



# Healthier Washington Medicaid Transformation

# Mid-point Assessment of Accountable Communities of Health

January 6, 2019  
Initial report – for public comment

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## Executive Summary

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor (IA) for the State's Healthier Washington Medicaid Transformation Project (MTP), Section 1115 Medicaid waiver. As part of this engagement, the IA conducted a mid-point assessment of progress for each of the nine Accountable Communities of Health (ACHs). ACHs are regionally situated, self-governing multi-sector organizations focused on improving health and transforming care delivery for the populations that live within their region. Each ACH is implementing selected projects inclusive of evidence-based strategies that address health systems capacity building, care delivery redesign, and prevention and health promotion.

The mid-point assessment (MPA) is a requirement of the State's agreement with the Centers for Medicare & Medicaid Services, and included in the [special terms and conditions \(STCs\)](#). The purpose of the assessment is to 1) examine and confirm demonstrated compliance with the STCs and approved protocols, and 2) assess implementation progress to determine a recommendation for project continuation, modification, corrective action, or discontinuation. This report outlines the mid-point assessment methodology, summarizes statewide discoveries, ACH-specific evidence and findings, and documents regional experiences. For the reader's convenience, please see a listing of acronyms and glossary of terms at the end of this report.

### Section I — Introduction

#### 1. Healthier Washington Medicaid Transformation Overview

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Washington's application to implement a five-year *Medicaid Transformation* (No. 1 1-W-00304/0) through December 31, 2021. The State has the following goals for the Medicaid Transformation:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs.
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume.
- Support provider capacity to adopt new payment and care models.
- Implement population health strategies that improve health equity.
- Provide new targeted services that address the needs of the state's aging population and address key determinants of health.

HCA plans to accomplish these goals through the following three initiatives:

- Initiative 1: Transformation through Accountable Communities of Health (ACHs)
- Initiative 2: Long-term Services and Supports
- Initiative 3: Foundational Community Supports

The focus of the Independent Assessor's work and this report is on Initiative 1, Transformation through ACHs, for which an estimated \$1.1 billion of the \$1.5 billion federal waiver funds are allocated. The objectives as set forth in the STCs are as follows:

- **Health Systems and Community Capacity.** Efforts focus on creating appropriate health systems capacity to expand effective community-based treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.
- **Financial Sustainability through Participation in Value-based Payment.** Medicaid transformation efforts must contribute meaningfully to advancing the state's use of value-based payments (VBPs). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation.
- **Bi-directional Integration of Physical and Behavioral Health.** Medicaid Transformation is requiring comprehensive integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Along with directly promoting integration of care, the projects promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes, and creating integrated care delivery protocols and models. The state has provided increased incentives for regions that implemented fully integrated managed care prior to January 2020 as early, or mid-adopters.
- **Community-Based Whole-person Care.** The state has prioritized the use or enhancement of existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. In addition, Medicaid Transformation seeks to develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and promotes accountable tracking of those beneficiaries being served.
- **Improve Health Equity and Reduce Health Disparities.** Medicaid Transformation supports implementation of prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity. Projects require the full engagement of

ACH Regions Map



traditional and non-traditional providers, and project areas include: chronic disease prevention, maternal and child health, and the promotion of strategies to address the opioid epidemic.

The ACHs operate in nine separate regions and bring together health care and community leaders to focus on improving population health, achieving health equity, and addressing specific health-related issues affecting quality of life. They are self-governing multi-sector organizations with non-overlapping boundaries that align with Washington's regional service areas for Medicaid purchasing. ACHs are not new service delivery system organizations nor a replacement of Medicaid managed care organizations (MCOs). ACHs include managed care, health care delivery, and many other critical organizations as part of their multi-sector governance and as partners in implementation of delivery system reform initiatives.

With support from the State, ACHs are pursuing transformation projects focused on three domains:

- **Domain 1 — Health systems capacity building:** Workforce development; system infrastructure technology and tools; and system supports to assist providers in adopting value-based purchasing and payment.
- **Domain 2 — Care delivery redesign:** Integrated delivery of physical and behavioral health services; care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach, engagement, and recovery supports.
- **Domain 3 — Prevention and health promotion:** Prevention activities for targeted populations and regions.

Domain 1 strategies address the core health system capacities to be developed or enhanced to support the transition to Domains 2 and 3.

HCA defined a portfolio of eight Transformation projects as shown in *Table 1*. The final portfolio required that ACHs implement the baseline requirement of four projects; two required projects, and one project from Domains 2 and 3. Through the project plan selection and approval process, five ACHs are implementing the baseline number of four projects, three ACHs are implementing six projects and one ACH is implementing all eight projects.

Table 1. Medicaid Transformation: Project Plan Portfolio

Domain 2: Care Delivery Redesign	Domain 3: Prevention and Health Promotion
Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation <i>(Required)</i>	Project 3A: Addressing the Opioid Use Public Health Crisis <i>(Required)</i>
Project 2B: Community-Based Care Coordination	Project 3B: Reproductive and Maternal and Child Health
Project 2C: Transitional Care	Project 3C: Access to Oral Health Services
Project 2D: Diversions Interventions	Project 3D: Chronic Disease Prevention and Control

HCA established various milestones and project goals for which each ACH is being held accountable to receive Medicaid Transformation funds. Payments are initially available for meeting process milestones and later will transition to payment based on improvements made in outcomes. The CMS-approved Medicaid Transformation Project Toolkit (Toolkit) contains the final projects, evidence-based approaches/strategies, milestones and pay-for-performance metrics. The STCs, Toolkit and corresponding milestones formed the criteria for the mid-point assessment.

## Section II — Independent Assessment for Initiative 1: Transformation through ACHs

### 1. *Independent Assessor Role*

As part of its approval of the Washington Medicaid Transformation, CMS issued STCs that include a requirement for the HCA to contract with an IA. To maintain independence, the IA has no affiliation with the ACHs or their partnering providers. As HCA's Independent Assessor for the Healthier Washington Medicaid Transformation Initiative 1 projects, the team conducted the initial review of project plan applications, conducts on-going reviews of semi-annual reports, and conducted the MPA as reported herein.

In addition to the IA role, as a part of the Washington Medicaid Transformation project, the State is required to contract with an Independent External Evaluator (IEE). The contracted scope of work of the IEE includes evaluation activities for all three Medicaid Transformation initiatives that includes both qualitative and quantitative components. The IEE is expected to perform interim and final evaluations of the Medicaid Transformation, and provide rapid-cycle monitoring of the ACHs' project implementation for purposes of identifying when and how specific efforts did or did not achieve the expected outcomes.

### 2. *Mid-point Assessment Purpose*

In accordance with the STCs the Independent Assessor was engaged to systematically review and confirm project implementation progress and identify recommendations for improving individual Accountable Communities of Health (ACHs) and implementation of their approved Project Plans.

The purpose of the mid-point assessment, as defined by HCA and conveyed to ACHs, is as follows:

- Provide a "point in time" assessment of progress on milestones and deliverables, as agreed to in the project plans.
- Provide information to aid ACHs in correcting any midpoint difficulties and support future success.
- Provide "at-risk" project identification, guidance, and monitoring to ACHs and HCA.
- Obtain feedback from partners on whether they have received the support they need to be successful.
- Gather diverse perspectives and experiences related to the Initiative 1.



### 3. *Mid-Point Assessment Methodology*

As a part of the mid-point assessment, relevant Medicaid Transformation requirements were taken into consideration to develop the criteria for the assessment, including the STCs, the Medicaid Transformation project Toolkit and the corresponding milestones for implementation during the review period.

Based on a comprehensive document review, our methodology first determined the objectives to guide our review approach. The following two objectives were defined and approved by HCA to guide the MPA process:

- Objective 1: Demonstrate compliance with the STCs and approved protocols
- Objective 2: Assess project health to provide final recommendations of continuation, modification, corrective action or discontinuation

During this process, we took note of federal authorities described in the special terms and conditions as pertinent to Initiative 1, including STC 34 - ACH Project Plans, STC 18 - ACH Management, STC 19 - ACH Composition & Participation, STC 90 - Program Integrity, and STC 34- ACH Project Plans.

Next, our approach classified the review between regional and local efforts. These two system-levels were necessary to consider separately to properly assess implementation activities. The regional level sought to confirm activities performed relevant to the organization and administration by the ACH. The local practice and community-level sought to confirm progress of project activities, or need for additional support. As the regional convener, the ACH is responsible for managing and coordinating with partnering providers, including offering on-going operational and funding support to enable project success.

*ACH Management & Project Plan Execution.* MPA procedures were developed to examine and confirm that the ACH governance is intact, that funds distribution is occurring, and that enabling activities are in place to support successful attainment of milestones and regional improvement outcomes. These procedures applied to each ACH.

*Local Health Initiative Efforts.* MPA procedures were developed to examine and confirm that partnering providers have arrangements in place with ACHs to implement evidence-based approaches specified in the Toolkit, to receive and utilize funds in the course of implementing those approaches, and are being offered operational support by their ACH to enable project success. These procedures applied to selected ACH partnering providers actively engaged in project implementation.

Following the division of review by these two groups, we organized the review by themes related to Initiative 1. The MPA review specifically examined and confirmed demonstration of compliance and project health through procedures for the following ten components:

1. *ACH Organization Governance & Compliance* - The vision, strategy, and structure of the ACH decision-making body that guides partnering provider engagement, implementation activities, and outcomes.

2. *Distribution of Earned Incentive Funds* - The strategic use of funding and incentive distribution including decision-making policies and procedures and the dissemination of funds to partnering providers.
3. *Workforce Transformation* - The processes and efforts to hire, integrate, and deploy positions for team-based, patient-centered care to meet the needs of the redesigned system of care.
4. *Health Equity* - The ACH approach is focused on reducing and ultimately eliminating disparities in health and their determinant that adversely affect excluded or marginalized groups.
5. *Population Health Management Through Data Exchange & Usage* - The electronic transmission of healthcare related data to allow health care professionals to share medical information and to collect data for analysis and reporting to support transformation efforts.
6. *Transition to Integrated Managed Care* - Support for providers in the state-wide move to whole-person care to offer better coordinated care for patients and improved access to physical health, mental health, and substance use disorder services.
7. *Bi-directional Integration* - Addressing physical and behavioral health needs in one system through an integrated network for providers, offering better coordinated care for patients and more seamless access to the services they need.
8. *Community-Based Care Coordination* - The coordination of care across the continuum of health ensuring those patients with complex needs are connected to the interventions and services needed to improve and manage their health.
9. *Training & Technical Assistance* - The services and support provided to partnering provider to aid in project implementation.
10. *Project Implementation* - The conformity and timeliness of project execution including target population outreach to achieve project plan milestones.

In review and consultation with HCA, procedures were developed for each review component. Procedures were established to review and confirm evidence or inquire with ACHs and partnering providers about actions taken and/or progress made. Results of these procedures informed our final recommendations.

Figure 1. Mid-point Assessment Overview depicts an overview of the MPA and each aspect of our review approach.

Figure 1. Mid-point Assessment Overview



*Limitations.* Although this report does not identify partnering providers by name, robust information and insight derived from interviews, along with submitted documentation, is captured throughout the report. When direct quotes are used, they are shown with quotation marks and have been italicized.

It should be emphasized that the perspectives included in this draft report are those of the ACH and partnering providers, along with attendees of focus groups. Concerns raised were not evaluated for validity and fact finding did not occur. Recommendations were developed based on the criteria and information gathered as described in the report. State administrators were not interviewed, but have offered input during the report review process.

In addition, due to the status of implementation activities, quantitative data specific to outcomes, has not yet been collected. During October – November DY 4 2020, the IA will (1) score pay-for-performance (P4P) achievement values (AV) that will be used to determine earned P4P project incentives; and (2) calculate ACH quality improvement to determine eligibility for ACH high-performance incentives. As a part of our MPA review, we did examine ACHs strategies and progress toward collection and analysis of population health data and we note progress where observed.

#### 4. Mid-Point Assessment Process and Timeline

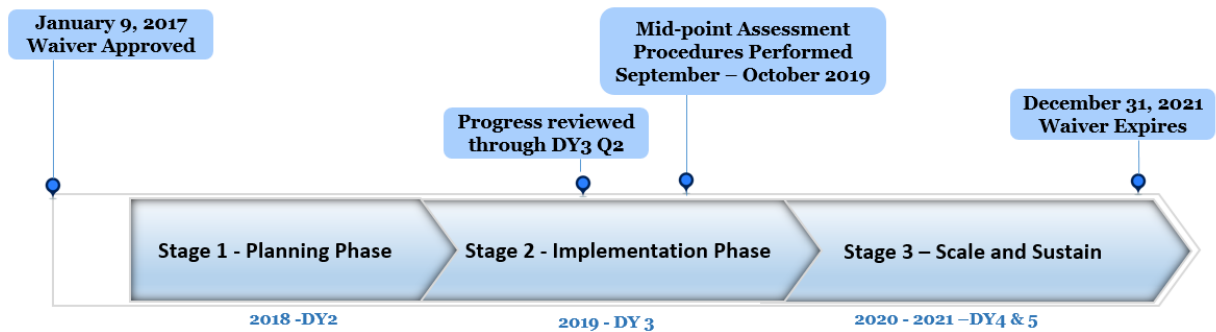
The MPA process took into consideration activities and progress between the Stage 1 – Planning phase through Stage 2 – Implementation phase. Requested documentation was for information through June 30, 2019 (DY3Q2). *Table 2* below relates the stage, demonstration year and calendar year for the Medicaid Transformation.

*Table 2. Waiver Timeline*

Stage 1 – Planning phase	Demonstration year 2 (DY2)	January 1 – December 31, 2018
Stage 2 – Implementation phase	Demonstration year 3 (DY3)	January 1 – December 31, 2019
Stage 3 – Scale and Sustain	Demonstration years 4 & 5 (DY4 & 5)	January 1, 2020 – December 31, 2021

Figure 2 is a graphic of the mid-point assessment timeline.

*Figure 2. Mid-point Assessment Timeline*



*MPA Procedures.* As noted above, ACH Management & Project Plan Execution procedures were applied to each ACH. *Table 3* identifies each ACH by name and abbreviation.

*Table 3. Accountable Communities of Health*

Accountable Communities of Health (ACHs)			
Name	Abbreviation	Name	Abbreviation
Better Health Together	BHT	North Central ACH	NCACH
Cascade Pacific Action Alliance	CPAA	North Sound ACH	NSACH
Elevate Health	EH	Olympic Community of Health	OCH
Greater Columbia ACH	GCACH	SWACH	SWACH
HealthierHere	HH		

Representation from primary care, behavioral health, hospital systems, and community-based organizations (CBOs) were selected to assess Local Health Initiative Efforts in each region. Partnering providers were selected using provider rosters received from each ACH in their July 2019 Semi-Annual Report (SAR) submission. Selection was based on active participation status and factors such as size, scope, or funding level. In addition, the top ten partnering providers who received the greatest investment dollars were included in our review.

