgroup partners about the work occurring at the state level. Each partner participating in a project is required to report regularly to the workgroups/NCACH staff to ensure that each project is proceeding in alignment with regional priorities. The specific details of each project are below:

Project 2A

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?*
  - o NCACH has coordinated with the Practice Transformation Support Hub and Qualis since early 2017 around the statewide practice transformation efforts. In addition to periodic check-ins with DOH and Qualis staff, NCACH's WPCC Director has been participating in the monthly Clinical Transformation calls hosted by DOH to promote collaboration and alignment among ACHs on practice transformation. We also reached out to the UW AIMS Center and the Washington Council for Behavioral Health to provide input into the development of the bi-directional integration section of our change plan. We continue to work with the UW AIMS Center and have engaged them as faculty and coaches for one of our bi-directional integration Learning and Action Networks. Coordinating with these statewide entities facilitates alignment and avoids duplication of efforts.

Project 3A

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

  o As a rural region that has been moderately affected by the opioid epidemic, few state efforts are focused in our service area. NCACH is working with other ACHs, the Health Care Authority, WA Department of Health, and USDA to ensure our programs are not duplicative of other efforts. As other state-led efforts are identified, NCACH will coordinate with the responsible entities. For example, NCACH recently held a call with staff at the USDA to discuss their plans to facilitate a state-wide opioid round table. NCACH had heard of this effort and wanted to ensure it would not compete with or duplicate the ACH's planned regional opioid response conferences next year.

  o NCACH continues to participate in weekly cross-ACH/Tribal Opioid Project calls to monitor work that is being done statewide and in other regions.

  o NCACH staff will review WA State Interagency Opioid Working Plan annually and incorporate any changes into our project implementation plan.

For ACHs implementing Project 2B

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

  o The First Steps Maternity Support Services program is currently only being offered in one of our four counties (Grant). It is administered by two of our partnering providers: Columbia Basin Health Association and Moses Lake Community Health Center. NCACH intends to pilot the Pathways Community HUB in Moses Lake starting in October 2018. Moses Lake Community Health Center has been identified as one of the initial Care Coordination Agencies and also is represented on the Pathways Community HUB Advisory Board. Through those two venues, the Pathways Community HUB will coordinate Pathways services and First Steps Maternity Support Service Program.

  o NCACH is unique among ACHs in that its Pathways Community HUB lead agency is also a lead organization for Health Homes. This puts Community Choice in a good position to identify clients who have been referred to the HUB that are Health Homes eligible. Those clients will first be referred to the Health Homes lead agency for engagement. They will be eligible for Pathways services only if they opt out or if the lead agency is unable to contact them. NCAHC has been intentional in trying to identify a target population that is at risk but that does not duplicate the Health Homes target population.

- *What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?*
  - *Home Visiting Planning for Chelan-Douglas Counties:* Chelan Douglas Health District (CDHD) and Catholic Charities have been working with THRIVE Washington for grant planning support. CDHD is planning to apply for Department of Children, Youth, and Families start-up funding to bring Nurse Family Partnership (nurse-based care coordination) to Chelan County. Catholic Charities is applying for Department of Children, Youth, and Families expansion funding for the Parents As Teachers (non-nurse based care coordination) program expansion into Douglas County. NCACH and Pathways Community HUB staff have been collaborative partners in the move to align evidence-based programming and target populations to ensure collaboration and avoid duplication of services to families in these counties.
  - *Home Visiting Planning for BHT region:* NCACH and Pathways Community HUB staff are meeting with BHT and Early Learning partners in the BHT region to discuss the Fall 2017 Home Visiting Scan and possible Governor's plans to offer voluntary home visiting to all families, which will likely include Medicaid provisions. These early discussions have identified Parents as Teachers program delivered out of Children's Home Society in the BHT region. NCACH and Pathways Community HUB are participating due to the potential sharing of transient clients across ACH boundary borders.
  - *Communities is Schools-Washington:* Communities in Schools (CIS) policy staff offered early support for Community Choice's effort to secure the contract to be the Pathways Community HUB lead agency. Eastmont School District piloted CIS during the 2017 school year in three schools, and there are plans for expansion in that school district. Community Choice is working through the Coalition for Children and Families NCW Board to engage in further conversation for collaboration with CIS and Pathways Community HUB after the HUB is launched.
  - *Community Care Coordination Environmental Scan:* This scan is an ongoing process. The results will support prioritization of presentations about the HUB and also serve as an inventory of existing care coordination services in the region. Preliminary results show:
    - 71% of respondents (person/agency) indicate they provide community care coordination services.
    - 58% of respondents (person/agency) indicate the services are delivered to families.
    - Only 21% of these services are delivered by nurses, most are social workers or CHW/peers.
    - 45% of respondents indicate that they have no reporting requirements for services delivered.