Procedures were also developed to gather, to the greatest degree possible, broad regional stakeholder perspectives. Focus groups were held in each region for this purpose. Focus groups represented the following stakeholders: managed care organizations (MCOs), tribal representatives, behavioral health, substance use disorder (SUD) providers, primary care and federally qualified health center (FQHC) providers, CBOs, social service providers (e.g. housing, transportation), public health representatives, emergency service representatives (i.e. EMS, police), education representatives (school districts) and ACH representatives.

The following table identifies the number of interviews conducted by stakeholder type by ACH. A shaded cell represents a top ten provider in that category.

Table 4. Stakeholders interviewed as a part of MPA

Stakeholders	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH	Total
ACH Leadership	1	1	1	1	1	1	1	1	1	9
Hospital	1	1	1	1	1	1	1	1	1	9
Primary Care	1	1	1	1	1	1	1	1	1	9
Behavioral Health	2	2	2	2	2	2	2	2	2	18
Community-Based Organization	2	2	2	2	2	2	2	2	2	18
Government Office & Agencies			1							1
Public Health							1			1
Behavioral Health Organization/ BH-ASO							1			1
Focus Groups	1	1	1	1	1	1	1	1	1	9
<b>Total</b>	<b>8</b>	<b>8</b>	<b>9</b>	<b>8</b>	<b>8</b>	<b>8</b>	<b>10</b>	<b>8</b>	<b>8</b>	<b>75</b>

The IA conducted webinars on June 24, 2019 and July 22, 2019 presenting mid-point assessment objectives, examples of procedures, and timeline for Medicaid Transformation stakeholders including representatives from HCA, ACHs, providers, tribes, and health plans. During August through October, the following activities occurred:

- Partnering providers were selected and notified of their required participation.
- Request, submission and review of source documentation that supports actionable steps taken by partnering providers in implementation of Medicaid Transformation.

- Request, submission and review of source documentation that supports actionable steps taken by ACHs in implementation of Medicaid Transformation.
- Partnering provider interviews (either site visits or conference call) were held with staff members knowledgeable of project status and intervention activities. Meeting notes were captured and returned to the interviewee to allow the opportunity for endorsement or to edit and return final stakeholder input.
- ACH interviews were held with individuals with direct involvement with partnering provider engagement and project activities, including the development and execution of implementation plans. This may have included the following types of individuals: Executive Director, Chief Operating Officer, ACH Financial Lead/ Financial Analyst, Clinical Director/ Medical Director, Analytics and Reporting Lead, Project Manager(s). Meeting notes were captured and returned to the interviewee to allow the opportunity for endorsement or to edit and return final stakeholder input.
- Focus group interviews were held.
- A total of 75 interviews were conducted.
- A total of 66 desk reviews were conducted. (Desk reviews were not conducted for focus groups.)
- The IA conducted extensive review of documentation for each component to assess progress made to date.
- Based upon this review, the IA developed final recommendations for project continuation, modification, corrective action or discontinuation.

### Section III — Overview of Findings

Below is a summary of MPA findings that relate to Medicaid Transformation goals, administration, and achievement. These findings and observations are not specific to a single ACH.

**Advancing Medicaid Transformation Goals.** There is clear and convincing evidence of statewide progress related to health systems capacity building and care delivery redesign as expected for milestones between DY1 through DY3 Q2. Submitted documentation and interviews with ACH leadership and partnering providers, along with stakeholder feedback confirm progress.

Stakeholders throughout the state offered positive feedback when asked about their experience with the Medicaid Transformation overall. One interviewee commented about their organization's activities underway as a result of the waiver, *"...without this prioritization, it would have taken years."* Many provider representatives indicated that initiatives have been able to progress efforts more thoroughly through the ACHs' organization and direction, facilitation of relationship building in the region, as well as due to the availability of additional funding.

It was also observed that more work in the Stage 2 – Implementation phase is necessary for partners to move to Stage 3 – Scale and Sustain. Given that the MPA only captures the first half of DY3 activities, additional progress is expected. The Toolkit, which identifies the milestone requirements for ACHs, indicates that by DY3 Q4 ACHs should demonstrate progress by providing a description of training and implementation activities by means of their submitted semi-annual report. This will offer another opportunity to confirm the status of implementation progress. In the case of one ACH, we recommend that additional monitoring occur due to delayed implementation activities.

**Fostering Cross-sector Relationships.** Through the Medicaid Transformation, ACHs have facilitated building meaningful relationships across the care continuum including primary care, behavioral health, hospital systems, and community-based organizations. In every region, ACH and partnering providers commented that the Medicaid Transformation has brought about stronger connections within the community that would not have otherwise occurred.

These linkages have facilitated enhanced communication and understanding of community resources available to support both providers and patients. There are also examples of newly established organizational agreements between providers that have highly integrated arrangements. One such example has executive leadership regularly meeting, implementing, and expanding co-located treatment and data sharing for their patients. ACH direction and support, along with the buy-in and sustained commitment from executive staff has allowed dedicated focus and empowered decision-making to rapidly move their project forward. One interviewee commented about the role of the ACH, *"As a neutral convener role, no one was threatened by the ACH. They brought a model, passion, resources, and accountability to the process."*

**Care delivery redesign.** As a part of the interview process, partnering providers were asked about their reasons for being involved in the Medicaid Transformation and what they hoped to achieve. The IA

regularly heard from partners that the Medicaid Transformation goals aligned with their organization's mission and/or, if not specifically the evidence-based model, the project objectives. Bi-directional care, chronic disease management, population health, and value-based purchasing were mentioned as aligned areas of focus either prior to, or as a result of the Medicaid Transformation.

In some instances this alignment allowed organizations to begin initiatives that had been planned, but not started, in other cases the Medicaid Transformation accelerated, or enhanced, redesign efforts already underway. Partnering providers in many instances discussed their ongoing work on initiatives pre- and post-waiver to give a fuller perspective of the evolution of transformation in the region. Similarly, some ACHs have harmonized work across their selected projects. They approach the activities of the Medicaid Transformation as a portfolio seeking to benefit from, and maximize, the collective impact.

**Health Equity.** A stated goal for the Medicaid Transformation is to implement population health strategies that improve health equity to reduce disparities in access and outcomes. Progress was shown by ACHs and partners in addressing health equity both through funding and practice. ACH and partner contracts include requirements for addressing health equity. For example, Better Health Together considers health equity to be a major focus area and is working to ensure partnering providers engage in critical self-reflection on how their agencies' culture and policies may perpetuate or disrupt inequities. Funding is tied to pay-for-equity requirements, and also includes payments for volume and recognition of partners serving more than the region's ethnic diversity. Partners have indicated that early endorsement for working on health equity helped focus activities. One provider submitted a Diversity Equity and Inclusion Plan that has been developed as a result of Medicaid Transformation. Additional health equity activities include:

- GCACH established a \$1.4 million Community Health Fund to mitigate the effects of social determinants impacting the health of their region's population. GCACH noted that the funds were allocated across the region with equity in mind.
- North Sound ACH leadership and partners confirmed that their agreements, referred to as change plans, require that partners attend equity events. Moreover, they reinforce the training by presenting equity slides and videos at the beginning of each of their meetings.
- HealthierHere was noted to have a very strong focus on equity and has been going deep in the community with an inclusive approach, while striving to focus on SDOH.
- ACHs reported a variety of trainings and technical assistance on health equity, for example, an Equity Toolkit, Equity and Tribal Learning, and Leading for Social Justice and Equity. Olympic Community Health also found that equity has the second highest rating for training needs identified in a provider survey.
- SWACH has an Equity Manager who is regularly receiving requests for technical assistance. They have established an Equity Collaborative with a current focus on organizational change and the next phase on guiding participants through opportunities and improvements.



**MTP Accountability.** The Medicaid Transformation is based upon accountability principles established in the special terms and conditions of the program. ACHs were required to go through a certification process, and subsequently submit and receive approval for project applications. ACHs had to commit to a funding methodology contingent on reporting achievement of project milestones followed by pay-for-performance (P4P) of quality outcomes. The Toolkit defines the milestones that ACHs must attain, as well as the mechanisms to report progress on a semi-annual basis. ACHs were required to develop and update Implementation Plans that describe intermediate work steps necessary to achieve milestones. They were also required to describe their strategies to implement and monitor project performance through a quality improvement lens continuously gathering lessons through data collection, analysis, and feedback processes.

ACHs have replicated many of these practical tools that offer an operational framework and promote project management success at a regional level. ACHs and their partnering providers have developed agreements, process and outcome measures, work plans and cycles of reporting that ensure documentation of partner milestones, data collection, and performance monitoring. This has not only provided structure and reliable processes to the Medicaid Transformation overall, it has offered partners unfamiliar with quality improvement (QI) to be trained and to become skilled at practicing these QI fundamentals after the waiver sunsets. This has been especially instructive for behavioral health and community-based organizations who have not been traditionally exposed to these techniques.

**MTP Administration.** As noted previously, there is broad support for the goals and activities of the Medicaid Transformation. ACH leadership and partners alike reported meaningful and potentially long-term improvements in their communities. Administratively, interview questions regarding the level of state support and direction received mixed feedback. Some interviewees described the complexity of the waiver requirements and offered they could have benefited from greater communication with and guidance from the Health Care Authority (HCA).

Navigating the transition to the waiver was an example. Washington's Accountable Communities of Health model originated through funding provided by the State Innovation Model (SIM) grant. ACHs began health improvement projects under SIM related to areas such as care coordination, integration, and opioid use. The Medicaid Transformation evolved these initiatives and expanded on the foundation established under SIM. However, it was raised that the transition brought challenges that caused implementation delays and change in direction of some project work.

Interviewees indicated that the SIM grant focused more on addressing social determinants of health with work being generated from the public health sector. Under the Medicaid Transformation, there is a greater focus on payment and care redesign for the Medicaid population that required knowledge of contracting, claims processing and provider reimbursement that ACH leadership did not have. This resulted in the need for ACH executives to come up to speed and/or hire staff with the requisite background. One ACH reported that this change in focus to the Medicaid population narrowed thinking and altered the ability to address challenges across payer types.

HCA offered the perspective that the Medicaid Transformation brought with it an intentional structure for balanced decision-making between clinical and social partners, along with flexibility to tailor approaches to their region. While this unique Washington framework may have presented initial challenges, there was greater opportunity for collaboration and sustained buy-in. At the state level, HCA continues to promote alignment across payers and views Medicaid Transformation as a means to redesign care delivery for all patients and is not intended to restrict transformation by payer source.

**Transformation Sustainability.** As ACHs and partnering providers look toward sustaining actions post MTP, they did note areas where they believe work will be sustainable long-term. However, it was widely reported that they want to understand the state's long term transformation vision as it may inform regional sustainability of investments and transformation. Both voiced the desire for commitment to the vision over the long-term, recognizing the importance of foundational investments and transformation. This perspective was attributed to their thoughts regarding potential leadership changes at both the federal and state levels as well as the potential for shifting priorities.

A specific project concern that some interviewees raised is related to Project 2B: Community-Based Care Coordination and the long-term financing of the project approach. Some ACH's perceive HCA support for the approach may be waning just as opportunities for patient impact accelerates. It was pointed out that MCOs, which have the most to financially gain from improved care coordination, have been slow to offer support to the approach or change their business practice of relying on telephonic care coordination. In response to similar concerns heard, HCA has recently formed a work group that includes MCOs and ACHs working on a variety of care coordination priorities with the goal of aligning activities and incentives.

Some interviewees also noted that a disconnect remains to be resolved between the systems in place for Health Homes and Project 2B: Community-Based Care Coordination which is now up and running across several regions across the state. HCA noted the State is already actively working with ACHs, MCOs and Health Home leads to further align efforts between the programs.

## Section IV — Findings across ACHs

This section highlights summary-level information, findings, and opportunities identified during the Mid-point Assessment that apply to all or multiple ACHs.

Where appropriate, this section provides recommendations for additional monitoring as the MTP implementation phases progress.

**Project implementation.** Based on the submitted SAR3 partnering provider roster, the following table reflects the number of active partners working on implementing selected projects. If a value is not represented, the project was not selected by the ACH. Large partnering provider organizations may be working across the state in multiple ACHs on the same or various projects.

Table 5. Active Project Partners

Project	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
<b>2A: Bi-directional Integration of Care</b>	92	51	46	41	117	41	103	57	28
<b>2B: Community-Based Care Coordination</b>	81	38	44	•	•	42	8	•	12
<b>2C: Transitional Care</b>	•	36	•	41	105	47	106	•	•
<b>2D: Diversions Interventions</b>	•	•	•	•	•	47	94	57	•
<b>3A: Addressing Opioid Use</b>	78	58	46	41	109	49	133	57	16
<b>3B: Reproductive and Maternal and Child Health</b>	•	34	•	•	•	•	65	57	•
<b>3C: Access to Oral Health Services</b>	•	•	•	•	•	•	26	57	•
<b>3D: Chronic Disease Prevention and Control</b>	78	50	23	41	101	41	92	57	37

In review of the documentation submitted as evidence for project implementation progress, no single project was identified as having systemic implementation delays that would result in a project being discontinued across ACHs at a statewide level. Evidence did confirm that ACHs and partners were at varied levels of project implementation and in one case, project activities were delayed.

**Recommendation:** We recommend HCA continue to monitor implementation efforts as partners move towards Stage 3 – Scale and Sustain to determine whether the volume of partners engaged continues or expands.

**ACH Governance.** ACH organization and structure has facilitated project development and implementation. Partnering providers were highly complementary of ACHs in their overall organization and structure for facilitating transformation. In the beginning, partners described how there were unknowns and uncertainty about how to proceed. ACHs listened to the concerns and acted to alleviate them. For example, there has been extensive communication over time and the partnering providers were overwhelmed in keeping up with all the information being provided. ACHs have worked to streamline communication strategies and partners indicated that has been extremely helpful.

ACHs also gave examples of extensive cross-collaboration efforts. For example, ACHs have the following ongoing communications:

- ACH Directors: Weekly calls and monthly in person meetings.
- Topic-specific Cross-ACH meetings: Pathways Community HUB model (6 ACHs), Center for Evidence-Based Policy contracted as a consultant (5 ACHs), and IMC mid-adopters (6 ACHs).
- ACH Program Staff: Bi-weekly calls, and monthly Program Lead calls.
- Data Leads and CFO/Finance Leads: Each have cross-ACH monthly calls.
- ACH Opioids and tribal Affairs: Weekly calls for project staff.

ACHs also share materials (e.g., job descriptions, policies and procedures) and have conducted joint trainings and learning collaboratives/summits. While there is collaboration, projects are tailored to each region as needed due to the flexibility of the waiver.

**Recommendation:** We recommend ACHs continually work to determine where streamlining of efforts such as communications or meetings can occur as implementation progresses. ACH collaboration and sharing of information should also continue to identify lessons learned and successes in a region that others may be able to use in their regions. Continued sharing of resources may also help to ease time constraints for ACH and provider staff (e.g., through avoidance of development of materials that already exist).

**Training and Technical Assistance.** There is evidence that ACH training and technical assistance is occurring regularly across the state and improving both the knowledge-base and culture for partnering providers. ACH staff and contracted entities, such as the AIMS Center and Comagine Health, have been readily available to provide technical assistance (e.g., to help with development of the change plans). Some ACHs have conducted joint learning collaboratives, where appropriate, to avoid duplication. Some providers that are further down the path of implementation and operations in certain project areas also noted that the ACH looks to them to provide trainings, as well as to link them to providers that may have specific implementation questions with which the provider has had experience.

**Recommendation:** We recommend ACHs continue these joint learning forums for sharing of best practices and building continuity across regions. We further recommend that ACHs continue to work with partnering providers to identify topics of most need for training. Particularly, as performance measurement begins ACHs should offer routine technical assistance on measure specifications, data collection and analyses. Partners that are further along in implementation and operation of certain initiatives showed eagerness and willingness to support training for other providers, and we recommend ACHs continue to consider such opportunities within and across regions.

**Statewide Solutions.** During focus group discussions, ACHs, partnering providers, and MCOs, raised concerns about continuing certain efforts at the regional level. In fact, they suggested the State should

lead efforts to identify statewide solutions. The two primary opportunity areas of cited were the following:

- **Health Information Exchange.** While a few ACHs and partnering providers are moving forward with regional solutions, there was great concern raised that these regional solutions may not support the ability to more fully coordinate information exchange across regional boundaries and between different types of organizations. While regional systems may help in some ways, they are potentially adding to the number of systems being used that “do not talk.” Regional systems also create challenges for health systems that operate in multiple regions across the state, as well as for accessing patient information for individuals who move across regions. Partners also mentioned that community information exchanges (CIEs) that are regularly maintained and updated with an inventory of community resources is necessary to support addressing social determinants of health.
- **Workforce Transformation.** There is evidence that ACHs and partnering providers are working to address workforce through efforts such as recognizing opportunities to assure provider time is being used to their full credentials, as well as to supplement workforce through addition of staffing such as community health workers (CHWs) and navigators. However, these are considered by the ACHs to be “smaller fixes.” Both discussed that workforce issues are so large nationally and within the state, particularly for behavioral health, that it is “too big” for regions to individually address specific gaps. There is also competition in the state for these providers, and smaller rural areas cannot compete with more urban areas where salaries are higher and technology is more advanced.

**Recommendation:** HCA may wish to consider opportunities to expand upon work with the ACHs, MCOs, and partnering providers through existing or new workgroups to address larger, more impactful solutions such as use of the HIE and/or CIE and workforce transformation. The Medicaid Transformation Priorities workgroup launched by HCA to address complex issues that require collective action and alignment is such an example where this work is already being done. Additionally, we recommend HCA confirm for the ACHs if statewide solutions will be pursued for any areas, and if so, if and how regional solutions for those areas should be scaled back or modified.

**Resource Availability.** Many partnering providers, as well as ACHs, discussed challenges with resource availability from a funding and staffing perspective.

- **Funding.** HCA provides funding allocations for the \$1.1 billion dollars across ACHs based on an established funding methodology, and then ACHs are responsible for determining the mechanisms in which funds are distributed to their partnering providers. Some partners noted that the level of funding was commensurate with accomplishing the goals, while others felt that the funding levels were lower than they expected causing them to shift efforts and do more with less. Some community-based organizations (CBOs) have stopped participating or are minimally involved due to receipt of limited to no funds combined with time commitment for already busy staff. One

provider noted that in hindsight because funds have been spread so thin across so many providers and so many projects, it may have been better for the ACH to use funds towards one big objective.

- **Staffing.** Partnering providers also discussed the significant amount of time and focus that has been required, indicating administrative burden has been much higher than expected. This is a concern for long-term sustainability, and particularly when funding is no longer available. However, some ACHs and partners discussed that they are trying to minimize burden as much as possible. Partners noted to avoid staff fatigue they are staging implementation activities so that staff are not trying to address too many changes at one time.

**Recommendation:** The IA recommends that ACHs consider on an ongoing basis if there are opportunities to adjust funding reserves and allocation strategies to address funding challenges (i.e., could more be provided over the next six months rather than keeping reserves for later sustainability). Also, similar to our recommendation in review of project plans, the IA recommends ACHs continually consider opportunities for efficiencies and coordination so as to decrease provider administrative burden and fatigue and to increase likelihood of continued participation. We also recommend HCA continue to monitor funding distribution and reserves, as well as provider participation to assure sufficient engagement continues to contribute to the transformation.

**Behavioral health/ Community-based organization support.** Behavioral health and CBOs regularly mentioned challenges related to workforce and resource limitations as mentioned above. Additionally, interviewees representing these organizations mentioned that the cultural change necessary for primary care to integrate behavioral health and social services was advancing slowly. Through ACH training and networking opportunities, culture change has been discussed, but they surmised that the speed of change may directly depend on clinic readiness.

**Recommendation:** The IA recommends that ACHs continue to evaluate through the completion of partner surveys or quality improvement mechanisms, the degree to which primary care partners support and engage with behavioral health and CBO partners. HCA and ACHs may wish to consider tailored approaches for technical assistance related to change management principles and best practices to navigate change for these partnering providers.

**Managed Care Organization (MCO) Partnership in Transformation.** Interviewees provided differing experiences on involvement of MCOs in the Medicaid Transformation. Some commented that they have good partnerships, and we witnessed collaborative relationships during some focus group discussions that included MCO representation. During these discussions there was appreciation voiced by the MCO representatives for the ACHs allowing them to have a voice and a “seat at the table.” In other instances, ACHs and partnering providers in some regions noted that MCOs are not as engaged. Concerns were shared around MCO provider reimbursement strategies which may challenge sustainability to provide certain services (e.g., telehealth). MCOs also commented that they are more engaged in certain regions than others.

It is important to also recognize the significant undertaking in the state to transition regions to Integrated Managed Care beginning in 2016 and concluding in 2020, as described in further detail later. This has created additional challenges regarding MCO and provider capacity, reimbursement strategies, and other contracting and operational hurdles.

**Recommendation:** HCA, ACHs, and MCOs should consider opportunities to identify and address key issues that have historically limited engagement in certain regions. Determine lessons learned from regions where collaboration is occurring, and whether those can be applied in other regions to improve relationships between the MCOs, the ACHs, and partnering providers. Additionally, ACHs should continue to work with partnering providers to identify payment and reimbursement challenges to raise to the MCOs and HCA. HCA should work with the ACHs and MCOs to review provider reimbursement strategies to, for example, determine if MCOs are not reimbursing for services that are covered benefits for which MCOs have contractual obligations for payment, or if there are other barriers to consider. As opportunities are identified to align the MCO and MTP goals and objectives, certain requirements that continue the alignment should be considered for future addition within contracts between HCA and the ACHs and MCOs.

**Integrated Managed Care (IMC):** State legislation passed in 2014 mandated that every county in Washington State transition to IMC by 2020. IMC integrates physical and behavioral health administration and purchasing to support a whole-person approach to care where physical health and behavioral health are addressed in a single system through an integrated network of providers. The Medicaid Transformation provided additional incentive funds to regions that accelerated the timeline and transitioned to IMC prior to 2020. These regions are referred to as early, or mid-adopter regions. These incentive funds were provided to regions to support providers and the implementation process for purposes of successful launch of IMC. Financial support for IMC was considered by HCA to directly relate to the clinical integration success of Project 2A: Integration of physical and behavioral health, which is a required project for all ACHs to conduct. Prior to IMC launch, each region is required to pass a readiness review. This offers HCA an opportunity to assess capacity, network adequacy, and inform the successful launch of IMC.

For those regions that have recently transitioned or are in process of preparing for IMC transition, frustration was voiced about the amount of time and resources required. This lift was referenced as particularly heavy for substance use disorder (SUD) agencies, and those agencies that have had to implement new or modified electronic health records (EHRs) to participate. Although IMC and Project 2A have complementary goals, some indicated that the decision to do IMC at the same time as Medicaid Transformation created too many competing priorities. Additionally, concerns were raised about the level of MCO accountability in supporting the transition and addressing ongoing operational issues.

Some noted MCOs seemed unprepared to assume responsibilities previously held by the Behavioral Health Organizations (BHOs). Concerns were raised about the MCOs' consistency of care coordination and whole-person care approaches across the ACHs and their partnering providers. Concern was raised about contracting delays and contracts that are based on fee-for-service only payments without a value-based

purchasing component. However, as is typical when transitions occur to a managed care model, billing and claims issues seem to drive much of the frustration that has occurred after transition. In many cases, partnering partners indicated the ACHs were very helpful in working with HCA and the MCOs to support providers and resolve the challenges. Some also voiced they have been able to collaborate with providers and ACHs in other regions that previously transitioned to understand “what is coming” and work to address ahead of time to the extent possible.

**Recommendation:** We recommend ACHs continue their efforts in offering technical assistance and support where IMC transitions are occurring and determine whether additional incentive funds would be beneficial to support the process, and if so, whether there are opportunities to reallocate funds. We also recommend that post-implementation, HCA continue assessing challenges in regions that have transitioned. Provider complaints, network access and claims payment may be key areas to monitor.

**Duplication of Federal Funds.** As set forth in the Delivery System Reform Incentive Payment (DSRIP) program Planning Protocol, ACHs must “attest to securing descriptions of any initiatives that its partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place and ensuring these projects are not duplicative of DSRIP projects. In Demonstration Year 2 (DY 2), partnering providers will be required to provide descriptions and attest that DSRIP projects are not duplicative of other funded projects and do not duplicate the deliverables required by the former project(s). If projects are built on one of these other projects, or represent an enhancement of such a project, that may be permissible but the ACH will be required to explain how the DSRIP project is not duplicative of activities already supported with other federal funds.”

In our desk review, the IA received documentation from several ACHs addressing non-duplication of federal funds. Some ACHs addressed non-duplication through contract requirements and policy documents. Several projects that ACHs and partners are implementing are an extension of work that had started prior to the Medicaid Transformation. Additionally, there was discussion that efforts were underway to secure other grant opportunities to further support work related to the MTP. Should these opportunities be realized, additional monitoring for non-duplication of funds will be necessary.

**Recommendation:** Although an expansion of an existing project is not prohibited under the Medicaid Transformation, to be compliant and assure non-duplication of federal funds, we recommend that documentation be maintained when ACHs and partnering providers are seeking additional dollars to further a project’s reach or scope in the event that HCA or federal partners request it. HCA may also consider ongoing guidance or reporting requirements of the ACHs that provides assurances of non-duplication of federal funds.

**Data Sharing.** There has been progress as well as challenge with sharing of patient information. Some partners have established referral pathways and tracking, patient registries, and agreements to share data for common patients. Common challenges raised include incompatible EHRs or other systems that “don’t talk,” and federal regulations regarding data privacy and security (e.g., 42 CFR Part 2).



**Recommendation:** In addition to consideration of opportunities for leading efforts around a statewide HIE solution, we recommend HCA consider working with ACHs and partnering providers on issues related to 42 CFR Part 2. For example, providers indicated that various interpretations are occurring, which has led to providers being more or less willing to share patient data based on their interpretations. Individual provider groups also discussed efforts to talk with CMS about the challenges that have been created due to the regulation. If not already underway, HCA may want to consider opportunities to support common interpretation of the regulation and a coordinated state effort for discussions with CMS.

**Population Health Management.** To support population health management and identify where best to dedicate project resources for target populations, ACHs have supported partnering providers through collection and analysis of data, developing dashboard reporting, and providing preliminary information to providers. Some have contracted epidemiologists which they have described as being extremely helpful with analytics. Some ACHs have received data from the Washington State Department of Health which one ACH indicated has helped the group to understand health and housing needs together and provided opportunities to pursue additional grants (e.g., to look at housing). One interviewee noted that as a result of monitoring the rate of depression screening for their patient population, the completion rate for the Patient Health Questionnaire (PHQ) has increased from 36 percent to over 60 percent in six months.

**Recommendation:** Within the Toolkit, population health management is defined as inclusive of four activities: data aggregation, data analysis, data-informed care delivery, and data-enabled financial models, with progress expected in DY4. Infrastructure, staffing and capacity building are required to become proficient at each of these four activities. Data analysis, in particular, takes sustained validation effort and attention overtime before relevant insights surface.

We recommend HCA continue to work with ACHs in assessing local capacity to support population health management's foundational activities: data aggregation, data analysis, data-informed care delivery, and data-enabled financial models. We recommend that with each report submission, ACHs should be asked to describe partners' progress in these areas, denote any identified barriers, and document how ACHs are working to resolve barriers to population health management.

**Long-term Sustainability.** ACHs and partnering providers discussed that they are hopeful about long-term sustainability of transformation activities.

- Some noted initiatives that were underway before Medicaid Transformation have been propelled forward (e.g., integration) as a result.
- EHR and population health systems have been purchased or enhanced.
- New staff, such as CHWs, have been hired that they anticipate will be fully integrated into partner agencies and self-sustaining when Medicaid Transformation funds are no longer available.
- Importantly, providers think the relationship building that has occurred across provider sectors will be sustained.

Many comments were also received about the uncertainty of sustainability due to a variety of factors. As indicated, there is strong feeling that HCA must move to a statewide approach and lead on specific issues such as HIE and workforce for long-term sustainability of transformation. Concerns were raised about the ability of providers to continue to focus on transformation initiatives to the extent they have been doing so, and that the five-year duration of the Medicaid Transformation may not be sufficient amount of time to show progress on many of the areas being targeted for improved outcomes. Some regions raised questions regarding the long-term role of the ACH and in what format they will continue.

**Recommendation:** As the Medicaid Transformation continues, we recommend ongoing collaboration across HCA, ACHs, MCOs and local health and community providers to discuss methods and opportunities to assure sustainability of positive transformations. This will be important in keeping a focus on continuously improving outcomes that many described as an effort that will surpass the five-year demonstration period. Additionally, as providers transition to value-based payment models, ongoing training and technical assistance to support these models will also be beneficial in impacting overall costs and furthering improved outcomes throughout the state.

## Section V — Key Findings by ACH

This section includes information gathered from our independent assessment process, including desk reviews and site visit interviews with ACH leadership and selected partnering providers and recommendations. Please note that information may be derived from one or multiple review sources (e.g. semi-annual reviews, ACH website reviews, submitted documentation materials and/or interviews).