- *Frontiers of Innovation hosted Shared Community Inventory meetings:* NCAHC and Pathways Community HUB have been participating in statewide Shared Community Inventory stakeholder meetings.

- *WA211:* The Pathways Community HUB lead agency has been working collaboratively with WA211 and the Greater Columbia Call Center for the past four years through the 1422 Grant (WSDOH/CDC). The early collaboration has worked to increase the social services asset inventory in the region through outreach and education to social service providers. The Pathways Community HUB has proactively worked with WA211 on website improvements and most recently presented at the annual WA211 call center retreat to raise awareness of the local and statewide work with Pathways Community HUBs.

- *Choosing Health Together:* Community Choice is a community partner in the Washington State Network learning collaborative funded through the National Council on Aging (NCOA) and coordinated through Aging and Long Term Support Administration (ALTSA) in Washington State. The goal of this 11-month collaborative is to bring community-based organizations (CBOs) together into a network that,

  > "utilizes a centralized, coordinated model for service provision by incorporating uniform logistical practices for recruitment, referral, enrollment, marketing, quality assurance, and evaluation. This process is carried out under the direction of the hub's central organization and is coordinated among the collective service delivery network. It provides a unified and consistent approach to program delivery across a geographic area, either regional or statewide. The central organization is the center of activity that connects a network of partners, including health care systems and local community organizations who offer evidence-based programs, all working together toward a common goal."

- *How is the ACH's approach aligned with MCO care coordination contract requirements?*
  - HCA is not requiring MCOs to participate in the Pathways HUB but has advised them to think of it in terms of what potential value an MCO might receive from participation. MCOs are advised to think about if they would obtain value from Pathways and opt to support the Pathways HUB if it makes business sense.. NCACH is focused on making a business case to all potential payers, including MCOs, for the use of Pathways HUB services.

For ACHs implementing Project 2C

- *How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?*

o The Transitional Care Management (TCM) program provides a bridge between inpatient discharge and outpatient services such as Health Homes or clinical case management. Once the patient is discharged, the TCM nurse completes a phone call to ensure the patient understood their discharge instructions and evaluates their needs to ensure that the patient is connected with appropriate services. The TCM nurse does not provide in-home follow-up care such as what is provided by Health Homes or the Pathways Hub. However, the nurse may identify clients eligible for those services to ensure that they receive the appropriate referral for follow-up care.

- *What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?*
  - o Health Homes and Pathways Hub Models
  - o Utilization of EDie and PreManage in information sharing
  - o Support for State efforts on Health Information Exchange practices
  - o Formation of the North Central Community Partnership for Transition Solutions
  - o Washington State ER is for Emergencies Seven Best Practices Committee

For ACHs implementing Project 2D

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)*
  - o NCACH has chosen to have partners implement projects that support two of the seven ER Is for Emergencies Seven Best Practices. Those two best practices include (1) patient education of appropriate use of medical care and (2) addressing frequent ER users. Partners are submitting detailed plans on how they will achieve work by DY2 Q3. To enhance communication between inpatient and outpatient providers, Emergency Department partners will also have the option to work with a vendor to enhance utilization of the Emergency Department Information Exchange (EDie) system through direct integration into their EMR and by training staff to utilize EDie in their patient workflow.
  - o Outside of the assigned ED Diversion Strategy tactic, NCACH is working with EMS partners to align regional Treat and Release programs with Washington state legislation (House Bill 1358). Currently the Health Care Authority is developing reimbursement models for programs that focus on this legislation and are defining what "Treat and Release" would look like. NCACH will work with the North Central Emergency Care Council over the next six months to stay connected with the statewide workgroup as the model is developed and ensure that we align with its provisions.

For ACHs implementing Project 3D

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?*
  - o NCACH has coordinated with the Practice Transformation Support Hub and Qualis since early 2017 around statewide practice transformation efforts. In February 2018, we participated in a regional meeting organized by Qualis to discuss Chronic Disease Self-Management Education (CDSME) programs offered in our region with a specific focus on sustainability. We also coordinated with DOH's TCPI program by engaging our local P-TCPI practice coach in our Whole Person Care Collaborative (WPCC) and some learning activities. In addition to periodic check-ins with DOH and Qualis staff, NCACH's WPCC Director has been participating in the monthly Clinical Transformation calls hosted by DOH to promote collaboration and alignment among ACHs on practice transformation.