### 1. *Overview and Findings*

Upon completion of all MPA procedures, review and analysis of findings, this section indicates the Independent Assessor's composite recommendation for continuation, modification, corrective action, or discontinuance of ACH projects.

### 2. *Regional Insights*

ACH leadership and partnering providers were asked about their experiences to date relevant to participation in the waiver and lessons learned through the planning and implementation phases. The primary objective of the inquiry being to highlight successes and promising practices for potential replication and scale during the sustainability phase, or identification of barriers to achievement that may be mitigated or resolved through mid-course corrections. Each table includes their noted successes and challenges, and may generally reflect positive and negative comments gathered.

### 3. *Review Components*

Specific to each ACH, this section summarizes information obtained and used to confirm project health and implementation progress by each of the following review components. Note that key findings related to Health Equity has been described in Section III.:

- ACH Organization & Compliance Representation.
- Distribution of Earned Incentive Funds.
- Workforce.
- Bi-directional Integrations.
- Community-Based Care Coordination.
- Population Health Management through Data Exchange & Usage.
- Transition to Integrated Managed Care.
- Training & Technical Assistance.
- Project Implementation.

This information offers evidence and support of our recommendations. Information may identify examples of the types of materials submitted, excerpts of documents, or capture participant comments or quotes (*italicized*) to allow for greater understanding and context for relevant activities.

## Summary Findings for Better Health Together

Better Health Together

- **Counties:**
  - Adams
  - Ferry
  - Lincoln
  - Pend Oreille
  - Spokane
  - Stevens
  
- **Tribal Reservation/Trust Land:**  
Spokane tribal lands and part of the Colville tribal lands are located in Stevens and Ferry counties, respectively. Kalispel Indian Reservation is located in Pend Oreille County.
  
- **Medicaid Population Size (2018 Client Count):** 196,738

ACH Regions Map

HCA 82-008 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	■ <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

### 2. Regional Insights

ACH leadership and partnering providers were asked about successes and challenges identified to date.

Table 6. BHT Successes and Challenges

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>The transformation project has supported relationship and trust building in the region. Rural communities are collaborating with larger community members and the MCOs have been great partners.</li> </ul>	<ul style="list-style-type: none"> <li>Regional infrastructure is very different with five very rural areas. Supporting differing needs is a challenge (e.g., 40 BH providers are contracted ranging from large to small practices with staff of three).</li> </ul>
<ul style="list-style-type: none"> <li>HCA direction has improved from early in the project when there were not a lot of guidelines or support for a very challenging project. Changes were coming often requiring more movement than normal, but fortunately there was enough provider interest to stay involved.</li> </ul>	<ul style="list-style-type: none"> <li>The MTP could have benefited from a “Phase 1” to get things started and make corrections early. The MTP toolkit has been somewhat of a challenge – it is a base to start, but does not provide enough specifics.</li> </ul>
<ul style="list-style-type: none"> <li>BHT has provided structure and organization, and has done a great job in guiding and supporting development of transition plans. Overall technical assistance and training opportunities are extremely beneficial. Communications are helpful and clear.</li> </ul>	<ul style="list-style-type: none"> <li>Doing the work and keeping up with the time commitments in participation and collaborations can be a challenge.</li> <li>The ACH provides some workshops on contracting and VBP, but there is not a lot of detail on how to make this transformation happen.</li> </ul>
<ul style="list-style-type: none"> <li>MTP funding has helped providers to move forward on initiatives that existed prior to MTP (e.g., integration). A review of what is already available in the community was used for collaborative structuring.</li> </ul>	<ul style="list-style-type: none"> <li>Financial uncertainty is a challenge; including how to meet the number of people and resources needed.</li> </ul>
<ul style="list-style-type: none"> <li>Work has come together over the last 18 months. There is movement toward integration and aggregate care for the community, which helps to create the value based component.</li> <li>In the past, patients received referrals, but not necessarily the services. Partners can now immediately determine who has been referred.</li> <li>Early endorsement of working on health equity has helped.</li> </ul>	<ul style="list-style-type: none"> <li>Work needs to be done at a statewide vs. regional level.                             <ul style="list-style-type: none"> <li>A statewide HIT solution is needed. Regional solutions are not resulting in connectivity and sharing that could result from a statewide HIE. Funding is not sufficient to allow for comprehensive systems.</li> <li>Nine regions are trying to work together on workforce issues. Determining the roles for each and the State is a challenge.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>A provider noted that for BHT, the project focus is about goal completion. They are doing a great job in moving the region, but there is a concern about what this will look like in a year based on contracting and if providers can diversify fast enough.</li> </ul>	<ul style="list-style-type: none"> <li>Significant policy work is still needed to align primary care and behavioral health.</li> <li>CFR 42 Part 2 prevents some collaboration that would be helpful and cost effective.</li> </ul>
<ul style="list-style-type: none"> <li>BHT is forward-thinking regarding technology solutions to support moving to the same EHR and working on an environment for population health management. Incentives aren’t strong for reporting outside of your own agency, but through collaborations and some resources we are seeing providers can become more connected.</li> </ul>	<ul style="list-style-type: none"> <li>Sufficient credentialed staff are not available (e.g., nursing shortages, role limitations). Lack of BH providers has consequences.</li> </ul>

### **3. Review Components:**

#### **ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that BHT's Board of Directors includes eighteen (18) members and maintains the required sectoral representation. This includes health system, primary care, tribal, behavioral health, public health, rural health, housing, county, education, aging and long-term care, managed care, and philanthropy sectors. In addition to the Board, the governing structure includes:

- County-based Collaboratives of partnering providers across sectors that participate in setting local direction and reaching goals.
- Five Technical Councils to guide Medicaid Transformation requirements and policy. Councils are co-chaired by a Board and Community Member and include partnering providers and community leaders.

*Communication methods.* Documentation and interviewees confirmed that BHT communicates with partners through multiple methods. BHT's website is a resource for many communications, including meeting minutes and schedules, information and webinars about specific topics, among others. Providers also indicated they receive regular updates via email and onsite presence of BHT staff.

*ACH partner support.* Partners did not raise concerns about BHT's governance. It was commented that the County Collaborative model is helpful.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and interviews confirmed that BHT and providers are engaged in efforts to support the Medicaid Transformation. They have signed MTP partner agreements and/or Memoranda of Understanding (MOUs). Agreements are signed for one-year terms and detail the following:

- General partner roles and responsibilities such as participation in: DSRIP projects; activities related to Implementation Plans and the county Collaborative; learning cohorts; network analysis; and development of an IT strategy with BHT. Reporting requirements are specified.
- Responsibilities related to DSRIP funds.
- Project milestones, including aim statements, milestones, and targeted dates for each project in which the partnering provider participates.
- Achievement metrics, including concepts, rationales, and definitions.
- Equity requirements.
- Payment schedule and volume category. Expectations for meeting specific milestones, pay-for-achievement measures and pay-for-equity milestones are outlined with indication of payment amounts the partnering provider may earn.

### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted confirms the interviewed partners have received funding and the methodology. As stated above, the contract provides detail about calculation of eligibility for payments.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for Medicaid Transformation activities. This includes hiring additional staff to support project initiatives, HIT investments, planning for integration, ongoing operations, staff training, among others.

### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* BHT and partnering providers discussed the need for a statewide solution for workforce transformation, indicating for example, that workforce "is tight to the point services cannot be expanded." However, both discussed and provided information about how the region is using MTP funds to address challenges and gaps. For example, BHT invited college representatives to speak about and provide input into strategies for training a better workforce. Providers have hired additional staff, such as behavioral health and peer support staff and community health workers (CHWs). Additionally, a behavioral health partner is working to create an associate program which allows for training, then the trained staff will fill these roles.

Comments indicated that the MTP has allowed the region to broaden conversation around adequate workforce. For example, community-based services are not typically part of medical services provided, but conversations have helped to identify gaps in care (e.g., mental health training, a stronger BH community service).

### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* BHT's 2018 current state assessment found barriers to increased use of HIT/HIE including lack of interoperability of different systems, cost, technical issues with hosting or performance, workflow constraints and privacy/confidentiality concerns. Some rural clinics have insufficient broadband capacity. Also, in SAR 3.0, BHT indicated HIT is a significant problem, noting "... a statewide vision and solution is necessary."

BHT was found to be moving forward with supporting and working with providers to address technology solutions for the region. For example:

- Partner agreements require participation in developing and implementing an IT strategy. BHT has contracted XPIO to help develop a technical strategy to support coordination of care, addressing information sharing across the provider community, including outcome measures and other analytics.

- BHT has a license with Care Coordination Systems to use software to share client information with service providers and other care coordination agencies (CCAs) through the Pathways Community HUB model, as well as to compile statistics and reports.
- XPIO provides technical assistance (TA) to BHT and behavioral health agencies (BHAs) for bi-directional integration and integrated managed care, with a primary focus on billing and claims testing and technology readiness, particularly in regards to EHRs.
- BHT is supporting providers in implementing patient registries. This was noted to have been taking a lot of time and energy, but progress is being made.
- Partner agreements include project milestones and metrics for technology solutions (e.g., patient referral pathways, patient registries across provider sites, data collection and clinical information systems tools to support population health management, among others).

Interviewees indicated they have been experimenting with options for sharing of clinic records. They noted progress is being made, but it is very slow. However, there is recognition that the MTP has helped to drive conversations and the work. There was acknowledgement that moving forward, there are very limited resources, and it currently does not make sense to them to expend resources for technology solutions when a state HIE is more appropriate.

#### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* BHT was a mid-adopter eligible for enhanced funding. Examples of BHT support to providers with IMC implementation include: providing incentive payments for meeting IMC milestones; maintaining an IMC webpage to post meeting notes, provider questions and answers, resources from the State and MCOs, and upcoming meetings and trainings; and holding monthly IMC workgroup meetings since mid-2018. BHT has worked closely with MCOs and HCA to address questions and issues, and continue to connect providers to contacts for answers. They elevate longer-term issues to the State, to ensure policy decisions and next steps at the state level are in line with local provider needs.

Interview discussions indicated a potential retreat to a fee-for-service payment model, which participants believe would be difficult and would destabilize the program. Additionally, providers noted concern about future payments and that current contracts with MCOs are ending and have not yet been renewed.

#### **Bi-directional Integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* Partnering providers have submitted transformation plans, for which BHT supported development if needed. As part of their transformation plans, partnering providers selected either the Bree or Collaborative Care Models with indication of which elements apply for the initiatives they will undertake. They defined aim statements, and milestones to achieve each aim, and selected achievement measures to target for improvement. Example aim statements and include:



- Onboard and train at least one new Care Navigator by March 31, 2019.
- Implement Collaborative Care Model by March 2020 across all sites for any client with a chronic mental health condition who is not receiving treatment outside the agency.
- Increase community-based behavioral health assessments and referral to appropriate services for positive screens by 15 percent by December 31, 2019.
- Ensure care coordination services are offered to all patients who have not had an EPSDT screening within the last 12 months.

A provider gave an example of the whole-person care approach they are implementing. They hired five navigators and 15 care coordinators for intense coordination, i.e., the wrap-around model to facilitate cross family meetings, social workers, probations officers, etc. They help with SDOH screening and navigation efforts. Navigators have more internal duties such as insurance planning, tracking information in registries for services, and making sure patients' needs are met. The provider also hopes to use risk stratification to help streamline referrals.

#### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* BHT uses the Pathways Community HUB model. BHT's Project Plan defined the Community-Based Care Coordination project as a strategy to connect the project portfolio and to develop "accountable linkages between clinically based health care services with the community-based services" that play a key role in improving health outcomes. Our assessment found examples of this strategy being implemented. For example, of the sample partner contracts reviewed, each has care coordination elements included across the other three projects. Example aims from partnering provider agreements or transformation plans include:

- (Bi-directional care) Establish formalized referral pathways and coordination arrangements with at least three behavioral health and other service partners by March 2020.
- (Bi-directional care) Ensure care coordination services are offered to all patients who have not had an EPSDT screening within the last twelve months.
- (Chronic Disease Management) Implement at least three strategies for self-management support and/or coordination with community resources for patients with specified conditions. A related milestone is to hire at least one CHW and two Care Coordinators and 2 Case Managers.

Additionally, community agencies are contracted to provide CHWs and a Housing Specialist to support transitions from jail to community. They receive training and follow the Pathways Community HUB model, conduct needs assessments and help the participant to obtain required services or to seek housing. Information is entered into the BHT data system, Care Coordination System.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* BHT has used multiple methods to offer partner training and technical assistance. BHT posts extensive research to its website and holds monthly cohorts, and provided as evidence a 2019 curriculum that crosses project areas and describes other training and TA available, including:

- Technical Assistance (TA) Bank. Partnering providers can request TA for issues such as registries and tracking tools, organizational development, workflow, or others.
- Full day Shared In-person Clinical Training: Supporting Primary Care in Behavioral Health
- Contracting with XPIO to provide TA to BHAs. BHT also contracts with the AIMS Center for learning collaboratives regarding integrated care programs within partnering provider organizations.
- BHT maintains a roster of partners to track participation in each learning cohort. Providers showed evidence of emailed summaries from the BHT summarizing their attendance at the cohorts.

### **Project Implementation.**

For each project selected, BHT was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* The project is designed to improve whole person care and health outcomes by using approaches of care for high-needs populations, while increasing capabilities of current physical and behavioral health integration activities. BHT and partners are using either the Bree Collaborative or the Collaborative Care Model. BHT is leveraging HIT and existing care coordination infrastructure.

*Implementation Plan Progress.* Progress on Project 2A was clearly indicated through interviews and reviewed documentation. Examples of progress are as follows:

- BHT submitted a tracking file of project aims and milestones each partner is implementing.
- BHT developed achievement metrics from which providers must select and work to achieve based on their related aims and milestones. These are contractually required and the provider must report progress on the measures to receive funding.

- BHT provides monthly provider trainings. Since July 2019, topics related to Project 2A include Collaborative Care Billing, trauma-informed approaches, motivational interviewing, and psychiatric collaborative care models.
- Providers described initiatives and their progress, such as co-location of services, incorporation of screening tools (PHQ9 and GAD7) into internal processes, and development and implementation of registries to capture co-morbidities.
- A partner submitted sample policies and procedures that convey a person-centered approach that addresses both physical health and behavioral health needs, conducting assessments of needs, and helping with referral and accessing needed resources.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* BHT indicated in its project plan a focus on local needs and resources for prevention, access to treatment, overdose prevention, and recovery of opioid misuse. The county collaboratives are expected to identify community-level SDOH that are potential areas to target. They will work to educate stakeholders about the causes of opioid misuse, alternatives for pain management, and opportunities to receive treatment and recovery assistance.

*Implementation Plan Progress.* As part of their transformation plans, partnering providers defined aim statements, related milestones to achieve each aim, and selected achievement measures to target for improvement. Progress on Project 3A was identified through interviews and review of documentation provided by both BHT and providers. Examples of progress are as follows:

- A partner discussed an opioid use disorder program they began simultaneously with MTP. They have been gradually shifting to MAT over the past year and is operationally going well. There have been subsidized funds from BHT to work on accessing data for patient management of medications. The partner indicated they are confident about sustainability given this work started before MTP, therefore, it was an exclusive focus from the start.
- A partner provided samples of flyers targeted to populations to convey services provided, and have milestones for implementation of outreach (e.g., screenings for opioid use of all patients).
- A partner indicated policies and procedures are in place and a MAT certified prescriber will take their first patient on-site in October.
- A Task Force Charter was reviewed that indicates meeting schedules and participants. Meetings were held in Spring 2019. They note discussion of actions, including:
  - Care management teams working with patients to get them into MAT, and discussion of recruiting additional providers for this program.
  - Community educational events and provider education
  - Addition of mental health to the Task Force.

## Summary Findings for Cascade Pacific Action Alliance

Cascade Pacific Action Alliance

- **Counties:**
  - Cowlitz
  - Grays Harbor
  - Lewis
  - Mason
  - Pacific
  - Thurston
  - Wahkiakum
  
- **Tribal Reservation/Trust Land:** Seven federally recognized tribes are located in the CPAA region (Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinault Indian Tribe, Shoalwater Bay Indian Tribe, Squaxin Island Tribe, and Skokomish Indian Tribe).
  
- **Medicaid Population Size (2018 Client Count):** 185,163

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3B: Reproductive and Maternal and Child Health
  - 2C: Transitional Care
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: #2c5e8c; font-weight: bold;">■</span> Continuation
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

**2. Regional Insights:**

ACH leadership and partnering providers were asked about successes and challenges identified to date.

*Table 7. CPAA Successes and Challenges*

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>MTP has been a transformative opportunity with partners working towards the vision they created together. This has been demonstrated in clinical and non-clinical teams working together across the region to form real quality standards, training, and common data platforms.</li> <li>The regional opioid workgroup broke down county barriers with its very unique and successful partnerships.</li> </ul>	<ul style="list-style-type: none"> <li>Key challenges for the ACH include geography, as the ACH spans seven counties, and workforce. Workforce issues include staff turnover, lack of professional experience and lack of credentialed professionals to fill necessary positions.</li> <li>One partner raised the concern that the MTP expectations are somewhat vague; they want the expectations described more clearly.</li> </ul>
<ul style="list-style-type: none"> <li>Training has been beneficial to the partnering providers. Roll-out and training for the Pathways Community HUB model was described as outstanding in that it provided the tools and resources needed to deliver consistent and higher quality service.</li> <li>Bi-directional integration training provided assistance in establishment of registries and integration of health measurements.</li> </ul>	<ul style="list-style-type: none"> <li>In implementation of bi-directional integration, effective collaboration between physical health and behavioral health is a challenge noted by the ACH and partnering providers. Further support is needed in regard to professional recognition for CHWs, physical health provider buy-in, and information sharing.</li> </ul>
<ul style="list-style-type: none"> <li>The ACH makes sure to bring the right people together to get the most productive work done at these meetings. Learning Collaboratives are well attended with ACH working with MCOs on several initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>One partner indicated that there is an absence of wraparound programming connected to the low barrier MAT programs that are now becoming available.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance**

*Representation.* Documentation confirmed that the CPAA ACH, LLC board includes nineteen (19) officers and maintains the required sectoral representation. This includes BHO, public health, criminal justice, social services, tribal government services, and critical access hospital sectors. CHOICE, a 501 (c)(3) non-profit, oversees the Board which in turn oversees two committees, the Executive Committee and the Finance Committee, as well as the CPAA Council which acts in an advisory role to the CPAA LLC Board providing strategic direction.

*Communication methods.* Documentation confirmed that the ACH is communicating with partners through multiple methods including the ACH public-facing website, monthly newsletters, and project specific email communications.

*ACH partner support.* Documentation and site visit interviews confirmed that CPAA and partnering providers are engaged in efforts to support the Medicaid Transformation.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* CPAA and partners have signed Medicaid Transformation Partnership Agreements. The agreements reviewed were signed between September and November of 2018.

The agreement outlines reimbursement methodologies indicating that partners may receive payments based on achievement of project milestones and performance measures as specified in the implementation and change plans.

Addendum B "Scope of Work" of the agreement contains provisions that require the partner to:

- Collaborate with CPAA, as needed, to develop and submit a Change Plan for CPAA according to the number of projects the Partner was selected for.
- Complete and submit any administrative forms required in order for the Partner to receive funds via the Medicaid Demonstration's Financial Portal and CPAA's Financial Executor. Partners are required to report on pay for reporting measures quarterly by the end of the first month following every quarter. Late reporting could impact receipt of allocated funds.
- Participate in Quality Improvement activities for each MTP Program area they are selected for.
- Align and coordinate MTP activities with other CPAA selected partners.
- Participate in CPAA's MTP kick-off celebration; project area work groups, planning committees, MTP task force, webinars, and conference calls; CPAA Board, Council meetings and local forums. Active participation is linked to MTP incentives.
- Show evidence for expansion or deepening of partnerships projects, as this will be essential for the "scale" in DSRIP years
- Incorporate Health Equity Considerations into the execution of their project.

#### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, specifically use of a chart of accounts. The chart of accounts documentation supports discrete accounts established for MTP and for each individual project. However, the documentation does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted confirms the interviewed partners have received funding.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers have utilized funds for the following: staff (new hires, expansion of roles/hours); staff development; purchasing project related supplies; and IT software and hardware.

**Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* CPAA identified challenges related to staff turnover and also availability of applicants with professional experience and credentials.

Community health workers, which are heavily leveraged to achieve project goals by multiple providers, generally have life experience that makes them suited for the position, however, concentrated training is necessary. For providers in more rural areas of the region, it is expensive and difficult to recruit staff. They incur higher costs for hiring as recruitment must be conducted more broadly and there is the cost to re-locate hired staff. Providers noted general workforce shortages are a shared concern. Some efforts to address the concern include referrals and sign-on bonuses. The focus group noted over 100 positions open within the network of providers with \$4 million dedicated to recruitment, retention, and apprenticeship programs. However, this is still not enough to resolve issues.

**Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* In their implementation plan related to HIT/HIE provisions, CPAA identified the need for interoperability between EHRs within their region and across the state. They noted that they do not have the expertise or funding needed to bring about statewide change, therefore, in collaboration with HCA, would work to identify potential funding sources that could be used for the ten percent State match under Health Information Technology for Economic and Clinical Health Act (HITECH) and Medicaid administrative funding. As well, CPAA would look into interoperability between their Prescription Drug Monitoring Program (PDMP) and provider EHR systems.

The Care Coordination System (CCS) is utilized as a platform for case management by Care Coordinating Agencies in the ACH. CPAA encouraged the use of Community CarePort (Pathways Community HUB) as a referral portal for all partnering providers to connect patients with a care coordinator at one of the coordinating agencies. Tools such as these and purchases/upgrades made to EHR systems using enhancement funds as made available in the transition to IMC, allow partnering providers to share data and track services more readily.

**Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* CPAA is an on-time adopter of integrated managed care (IMC) with transition scheduled for January 1, 2020. They were not eligible for incentive funding as an on-time adopter. CPAA allocated funds to support behavioral health providers in the IMC transition with the opportunity to apply for reimbursement of costs up to \$30,000 in order to purchase or update systems. To support all providers in the transition to IMC, CPAA contracted with XPIO to provide

technical assistance to providers through January 31, 2020. Technical assistance includes readiness assessments and implementation plans for each agency.

### **Bi-directional Integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* CPAA has made integration investments in training, population health management, and financial sustainability. One area of focus has been AIMS Center training and use of the Caseload Tracker, a cloud-based, HIPAA compliant registry that manages depression caseloads.

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* CPAA implemented the Pathways Community HUB model. As a part of this model, partners designated as Care Coordinating Agencies earn outcome based payments. All providers are able to refer clients to the Care Coordinating Agencies through Community CarePort HUB. Through this HUB, clients are connected to a care coordinator. CPAA reported seven Care Coordinating Agencies with thirteen trained care coordinators as of June 13, 2019. One partnering provider emphasized the need for full support of the Pathways Community HUB model as the treatment model for homeless services based on their successful implementation and positive results.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* CPAA has provided multiple opportunities for partner training and technical assistance. Examples include:

- Contracting with XPIO to provide technical assistance in implementation of integrated managed care.
- Contract with Qualis Health to provide technical assistance through coaching to partnering providers in facilitation of MTP implementation as well as other considerations.
- Contract with Raghuram B. Bhat MD to provide psychiatric consultation to behavioral health providers.
- Memorandum of Understanding with Power to Decide to provide One Key Question training and consulting to providers.
- Contract with Care Coordination Systems LLC to provide various trainings on care coordination.
- Networking events and learning collaborative opportunities for providers hosted by CPAA.

### **Project Implementation.**

For each project selected, CPAA was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the



Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* CPAA is addressing physical and behavioral health needs of children and adults through an integrated system of care that centers on whole-person health. Partnering providers are expected to use shared care plans, track treatments in new patient registries, use evidence-based screening tools and treatment, and receive compensation for quality of care and clinical outcomes through VBP. In the project plan approach, CPAA stated that in behavioral health settings, primary care integration approaches focus on implementing off-site, enhanced collaboration; co-located, enhanced collaboration; or co-located, integrated care, along with the core principles of collaborative care.

*Implementation Plan Progress.* Overall, integration is reported by partner providers as in progress. Hiring, drafting of procedures, and learning from each other is all occurring. The ACH noted the adaptation of procedures from physical health to behavioral health partners to meet the shared needs. Demand for behavioral health professionals in order to integrate has resulted in difficulty recruiting staff.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* CPAA is focusing on Medication Assisted Treatment (MAT) and Harm-Reduction. Investments in this project are being supported by the other projects that CPAA is implementing, including Bi-directional Care Integration, Community Care Coordination (Pathways Community HUB model), and Maternal and Child Health.

*Implementation Plan Progress.* Partnering providers report that activities such as hiring and build-up of MAT programs are in progress with goals expected to be met. Delays they have experienced are attributed to staffing issues.

CPAA has hosted, coordinated, and attended many events and meetings related to addressing the opioid crisis. These include events such as:

- Pacific County Opioid Summit hosted by Willapa Behavioral Health
- Addressing the Opioid Epidemic: A Harm Reduction Approach and Olympia Bupe Clinic Orientation coordinated by CPAA and presented by the Capital Recovery Center and Olympia Bupe Clinic
- Buprenorphine Waiver Training hosted by CPAA

Clinical measures and tracking questions are beginning to be raised as programs go on-line. CPAA noted challenges due to demand for services and administrative barriers for partners in implementation. CPAA is

providing training and education for peer counselors, waiver trainings, and addressing stigma and provider discomfort with MAT to address the barriers.

## Summary Findings for Elevate Health

Elevate Health

- **Counties:**
  - Pierce
- **Tribal Reservation/Trust Land:** The Puyallup Tribe and Nisqually Indian Tribe are located in Pierce County.
- **Medicaid Population Size (2018 Client Count):** 229,713
- **Note:** Elevate Health was formerly referred to as Pierce County ACH.

HCA 82-006 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: #2c5e8c; font-weight: bold;">■</span> <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

### 2. Regional Insights:

ACH leadership and partnering providers were asked about successes and challenges identified to date.

Table 8. EH Successes and Challenges

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>Partners voiced positive feedback about the Medicaid Transformation and what they are doing. A partner indicated the MTP they never considered not being a part of it and playing a role in the transformation.</li> </ul>	<ul style="list-style-type: none"> <li>One interviewee commented that the Triple/Quadruple Aim was easy to understand, but the philosophy behind it was difficult. How it was happening was even heard and there was a learning curve.</li> </ul>
<ul style="list-style-type: none"> <li>Beginning November 2018, two partners entered into a comprehensive partnership, termed ‘Bridge of Hope’ to increase early access to behavioral health care services for pediatric patients with mild to moderate mental health needs. They are utilizing the Collaborative Care Model to ensure patients have wrap-around, whole person care.</li> </ul>	<ul style="list-style-type: none"> <li>Finding the right partner to work with and being aware of the culture within the clinics can be a challenge. If the culture doesn’t align between organizations it may be the root cause for slow implementation and impacts the organizations’ capacity for collaboration.</li> </ul>
<ul style="list-style-type: none"> <li>SDOH conversation is moving forward. Initially, clinical providers were more engaged and had a heavier lift than social services providers, but the ACH has done a good job of pulling SDOH providers in and establishing the community linkages. The ACH has specific funds for SDOH and major investors are moving the needle.</li> </ul>	<ul style="list-style-type: none"> <li>There are concerns that there is no investment around new programing yet from MCOs as they say that they can’t afford it. It was noted that MCOs should reimburse for telehealth to allow chronic care management goals to be met. Investment should come from sources other than the State. As a result, there appears to be a disconnect between the strategy and vision. MCO’s have significant influence, and that creates real challenges for the statewide MTP plans, including for State hospitals.</li> </ul>
	<ul style="list-style-type: none"> <li>The biggest barrier has been understanding how to build a collaborative care code and being able to enroll patients into an actual collaborative care environment.</li> <li>Initial challenges were faced in tracking data, establishing a shared cohort and defining measures for tracking patient access to services. There is a challenge in balancing metrics as defined in the Medicaid Transformation with other important quality measure and integration work.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that the Board of Trustee includes seventeen (17) staff and maintains the required sectoral representation. This includes housing, ministry, state senate, transportation, and labor sectors. The board oversees the ACH CEO and four (4) committees and five (5) workgroups.

*Communication methods.* Documentation confirmed that the ACH is communicating with partners through multiple methods including Board of Trustee minute meetings, and the ACH public-facing website where a library-exchange resource with waiver resources are made available for partners.

*ACH partner support.* Partners report that Elevate Health acts as a neutral convener and has offered important technical support in areas such as trauma informed care training, Learning Collaboratives and a community bulletin board where questions can be asked and answered. All of the partners commented on the capacity of the ACH team to effectively gather stakeholders, develop a shared vision, and lead with a clear mission in mind. Moreover, this competence quickly produced value alignment across partners.

Partner comments include:

- *“This ACH is really trying to be innovative and trying to go big and do exciting things.”*
- *“The ACH has forward thinking people there.”*
- *“Pierce did it differently. They are experienced in clinical areas, knew healthcare systems, and CBOs. There was a vision and model in mind. They got 4-6 of the biggest players to the table to start. Once the money came in, there was an explosion of activity. This kind of enthusiasm is necessary to make the care system work.”*

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and site visit interviews confirmed that Elevate Health and select partnering providers are engaged in efforts to support the waiver. Elevate Health and partners have signed three (3)-year Medicaid Transformation Project Partner agreements. The majority of the contracts reviewed were signed before December 2018, while one agreement was signed by April 2019. The following provisions are illustrative, but not all inclusive, of expectations from partner agreements:

- Collaborate with the Pierce County ACH, the HCA, the Financial Executor and other Partner Organizations in good faith to implement the Project Plan;
- Comply with the terms, conditions and requirements of this Agreement, the Project Plan, and the defined Statement of Work, including but not limited to timely and accurate reporting in accordance with the performance measures, project milestones, and timeline specified in the Project Plan and the Statement of Work.