Regional Readiness for Transition to Value-based Care

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

ACH Response

- *Explain how the region is advancing Value-based Care objectives.*
  - o In DY2, North Central has primarily focused on setting up the practice transformation efforts that will prepare partners for sustainable value based contracting. This has included setting up a learning community for providers, enhancing care coordination programs (i.e. transitional care management and Pathways Hub), assessing the current state of our outpatient providers regarding bi-directional integration and patient centered medical home, and working with acute providers to enhance strategies to reduce ED utilization. DY2 has been a planning phase that will move into actionable steps in DY3. As the region implements practice transformation efforts, it will also provide direct support to providers to assist them in better understanding what value based contracting/care means. Data collected in DY2 Q3 from NCACH specific surveys and the HCA VBP survey will help determine specific action items our region can implement as we move into DY3.

- *What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.*
  - o #1. NCACH is promoting Patient Centered Medical Home (PCMH) concepts through its learning activities and coaching which support success under a value based purchasing environment. Not all providers are seeking PCMH

certification, but foundational elements have been incorporated into the change plan template and learning activities offered to our WPCC Learning Community. For example, we are offering workshops on quality improvement. As of October 2018, we are leveraging our monthly WPCC meetings to shift the dialogue towards the role of WPCC leaders in accelerating improvement and sharing what is working and what is not. We will also be offering a 3-month empanelment sprint (Nov '18 - Jan '19). Empanelment is the assigning of individual patients to individual primary care providers (PCP) and care teams and is the basis for population health management.

- o #2. Partners will complete a VBP survey, the results of which indicate what NCACH can do to support partners at different points on the VBP continuum. Evaluation of the VBP survey results will lead to more direct training on VBP in DY3.

- o #3. To better manage the health of patients who are high-utilizers of acute services, partners will leverage increased health information exchange through the utilization of EDie, PreManage, and Care Coordination Systems (Pathways Hub) to provide more responsive care coordination.

- *What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?*
  - o NCACH is defining provider/practice champions in two formats, each with a specific goal:
    - **Regional Provider/Practice Champions**, drawn from a coaching network and other vendors/consultants, provide resources for our partner leads.
      - The Center for Collaboration Motivation and Innovation (CCMI) – Assistance in establishing a regional Learning Community to ensure partners can come together to learn and share successes as we move along the continuum
      - Confluence Health – Establishing a training program and learning sessions to assist partners in developing sustainable processes for transitional care management and establishing how to bill those services.
    - **Organizational Practice/Provider Champions** are organization-specific leads that are facilitating change within their organization and driving alignment with value-based goals.
      - The Whole Person Care Collaborative has established teams in each organization that will facilitate change within their department and across the organization. Those practice champions will take the lessons learned at the regional level and

work with their teams to implement change within their organizations.

Explain how the region is advancing HIT/HIE objectives.

ACH Response

Responses must cover the following:

- *What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples.*

    o #1. NCACH is actively working with Collective Medical Technologies staff to craft a strategy for increasing adoption and optimization of PreManage in outpatient settings and EDie in acute settings. We have had three meetings with CMT staff to date and plan to reach out to MCOs, as they are the ones who can sponsor PreManage platforms for outpatient providers. Helping outpatient providers use PreManage through technical assistance and training will facilitate information exchange at the point of care specific to patients who are utilizing acute care (i.e. hospitalization and ED). Helping inpatient providers optimize EDie through technical assistance and training will promote more robust and consistent data entry. These tools are an important facet of HIE because both outpatient and inpatient settings need to coordinate around shared incentives to reduce readmissions. In addition, this will support better MTP P4P metrics associated with follow-up care after hospital and ED discharge.

    o #2. NCACH continues to explore the functionalities of the Pathways HUB Connect platform developed by Care Coordination Systems (CCS). The platform allows for electronic referrals to the Pathways HUB from hospitals, outpatient clinics, and other organizations. It also allows for updates on a patient/client's progress in care coordination from the HUB. In addition to being the primary repository for the collection of Pathways and HUB information, the Pathways HUB Connect platform offers the Health Bridge interface, which connects with the Washington State 211 database. This includes a public-facing website for community-based organizations and providers to facilitate referrals associated with the social determinants of health.

    o #3. Promoting use of the Prescription Monitoring Program (PMP) through our opioid learning activity in 2019. The PMP is an important tool to achieve the goals of NCACH's opioid project. Most EHRs in use by NCACH's healthcare providers do not connect/integrate with the PMP (only two do). Many providers indicated that their clinicians are registered with the PMP, but it is

not clear how many of them are using it effectively within their workflows. The greatest deterrents to using the PMP include difficulty accessing the system and the lack of EHR interoperability. A majority of providers indicated interest in NCACH providing assistance on better use of the PMP system, and NCACH will need to understand this interface better in order to advocate for the system to be more user-friendly.