The agreement outlines reimbursement methodologies indicating that partners may receive payments in March and October of each year based on project performance and reporting, and their level of partnership. An appendix of the agreement requires partner participation in the ACH's Whole Person Care Collaborative.

#### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted indicates the funding methodology and confirms that selected partners have received funding during the time period reviewed.

It was noted by multiple partners that contingent to the agreement, ten percent (10%) of the dollars would be steered to OnePierce, a community benefit fund that would continue beyond the term of the Medicaid Transformation. The region is seeking additional funding partners to collect \$100 million for continued region-specific community efforts.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for waiver activities. Examples included: purchase of retinal scanners to improve care for diabetes patients; hiring of positions such as billing specialists and a data analyst; implementation planning for whole person care and to utilize the Pathways Community HUB model for complex patients; and supplementing the cost of the transition to the Integrated Managed Care (IMC) payment model.

Additionally, BHO enhancement fund dollars are supporting EHR transition, upgrading laptops for staff to increase ability to co-locate primary care and increase outreach and staff salary enhancement. Catalyst funds are being used for consulting, administration and staffing, space redesign, and data interoperability.

#### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* Elevate Health identified that there are currently limited incentives and misaligned payment systems. The ACH proposed that a centralized training and resource center for care coordination and workforce development should be created. A local community health center partner reinforced this understanding and shared that although staff report high degrees of job satisfaction, staff consistently leave for higher salaries. Besides billing staff, ACH funding has supported hiring community health workers. Partners are concerned that services may cease when the Medicaid Transformation ends and would like to see CHW sustainability prioritized.

Some organizations have been able to support workforce development by making recruiters available across partnering organizations, offering sign-on bonuses and through expanded residency programs.

#### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* Elevate Health identified that the lack of a global consent process for patients is a barrier for data sharing, and generally there is variability in the use of social service referral tools within the community. However, the region is making large investments in the usage and exchange of data. Elevate Health is developing a "data lake" which is envisioned to be the HIE strategy used to compile and share patient treatment to coordinate whole person care. They are using a phased approach to implementation. Phase 1 information will be gathered from pilot partners who will submit clinical and claims data. The Care Continuum Network data and mobile crisis information will also be added.

One partner noted that VBP activities have advanced as a result of the Medicaid Transformation. As an example, the lead organization is now collecting and sharing clinical performance data with reports and scorecards being generated and sent to managers and medical directors monthly. The organization will

also begin to send measure results and a gap list to their primary care providers to conduct patient outreach and engagement.

Another partner confirmed the execution of a 10-year data sharing agreement between partnering organizations that impacts approximately 90 sites and 12 counties. To facilitate this arrangement, an electronic health record conversion costing millions of dollars will occur. The partnering organizations have committed to building access and treatment capacity for shared patients.

### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* Elevate Health was an early adopter eligible for enhanced funding. ACH leadership and partners alike indicated that the transition was not without challenges. Claims payment issues resulted in delays of up to six months for reimbursement to partners. These and other issues took a great deal of staff bandwidth in 2019. Staff mentioned they are just now able to focus on quality and clinical integration work. Other partnering providers mentioned the following:

- Independent behavioral health providers are at a disadvantage in contracting without the ability to have data that represents their value proposition and due to their lack of experience in submitting claims. Billing and data analytics staff, along with a full time social worker to manage authorizations were required to handle the change to IMC for one partnering organization.
- MCOs were challenging and unresponsive during the transition. One interviewee noted that it was clear that MCOs were spread thin and didn't have enough systems in place. The ACH offered technical support to help resolve claims payment issues.

### **Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* Elevate Health has committed to several interventions to increase access and improve bi-directional care. Examples include:

- Increase appropriate use of suboxone among providers.
- Develop a clear intake tool for first responders and law enforcement to assess readiness for opioid use disorder treatment and where to take people.
- Increase awareness of the District Court's Resource Center.
- All partners who sign a binding letter of agreement are required to send at least two care teams to participate in the Whole Person Care Collaborative. The goal of the collaborative is to advance knowledge and skills to effectively co-manage patients.

Achievements described by partnering providers include:

- One set of partners have entered into a Business Associate Agreement with the goal of utilizing resources at both agencies to further integration goals. Currently they have established regular steering committee meetings comprised of executive leadership from both agencies.

- As of January 2019, another set of partners have a co-located therapist and are continuing to work on workflows and building communication between providers treating the same patient.
- Another set of partners indicated that in June 2019 they began to have provider meetings that include PCP, BHC, and specialty mental health to review shared patients. Monthly meetings are planned.

While partner examples of implementation were presented, one partner noted a limitation in the AIMS Center model in that it was developed for an all-inclusive system versus independent agencies trying to partner. This has resulted in challenges to their implementation progress.

#### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* Elevate Health is implementing a Care Continuum Network that includes launching the Pathways Community HUB model and Community Health Action Teams (CHAT). CHAT is a multi-disciplinary team that supports patients, including social determinants such as addressing housing, food, and job training. Partnering providers indicate that a particular benefit of the model is that it offers similar processes and uses the same language which allows partners to develop shared understanding. Concerns around sustainability and reimbursement of the collaborative care codes by MCOs were raised.

#### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* Documentation and interviews confirm that Elevate Health has provided partnering provider training and technical assistance. Examples include:

- Conducting an all-day training on MCO topics that included assistance to negotiate MCO contracts.
- Offering Improvement Advisors training through the Institute for Healthcare Improvement (IHI).
- Creating an IMC Learning Network to help mental health and SUD partners know where and who to go to for help in the IMC payment transition.
- Providing training materials from the AIMS Center that include information on risk stratification, registry processes, Ask Three, among others.

#### **Project Implementation.**

For each project selected, Elevate Health was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original



approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

**Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* By the end of the Medicaid Transformation, all providers expect to have implemented the Collaborative Care Model with some elements of the Bree model when flexibilities are necessary for the partnering providers. They note that integration efforts will help sustain system transformation by:

- Optimizing utilization and reducing system strain
- Reducing unnecessary ED and preventable hospital use
- Improving health and management of health

*Implementation Plan Progress.* Partnering providers submitted evidence and interviewees indicated that significant progress is being made. Approximately sixty-eight (68) sites are targeted for bi-directional integration. A partnering provider noted a limitation to progress is that a sufficient number of behavioral health staff are not available in the workforce to place in all sites. Staffing is being assessed based on the greatest need at locations with the highest uninsured and Medicaid rates. *“We are running at 800 mph.”*

**Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* Providers will implement the 2015 Washington State Agency Medical Directors Group (AMDG) Guidelines for Prescribing Opioids for Pain, the Washington Emergency Department Opioid Prescribing Guidelines, and/or the Substance Use During Pregnancy: Guidelines for Screening and Management.

*Implementation Plan Progress.* The Transformation Rules of Engagement identify required activities for partnering providers and specifically discuss reducing opioid-related deaths through prevention, treatment, and recovery supports. There is an expectation for primary care partners to increase access to MAT, naloxone, make linkages to PDMP, integrate telehealth, and implement family-based care.

## Summary Findings for Greater Columbia ACH

**Greater Columbia ACH**

- **Counties:**
  - Asotin
  - Benton
  - Columbia
  - Franklin
  - Garfield
  - Kittitas
  - Walla Walla
  - Whitman
  - Yakima
- **Tribal Reservation/Trust Land:** The Yakama Indian Reservation is located in Yakima County.
- **Medicaid Population Size (2018 Client Count):** 252,922

ACH Regions Map

HCA 92-009 (2/16) Okanogan and Whitman are transitional counties based on Medicaid regional service areas.

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- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2C: Transitional Care
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: #0056b3;">■</span> <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

**2. Regional Insights:**

ACH leadership and partnering providers were asked about successes and challenges identified to date.

*Table 9. GCAH Successes and Challenges*

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>GCACH takes feedback from partners in the community about what they need to hear and learn and includes those lessons in learning collaboratives. They have a very hands on approach. Staff can call them anytime and they will do a site visit.</li> </ul>	<ul style="list-style-type: none"> <li>It’s been difficult to align across the regions across certain initiatives. There is still shared information even if they’re doing things differently.</li> </ul>
<ul style="list-style-type: none"> <li>The transformation project helped bring everyone together to talk. Pulling in people from all different sectors to see what they really do compared to what you think they did. Project has helped break down silos and build relationships.</li> </ul>	<ul style="list-style-type: none"> <li>There are newer people at the State level but the staff at ACH level have been consistent. A challenge is that responses are disjointed between HCA and MCOs.</li> </ul>
<ul style="list-style-type: none"> <li>Funding helped move forward great conversations between behavioral health and hospital; it also helped strengthen the partnership with the jail.</li> </ul>	<ul style="list-style-type: none"> <li>The milestone reporting tool wasn’t written for behavioral health, it was written clearly for the physical health world. They had to translate it and flip the script regarding the language.</li> </ul>
<ul style="list-style-type: none"> <li>The biggest benefits of the MTP, as a whole, is getting the physical health world on board with case management, integration and whole person care - including wraparound care.</li> </ul>	<ul style="list-style-type: none"> <li>The region is so complex and diverse; it is difficult to create a tool that works for everyone.</li> </ul>
<ul style="list-style-type: none"> <li>Practice coaches have been invaluable.</li> </ul>	<ul style="list-style-type: none"> <li>The largest concern is the ability to share data.</li> </ul>
<ul style="list-style-type: none"> <li>Both the collaboratives and leadership council are great about showing national, regional and local level data and making it meaningful.</li> </ul>	<ul style="list-style-type: none"> <li>There hasn’t been a lot of HIE work yet. There has been a lot of examining vendors and software solutions to potentially launch in the region. Funding and buy-in are major issues.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that the Board of Directors includes seventeen (17) voting members and one non-voting member. Required sectoral representation was confirmed in documentation provided. This includes representatives from the following sectors: housing, transportation, workforce development, CBO/Faith Based Organization, education, social services, public safety, local government, and a consumer.

*Communication methods.* GCACH demonstrated they have several mechanisms in place to communicate with partners including, but not limited to: monthly emailed GCACH newsletters, weekly board recap emails, presentations and leadership council meeting materials (available on line). The GCACH also has a

portal with CSI Solutions which is an online reporting and content management tool to assist in the monitoring of participating provider organizations and other contract performance.

*ACH partner support.* Partners report that GCACH has been very engaged and supportive. The GCACH website was described as a user-friendly website that has a lot of great resources. GCACH was described as having an “open door policy” for questions while also providing webinars, collaboration meetings, and opportunities to share and give feedback.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* GCACH provided documentation of signed Medicaid Transformation Project Partner agreements supporting their partnership with the selected partnering providers. Sample provisions of the agreement required the partner to:

- Complete the Maine Health Access Foundation (MeHAF)
- Complete the Qualis Behavioral Health Agency Self-Assessment Tool (Billing Toolkit)
- Develop a plan that transitions to IMC including a Practice Transformation Implementation Workplan and Business Continuity Plan

Partners were also required to register in the Washington Financial Executor Portal. The agreement further stated that all deliverables shall be received by GCACH by December 31, 2018 with GCACH ensuring prompt payment once the deliverable was approved. The completion of MeHAF and Billing Toolkit each had a pre-determined payment amount. The development of a plan that transitions to IMC including Practice Transformation Implementation Workplan and Business Continuity Plan, did not have a pre-determined payment rate, but rather a payment not to exceed a listed dollar amount.

#### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* The contract agreements include an exhibit for Non-Allowable Expenditures which states “Contractor is not permitted to duplicate or supplant other federal or state funds from this Contract.”

*Distribution of funds to partnering providers.* Documentation submitted confirms the interviewed partners have received funding and the methodology. As stated above, the contract provides detail about calculation of eligibility for payments.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for one-time and/or operations waiver activities. This includes electronic health record system upgrades and staffing expenditures.

#### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* Interviewees identified workforce issues such as, scope of practice/licensing, common trainings, recruitment and retention (especially in rural areas), and telehealth. A Workforce committee is starting to meet and work with policies from other workgroups. There has been discussion on the role of the care coordinator/case manager and what service array they can perform and what they can bill for. Additionally, an interviewee

expressed concerns on how navigator positions, which were hired using transformation dollars, will be sustained.

**Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).*

GCACH noted enhancements to EHRs are needed including population health management tools, direct secure messaging between providers, software such as PreManage, and better linkages to State systems (ex. Prescription Monitoring Program). GCACH is coordinating with MCOs to sponsor providers to get Collective Medical and/or Collective Ambulatory in order to share information between partners. Additionally, GCACH has a contract with Quad Aim Partners to serve as Digital Health Advisor to design a new IT system to connect siloed organizations via eReferrals to join together people, systems, and processes in support of improved patient transitions.

One partner acknowledged the need to ask GCACH for assistance on exchanging data with partnering providers, while another partner noted they have been pulling data manually from their current system but are in the process of getting a new EHR.

**Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* A large majority of clinics/providers are already in some form of VBP or risk arrangement with MCO's so GCACH is providing TA to help them use population health management tools more effectively, maximize workflows, and provide better care coordination. One partner noted they have greater flexibility in how to incorporate IMC with another ACH they are working with.

**Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* ACH documentation confirms they have finalized contracts and a Practice Transformation Implementation Workplan (PTIW) is in place. They are holding meetings with the PCMH Cohort organizations to create goals specific to the PCMH model of care, and have an internal QI Team with Practice Transformation Navigators that hold monthly meetings with partnering providers. Achievements described by partners include:

- Nursing staff required to use the Columbia Suicide Screening.
- Trauma-informed training.
- Cultural competency training.
- Wellness training.
- Use of a brief health needs assessment.
- Use of a Health Action Plan.
- Monthly patient satisfaction survey.

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* GCACH provided agreements and contracts that detail the strategies in place for care coordination. GCACH also provided a summary from the State-ACH-MCO priorities work group. Examples of care coordination priorities include:

- Care Coordination initiatives should cultivate a “person-centered” system that enables providers to address physical, behavioral and social determinant needs, and where practicable and necessary, use community-based coordinators and community health workers.
- Effective collaboration, partnership and communication between MCOs, ACHs, providers and care coordination organizations (CCOs) is necessary to effectively and efficiently deliver services that support care transitions across physical health, social services, justice-involved and behavioral health settings.
- The MTP is an opportunity to introduce innovation that might result in changes to care coordination models, and can establish a clear value proposition that can help justify ongoing payment and sustainability.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* GCACH reported multiple methods for how they offer partner training and technical assistance. Examples include:

- Practice Transformation Implementation Workplan for Columbia County Health System
- Value based reimbursement tied to practice transformation
- Equity toolkit
- Education on literacy competency

### **Project Implementation.**

For each project selected, GCACH was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. GCACH provided all requested documentation. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, “Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation” and “Project 3A: Addressing the Opioid Use Public Health Crisis” the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* GCACH elected to utilize all of the models available in the Healthier Washington Toolkit to allow for the differing practice needs of partnering providers. GCACH is seeking to improve outcomes

identified in the Bi-Directional Integration project pay for performance (P4P) and pay for reporting (P4R) metrics, and align efforts with other projects.

*Implementation Plan Progress.* The ACH is monitoring implementation at the practice site level through a Practice Transformation dashboard. Partner progress is indicated in a red, yellow, green format showing status as “planning implementation,” “has been implemented,” or “has not been implemented.” Additionally, the dashboard identifies the evidence-based model selected for this project. According to the submitted dashboard, thirty percent of the partners are co-locating primary care and behavioral health, thirty percent reported implementing the AIMS Center model while another fourteen percent are implementing the Bree Collaborative. The remainder are implementing a mix of models. The dashboard indicates that all partners have implemented their selected model(s). One barrier noted is navigating 42 CFR Part 2 requirements for sharing information from behavioral health to primary care and primary care to behavioral health.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* GCACH is targeting prevention and management of chronic disease through multi-county collaboration and partnerships, with an emphasis on obesity and diabetes. In order to address upstream causes of chronic disease, project efforts are emphasizing prevention, patient education and engagement and utilize community health workers.

*Implementation Plan Progress.* The Practice Transformation dashboard also indicates that all partners have implemented Project 3A.

Through the MPA process, one partner noted the goal of the project is getting people into recovery care and there are three pieces to the project:

1. Case Management/Care Navigation - meeting and talking with patients, working up a root cause analysis, and determining barriers to care through a comprehensive assessment and survey.
2. Wrap-around care and support services – housing support and assistance, transportation assistance, outpatient MH services, etc.
3. Medication Assistance Therapy (MAT) – prescribing medications to combat addiction.

In most cases when a partnering provider has initial contact with a patient, they perform the case management and wrap-around care, but make referrals for the patient to receive MAT services.

## Summary Findings for HealthierHere

HealthierHere

- **Counties:**
  - King
- **Tribal Reservation/Trust Land:** The Cowlitz Indian Tribe, Muckleshoot Indian Tribe, and Snoqualmie Tribe are located in King County.
- **Medicaid Population Size (2018 Client Count):** 416,559

ACH Regions Map

HCA 82-008 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2C: Transitional Care
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: #0056b3;">■</span> <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

### 2. Regional Insights:

ACH leadership and partnering providers were asked about successes and challenges identified to date.



Table 10. HealthierHere Successes and Challenges

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>• HH is inclusive of many stakeholders. Key influential and respected clinical leaders in the community across sectors are engaged and help with mitigating concerns with the provider community.</li> <li>• The Medicaid Transformation has brought people to the table and has been one of the most productive experiences from a cross-sector perspective. The continued dialogue ensures that differing viewpoints are acknowledged and heard.</li> <li>• The HH focus group voiced appreciation for having DOH, HCA and others coming together to discuss how all the initiatives align, whether it be HIE, clinical data repository, or CHWs.</li> </ul>	<ul style="list-style-type: none"> <li>• Coordination is a challenge due to the large size of the county and number of providers. HH has had to figure out an approach due to this volume.</li> <li>• For the MTP, looking across the state to see what might be better statewide than regionally would be beneficial (e.g., Shared Care Plans may cross the state because patients cross boundaries – needed to decrease confusion). This would require some HCA involvement.</li> <li>• VBP – recognizing how to align the incentives. We are aligned but incentives haven’t caught up yet. Once we bring MCOs in more and further align, it will be helpful.</li> </ul>
<ul style="list-style-type: none"> <li>• Consumer and community voice committee members are on the Board and are highly involved, which is essential in making sure consumers are kept at the center of the work. MCOs are also very engaged in the ACH. They have one voting seat, but all have a seat at the table. The MCOs have also been found to be coordinating better among themselves, as they have been with them all along the way.</li> </ul>	<ul style="list-style-type: none"> <li>• A major challenge mentioned was insufficient funding to increase staff numbers to focus solely on these projects. Funding for workforce is a common problem. There are provider workforce shortages; their bandwidth is a challenge for transformation priorities and organizational priorities.</li> </ul>
<ul style="list-style-type: none"> <li>• HH’s governance is very professionally run and structured. Partnering providers find that there is clarity with a great process overall.</li> <li>• In response to concerns that DSRIP is complex, creating a lack of understanding of information provided, HH has worked with a communication consultant to help in simplifying and clarifying information so that stakeholders get what they need from a layperson’s understanding.</li> </ul>	<ul style="list-style-type: none"> <li>• A number of providers are in the process of implementing EHRs, so there is a challenge to add MTP activities. An initiative being pushed out without a lot of time doesn’t really facilitate seeing the results within a five-year period.</li> </ul>
<ul style="list-style-type: none"> <li>• Since moving to whole person care, HH has done a nice job helping to build infrastructure within the smaller behavioral health offices.</li> </ul>	<ul style="list-style-type: none"> <li>• Metrics are a point in time (e.g., ED). For example, homelessness is increasing which is creating additional people in shelters. ED visits may go up. It’s not because initiatives aren’t helping, but the environment is changing. This is a barrier.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that HealthierHere’s Governing Board includes twenty-three (23) members and maintains the required sectoral representation. This includes health system, primary

care, hospital, tribal, FQHC, managed care organization, behavioral health, public health, government, housing long-term care, social services and philanthropy sectors.

*Communication methods.* Documentation and interviewees confirmed that HealthierHere communicates with partners through multiple methods and is particularly strong at packaging information in a way that makes it organized and digestible. The ACH has a robust website that is a resource for many communications, including Medicaid Transformation project materials, partner learning webinars, pay for progress tools, value-based payment resources, innovation fund and co-design collaborative information, news and events calendars and other resources. E-newsletters and announcements are also utilized as methods of communication. HealthierHere has been able to effectively ensure that the work of committees inform the regions strategies.

*ACH partner support.* ACH partners confirmed that HealthierHere holds webinars, collaboratives, and monthly activities that are a useful part of the project implementation process. Examples of practice coaching, the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center Contract and motivational interviewing training materials were evidence of support.

One partner indicated that the ACH's communication "...is terrific and they're very visible." It was further noted that HealthierHere has had a very strong focus on equity and an inclusive approach, while striving to focus on SDOH. The forums have provided partnering providers with useful networking opportunities and a partner shared there have been some profound "aha moments" as a result.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and interviews confirmed that HealthierHere and providers are engaged in efforts to support Medicaid Transformation. ACH provided a copy of the Master Services Agreement and a listing of the providers the agreement was applicable to. Partners have signed project specific agreements, which were provided. Agreements are signed for three-year terms and detail participant and ACH responsibilities and funding schedules.

### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted confirms the interviewed partners have received funding and the funding methodology.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for Medicaid Transformation activities. For example, funds are being used for MTP operations, wages of new staff, EHR implementation, technical assistance, recruitment activities, staff time participating in learning activities, wellness integration projects, and registry development. One interviewee noted that funds were being used for 2-in-1 tablet/laptops to be able to document and collaborate more effectively with patients. The goal is to be able to connect to other online information options and then be able to integrate that with their new EHR system. The integration process

with other health providers is in progress with a long term goal to work with PreManage and One Health Port – an improved data exchange system.

**Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* HealthierHere and partnering providers discussed need for a statewide solution for workforce transformation. However, HealthierHere and providers discussed and provided information about use of Medicaid Transformation funds to address challenges and gaps in the region, including: recruitment activities, hiring of new staff, and providing learning opportunities for staff.

**Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* HealthierHere found barriers to increased use of HIT/HIE including large variability in HIE/HIT capacity and use. One interviewee noted that partners use eighteen (18) different EHR systems. Additionally, limited data partnerships and information systems that support clinical-community linkages, and fragmented referral and coordination systems to address social determinant needs were mentioned.

However, HealthierHere was found to be moving forward with supporting and working with providers to address technology solutions for the region. For example, clinical partners are implementing and optimizing their use of Collective Ambulatory software. HealthierHere contracted with Comagine Health to support the implementation and optimization of Collective Ambulatory platform for tracking ED utilization and hospital transitions. One interviewee pointed out that the technology being funded and implemented to identify patients in the ED is particularly useful when working to provide services to the large homeless population within the community. A community-based organization representative noted that funds were being used for 2-in-1 tablet/laptops to be able to document and collaborate more effectively with patients. The goal is to be able to connect to other online information options and then be able to integrate that with their new EHR system. The integration process with other health providers is in progress with a long term goal to work with PreManage and One Health Port – an improved data exchange system. ACH staff are offering financial support and guidance throughout the implementation.

The Public Health Department has been supporting the region with data analytics that has been useful for HealthierHere's partners. Example analyses have included the health status of specific communities, identification of county-wide utilization patterns, stratification of ED utilization, identification of high utilizers, and comparing health outcomes with housing data. Partnering providers voiced interest in understanding how data and measurement can inform their progress and answer the question: "How do you know when you have arrived?"

**Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* HealthierHere worked with King County government and all contracted BHAs to refine a proposal for distribution of the first portion of mid-adopter integration incentive funding for infrastructure investments to support the transition.

Examples of HealthierHere support to providers with IMC implementation are as follows:

- Governing Board Decision Memo: 2018 Fully Integrated Managed Care (FIMC) Allocation Methodology.
- 2019 HealthierHere Training Launch Timeline.
- List of BHAs Receiving Training/Technical Assistance in 2019.
- Qualis (Comagine Health) Contract and Examples of Training/Practice Coaching Materials.
- PreManage (Collective Ambulatory) support.
- VBP Academy.

### **Bi-directional Integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* ACH documentation and interviews confirm bi-directional integration has advanced as a result of Medicaid Transformation. Behavioral health organizations are jointly working with physical health providers and in one example, there are plans for a physician to offer services in a BHO once a week with the goal for co-location in the future. Additionally, BHOs are increasing the tracking the physical health needs of new and existing clients and creating registries for complex care cases that are shared across organizations.

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* Care coordination activities within the region have expanded. An example includes hospital support for jail transitions with a nurse assigned to help obtain data, support facilitation and communication, and consult with physicians in the jail system. A second method by which care coordination is improving in the region includes feedback loops between the ACH's Community Voice forums and hospitals. Forum members are providing recommendations to the hospitals for care coordination. One interviewee noted their interest in transitioning their staff from Care Coordinators to Care Navigators to help individuals navigate the full system and address whole person health.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* HealthierHere has pursued and conducted multiple methods to offer partner training and technical assistance. HealthierHere has described training and TA available, including:

- 2019 HealthierHere Training Launch Timeline.
- Qualis (Comagine Health) Contract and Examples of Training/Practice Coaching Materials.
- University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center Contract.
- Adam Falcone/Managed Care Contracting From a Position of Strength Contract.
- Motivational Interviewing Training Materials.

- Examples of Partner Learning Webinars.

### **Project Implementation.**

For each project selected, HealthierHere was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* HealthierHere indicated in its project plan partners would select from the following approaches: Core practice recommendations detailed in the Bree Collaborative Behavioral Health Integration Report, the Collaborative Care Model, and the Milbank report on primary care in behavioral health care settings. HealthierHere noted plans to work to integrate physical and behavioral health care, including oral health, and pregnancy intention screenings.

*Implementation Plan Progress.* ACH documentation indicates that the Bree Collaborative Behavioral Health Integration and AIMS Center Collaborative Care Model are being used. Partners indicate progress with patient registries, tracking, culture change activities, whole person care screenings/assessments, new service contracts, and new business development relative to behavioral health and trauma training.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* HealthierHere indicated in its project plan a multi-pronged approach utilizing four essential components: prevention, treatment, overdose prevention, and recovery. HealthierHere noted plans to support sustainable health system transformation through activities such as supporting providers to prescribe opioids appropriately and provide training, increase access to MAT and overall SUD treatment, work with MCO partners to identify VBP models that support easier access to MAT, provide education about and distribution of Naloxone kits, and provide ongoing recovery support for Medicaid beneficiaries with OUD and linkage to a primary health home.

*Implementation Plan Progress.* HealthierHere has leveraged work of the Opioid Taskforce for their Opioid Workplan and the work offered by partners has been a very collaborative approach. Partners have offered technical assistance and support to hospitals to use their providers to provide MAT services and follow up with their members.

## Summary Findings for North Central ACH

**North Central ACH**

- **Counties:**
  - Chelan
  - Douglas
  - Grant
  - Okanogan
- **Tribal Reservation/Trust Land:** Part of the Confederated Tribes of the Colville Reservation is located in Okanogan County.
- **Medicaid Population Size (2018 Client Count):**  
93,342

ACH Regions Map

HCA 82-008 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3D: Chronic Disease Prevention and Control
  - 2C: Transitional Care
  - 2D: Diversions Interventions

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: green; font-weight: bold;">■</span> <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

**2. Regional Insights:**

ACH leadership and partnering providers were asked about successes and challenges identified to date.

*Table 11. North Central ACH Successes and Challenges*

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>Relationship building across partners and networking has been beneficial in comparing what has or has not worked in order to streamline processes. There have also been connections made recently with the tribes to move forward new activities.</li> </ul>	<ul style="list-style-type: none"> <li>The project is large and explaining it was difficult. The whole process has felt like building the plane while in the air.</li> </ul>
<ul style="list-style-type: none"> <li>The Medicaid Transformation brought a lot of expertise and movement where it wouldn’t have changed by itself. The ACH team is strong and has been consistent.</li> </ul>	<ul style="list-style-type: none"> <li>HCA has been inconsistent in messaging and there has been a change in direction regarding support for the Pathways Community HUB model when at the start of the waiver it was the only option provided for that project.</li> </ul>
<ul style="list-style-type: none"> <li>Contracts and MOUs might not be as onerous in this region, as they have used more “carrots than sticks.”</li> </ul>	<ul style="list-style-type: none"> <li>Information exchange and capacity by partners is difficult and has been a large constraint. Partners have struggled to get data out of their systems for use in making organizational decisions, but participating in a learning community has been useful to hear alternative solutions. Focusing on technology has become a strategic imperative moving forward.</li> </ul>
<ul style="list-style-type: none"> <li>The theories and ideas of quality improvement were foreign. The knowledge gained related to QI processes has been a significant take away and the commitment to use these techniques will continue beyond the waiver. Organizations can use these skills for future initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>Five years may not be enough time to move the needle. It took over a year to get things up and going, and then you have to build the relationships, and then you start to do the work.</li> </ul>
<ul style="list-style-type: none"> <li>The successful Transitional Care Management model has spread across the region through a peer-to-peer process with a leading hospital supporting the training of other hospitals. This alignment has allowed physicians to know what to expect.</li> </ul>	<ul style="list-style-type: none"> <li>Administrative burden has been much higher than originally thought. Some partners have pulled back to focus on certain sections in their plans due to time and resources constraints. The change plan development process could have been handled differently. The plans were written, and then training was provided on how to draft the plan.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that the Governing Board includes nineteen (19) members of the required sectoral representation. This includes healthcare organizations, business, government, social

services and healthcare consumer sectors. The Governing Board is the principal and ultimate decision-making authority for the NCACH, with input from the Coalitions for Improvement.