- *How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?*
    - o NCACH staff are engaging in resources and activities offered by the Health Care Authority (HCA), including participating in the HIT technical assistance sessions hosted by HCA (which will now be folded into the weekly technical assistance calls). With regard to PreManage, we plan to coordinate with several other ACHs that are pursuing this strategy, which would strengthen the network of providers using the system. This would ideally complement the existing statewide information exchange that has been built through EDie (for hospital providers). We are also coordinating with other ACHs around the use of 211 for purposes of addressing social determinants of health. As specific needs and action steps become clearer, NCACH staff can propose HIT/HIE investments that could be funded through a portion of unallocated funds currently in our budget in order to advance health information exchange with tools that have a statewide reach.

Technical Assistance Resources and Support

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

ACH Response
Response should cover the following: - *What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?*   - o HCA staff gave a presentation at an ACH/HCA convening at the end of January 2018, with Emily Transue providing examples of how MCOs and ACHs might play complementary roles on VBP. These types of resources, with concrete examples and actionable guidance, are always appreciated, especially regarding Domain 1 areas. If NCACH is expected to focus on collective approaches to develop and reinforce statewide strategies and capacity, it needs a better understanding of those statewide strategies. Without a clear roadmap from the state, ACHs are left to devise their own solutions.

- HCA staff, specifically Isabel Jones, Alice Lind, and Jessica Diaz, have helped with our transition to Integrated Managed Care. They are responsive, helpful in coordination efforts, and very knowledgeable.

- NCACH has received support from the Alcohol and Drug Abuse Institute at the University of Washington to train staff to be trainers of Narcan administration and provide educational materials for consumers.

- NCACH has contracted with the Center for Evidence Based Policy through Oregon Health and Science University (OHSU). OHSU has provided technical assistance in partner engagement, application development, strategic planning, and evaluation of partner plans. In addition to the direct services provided to NCACH, they have also contracted with five ACHs (North Sound Accountable Community of Health, Olympic Community of Health, Cascade Pacific Action Alliance, Greater Columbia Accountable Community of Health, North Central Accountable Community of Health) to share best practices, build alignment, and pursue economies of scale.

- The Practice Transformation Hub and its partners at Qualis have offered valuable support to some of our outpatient clinics, as well as to NCACH staff. For example, a recent webinar on consent management increased our understanding of barriers to sharing SUD information while also offering solutions that we might be able to share with our network of outpatient providers. We know they would have a lot to offer around coding optimization, which is an important aspect of value based purchasing, and look forward to the technical assistance they will provide around collaborative care codes.

- *What technical assistance or resources does the ACH require from HCA and other state agencies?*
  - Funding for continued and expanded Opioid work
  - Better information sharing on statewide efforts and state agency work
  - HCA guidance on the ACHs' role in moving toward whole person care and Value-Based Payment (VBP) including a fuller understanding of ACH role in supporting VBP contracts between HCA, MCOs and provider organizations
  - Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) in relation to VBP, rural multi-payer models, how they should get prepared
  - Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration (i.e., Department of Health's (DOH) PTSH is coordinating with the University of Washington's Advancing Integrated Mental Health Solutions Center to provide guidance on collaborative care codes)
  - Support at the state level for expanding the scope of practice for current providers and allowing for reimbursement on additional billing codes.

- o Take leadership role on regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2); these laws prevent some of the ideals of healthcare reform and health information exchange from happening
- o Stronger collaboration with HCA and Managed Care Organizations (MCOs), to avoid triangulation of issues that are within the HCA-MCO contractor realm
- o Guidance from HCA regarding statewide investments in HIE/HIT that the ACHs may leverage to support Medicaid transformation. For example, streamlining the process for BHA participation in OneHealthPort's (OHP) Clinical Data Repository (CDR) and other systems.
- o Guidance on how to best work with tribal partners in region
- o Strong partnerships with Washington State Hospital Association
- *What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?*
  - o Pathways Community HUB; in particular payer contracting
  - o Funds Flow planning for allocating pay for performance incentive payments between clinical providers (attribution) and community-based organizations (unknown methodology).
  - o Sustainability planning for projects, including support for partners in achieving the goals of the state's value based payment continuum.
  - o Aligning work with other non-Medicaid payer sources.
  - o Including Health Equity into the work plan of partners
  - o Meaningful consumer engagement
  - o Asset mapping and closed-loop referral system