*Communication methods.* Documentation confirmed that the ACH is communicating with partners through multiple methods including on-line web portals, newsletters, emails, training communications, webinars, and meetings. NCACH highlighted the practice of sending a “monthly meeting roundup” that has been found to be particularly useful in keeping organizations informed. Each month a summary is sent to all stakeholders that recaps key decisions made and current trainings and events available.

*ACH partner support.* Partners report that NCACH offers support via meetings, trainings, collaborations, and sharing of practices across partnering providers and ACHs. They indicate that the quarterly reporting has been helpful because it reminds partners to plan in a realistic manner. They also shared that the learning and action networks are very helpful and their knowledge has grown through support offered by NCACH.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and site visit interviews confirmed that NCACH and partnering providers are engaged in efforts to support the waiver. NCACH and partners have signed Medicaid Transformation Project Partner agreements. The majority of the contracts reviewed were signed before December 2018, while one agreement was signed by June 2019. As way of example, Stage One for the Whole Person Care Collaborative Learning Community, the partner requirements included:

- Complete a MeHAF/PCMH-A baseline assessment to establish current operational state relative to the PCMH model (organizations may use Qualis, now Comagine Health, or another consultant of their choice.)
- Identify interdisciplinary team(s) to attend training and share knowledge within their clinic and peer group, including members in the following key roles: a senior leader, a day-to-day leader, and a clinical champion who is a licensed medical professional such as an MD, RN, RD, RPh, NP, or PA, and one or more support staff such as RN, LPN, MA, who are involved in the day to day support of clinical activities.
- Provide dedicated staff time to work on activities specified by the learning activity in order to reach desired outcomes. Activities may include change plan development, defining and collecting relevant measures, preparing assigned materials, using rapid testing cycles, and submitting reports.
- Develop and submit to NCACH a change plan by July 31, 2018 in a format (change plan template) approved by the Whole Person Care Collaborative Workgroup.

The agreement outlined reimbursement methodologies specific to partners and contracted activities. As way of example, Stage One funding to the partner was payable within sixty days of the signed MOU.



### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted confirms partners have received funding and the funding methodology.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed receipt of funds for Medicaid Transformation activities. Funds have been used by NCACH and its partnering providers for project activities, such as purchase of iPads to connect crisis response teams with medical providers, implementation of the Pathways Community HUB model, promoting preventive programs and engagement with EMS, purchase of supplies that help connect providers, and the selection and purchase of substance abuse curriculum for a school district partner. Partners also utilize the funds to address workforce issues including training and the recruitment and retention of behavioral health staff.

### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* NCACH identified that there are high turnover rates for dental and medical assistants, and a shortage of chemical dependency professionals. Partners noted the high cost of training to get professionals out in the field and the struggles to provide culturally competent care. Successes include contracting for telemedicine, adding peer support/counselors, mid-level support for screenings, and the formation of hospital coalitions to share expenses for recruitment.

### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* NCACH's approach has been to evaluate data at the macro level and then help providers collect data from the ground up. The ACH and partnering providers spent time strategizing about selection of the right measures for each partner to have an impact and focus on quality improvement. A particular data challenge noted is an inability to have data granular enough to complete analysis for targeted interventions. It was mentioned that the data capacity from the State stops at the county level, but the ACH paid a contractor to get more detailed data for purposes of emergency department hot-spotting at the zip code level.

Added to that concern is one related to the release of information and sharing of data by the MCOs. It was noted if MCOs released information sooner, organizations may be able to work directly with high-prescribing opioid providers to intervene with those clinicians.

An interviewee spoke positively about concrete HIT activities in their region, including the use of Collective Medical tools as they have been found to work and the State mandates use by all hospitals.

### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.*

An interviewee shared that a lot of work was still occurring for the transition to IMC and found the contracting process complicated, but indicated NCACH assistance with MCO contract language helpful.

### **Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* NCACH has provided symposiums and staff in the regions for training, education and to support sustainability. MAT trainings have been helpful for clinics resistant to MAT in the past.

Interviewees shared that training has been helpful to see what others have done to overcome issues. Additionally, that the waiver has brought multiple healthcare partners together at one table to discuss and integrate physical and behavioral health. *"No one has done that as well as NCACH...the work is still healthcare centric, but it is laying the foundation for strong partnership across all healthcare systems..."*

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* As care coordination expands in the region, a partner warned that a bigger issue statewide exists related to community-based organizations that are small and financially fragile and recommended that helping CBOs become electronically ready is a particular need. Another partner advised that agencies should not treat care coordination as a public health project due to the need to treat care coordination as a business model that is reimbursed for services provided. A change in mindset could be needed at multiple levels.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* NCACH has pursued and conducted multiple methods to offer partner training and technical assistance. Examples include:

- The ACH is providing boots on the ground resources for 17 behavioral health and primary care organizations with a purpose to meet each site where they are at in terms of integration. NCACH leadership has taken time to find out what matters to each organization and relate those priorities back to the partner's change plan.
- An interviewee remarked that NCACH has been invaluable in helping to choose the target population for the Pathways Community HUB model and to make the evaluation piece of the project clear.
- NCACH coaches have offered trainings such as motivational interviewing and quality improvement techniques (e.g., Plan Do Study Act cycles).

### **Project Implementation.**

For each project selected, North Central was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines,

policies, procedures and protocols.” The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

Documentation submitted included kick-off meetings, work flows, Pathways Community HUB model documentation, Action Health Partners documentation, monthly reports, change plan documents, workgroup notes, Opioid conference information, Learning and Action Network peer- consultancy and expert coaching training documents, practice sharing sessions, training sessions, and quantitative reports demonstrating progress.

For the required projects, “Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation” and “Project 3A: Addressing the Opioid Use Public Health Crisis” the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* In the project plan, NCACH described expectations for evidence-based approaches and promising practices, specifically the Bree Collaborative and Milbank Memorial Fund report. They are leveraging technical assistance from national experts, a full-time data analyst, and evaluation support from the Center for Outcomes Research and Education (CORE).

*Implementation Plan Progress.* Documentation and interviews confirm progress in the following examples:

- PHQ9 assessments are being provided and offering medical staff cues to see what follow-up is needed for patients. Workflows are now in process for warm hand offs the same day to behavioral health if needed.
- Blood pressure and metabolic monitoring has been implemented with nurses embedded in the behavioral health organizations doing that work.
- Referrals are made if patients need chronic disease management or there is a noted concern from the primary care provider. Referrals that can be made include: home safety assessments, comprehensive fall risk program, physical therapy assessments, assessment for a community SAIL (strength and balance class); chronic disease management classes, memory care support group. A partnering provider commented that going to the home allows the patient to get everything out and build a relationship to figure out how next to assist the patient.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* NCACH’s submitted project plan described an approach that planned to take into consideration the AMDG Interagency Guideline on Prescribing Opioids for Pain, CDC Guideline for Prescribing Opioids for Chronic Pain, and the State Interagency Workplan.

*Implementation Plan Progress.* In 2019, eight strategies were selected and most of them are being recommended to carry through in 2020. Examples of these strategies include: school based prevention, Narcan training and distribution, recovery coaches train the trainer, and a rapid cycle opioid application

process. Groups have been meeting and requested additional support for the work they have been doing. Participants are bringing information to the work group to share best practices.

## Summary Findings for North Sound ACH

**North Sound ACH**

- **Counties:**
  - Island
  - San Juan
  - Snohomish
  - Skagit
  - Whatcom
  
- **Tribal Reservation/Trust Land:** The Lummi Nation, Nooksack Tribe, Samish Indian Nation, Sauk-Suiattle Tribe, Swinomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe are located in the region.
  
- **Medicaid Population Size (2018 Client Count):** 281,247

HCA 82-008 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3B: Reproductive and Maternal and Child Health
  - 2C: Transitional Care
  - 3C: Access to Oral Health Services
  - 2D: Diversions Interventions
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	<span style="color: green; font-weight: bold;">■</span> Continuation
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

**2. Regional Insights:**

ACH leadership and partnering providers were asked about successes and challenges identified to date.

*Table 12. North Sound ACH Successes and Challenges*

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>Strengths and assets have been built through the region’s strong history of collaboration. Most of the efforts had pilots or regional work, but the Medicaid Transformation has provided opportunity to replicate and/or scale the prior work of five jurisdictions. Examples include community paramedicine, general diversion work, and integrated care.</li> </ul>	<ul style="list-style-type: none"> <li>Balancing the focus of the projects is a challenge due to the understanding that what goes into a person’s health isn’t just in a clinical setting. There are not a lot of tools in the toolkit to include SDOH and the community-based organizations.</li> <li>Time is described as a significant challenge and partners proposed that consideration should be given for more time and capacity to allow for greater cohesive intercommunity projects and connections.</li> </ul>
<ul style="list-style-type: none"> <li>A lot of stakeholders were brought to the table that weren’t already communicating and talking about better serving the population is very helpful.</li> </ul>	<ul style="list-style-type: none"> <li>It took time to understand how to create the partnerships between clinical partners and community providers. The value in connections between EMS and primary care, care coordination and primary care are now becoming clearer. A lot of energy has been used getting folks to the table and on the same page and momentum can be lost</li> </ul>
<ul style="list-style-type: none"> <li>A sustainability model built around cross-sector relationship building has been seen as a success. However, this is not what is being measured, but it is what funders are investing in. That is where there is opportunity in the future.</li> </ul>	<ul style="list-style-type: none"> <li>There are limited funds with an expiration date, but there has been little focus on sustainability, for instance, the use of telehealth is a prime example.</li> </ul>
<ul style="list-style-type: none"> <li>Participation occurred because the Medicaid Transformation aligned with the organization’s mission, vision, and values and the work was already on their strategic roadmap. The funding was integral in getting the integrated behavioral health and opioid management and care management/care coordination going.</li> </ul>	<ul style="list-style-type: none"> <li>From the behavioral health side, having SUD agencies becoming part of the BHO and then having the financial transition was a lot of change. They were already invested in new EHRs. Those agencies have had a heavy lift.</li> </ul>
<ul style="list-style-type: none"> <li>The Medicaid Transformation helped shine light on the community services already being provided and has been an opportunity to connect community organizations.</li> </ul>	<ul style="list-style-type: none"> <li>Performance measurement specifications have shifted and that is something that has to be monitored. Additionally, reaching the goals in five years, when implementation started in year three, was ambitious.</li> </ul>

**3. Review Components:**

**ACH Organization Governance & Compliance.**

*Representation.* Documentation confirmed that the board roster indicates nineteen (19) positions with one (1) vacancy (the Stillaguamish tribe seat). The Board of Directors includes representatives from the county, community, health department, multiple tribes, physical health, and behavioral health providers. The Board of Directors oversees five (5) Committees/Councils.

*Communication methods.* Documentation confirmed that the ACH is communicating with partners through multiple methods. The ACH noted that communication has evolved over time and has become more operationally focused. The provider reporting portal has been a beneficial source for capturing quality improvement information and determining what technical assistance partners require. ACH leadership also described the benefits of direct site visits with every partner as a means for relationship building and connecting partners. The ACH learned that several organizations have capacity around trauma-informed care, and the ACH is assisting them in forming a network specific to this topic. These one-on-one conversations allowed partners to more robustly describe their progress compared to what is captured in the reporting portal. *“What we found, was that not only was progress being made, but they were doing so much more than was being captured in the reporting.”*

Partners confirmed that the ACH communicates via email, holds weekly webinars, and twice yearly convenes larger meetings which allows partners to see what the other North Sound communities are doing as a whole.

*ACH partner support.* Generally, partners offered positive reports about the guidance and training opportunities offered by North Sound ACH and noted that there has been a balance between mandatory versus voluntary attendance and reporting are not too burdensome and ask for just enough detail. One partner noted that communication with the ACH staff has been limited, while another partner shared that the ACH is responsive through emails and phone calls for questions and assistance with ACH contact weekly. It was noted that there could have been a stronger role from the ACH in getting partners to the operational level. While the ACH had convened cross-sector groups initially, those have tapered off.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and site visit interviews confirmed that North Sound ACH and selected partnering providers are engaged in efforts to support the waiver. The contract Scope of Work includes activities in the categories of Capacity Building, Cross-Cutting Implementation, and Implementation Strategies. Payments for Care Coordination Agency (CCA) staffing and outcomes are detailed in the agreement exhibit, Payment Model for Care Coordination Agencies

Partners communicated that the Medicaid Transformation aligned with their organizations' goals and the support offered them to address, accelerate, or achieve these goals. With so many Medicaid patients in the mental health space with unmet needs, there was a strong desire to participate. In regards to the overall financial support, one partner shared that the funds have helped get their MAT programs up and off the ground, especially at newer satellite clinics.

### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* North Sound ACH leadership confirmed that their team discussed with each contracted partner the funding methodologies and restrictions. Specifically, the ACH team reviewed that the partner could not use Medicaid Transformation funds to pay for something that Medicaid was already paying for, and they couldn't "double down."

*Distribution of funds to partnering providers.* Documentation submitted confirms payments made to partnering providers (traditional, non-traditional, tribe) and the methodology that North Sound ACH utilizes for funding.

*Partnering provider usage of transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed receipt and usage of funds for waiver activities. Documentation with transaction date, amount and the partner's name confirmed fund disbursement. Partners supported having the flexibility to use funds for local needs. Partners confirmed that investment for this region has supported activities such as securing new staff positions, development of a patient registry, a chronic disease prevention and management program, and providing operating funds for medical group operations,

### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* North Sound ACH leadership and partners identified that impacting workforce broadly is larger than one ACH can address, with some specific exceptions. Partnering providers shared concerns regarding their capacity to hire behavioral health staff, particularly for a community-based agency where lower pay scales and resources inhibit attracting and retaining staff. Partners suggested that expanding loan forgiveness programs found to successfully attract staff for FQHCs and rural providers and reimbursement increases are necessary.

Although there have been challenges, progress has occurred related to workforce development in the region and examples included:

- North Sound ACH offered community health worker training with the launch of the Pathways Community HUB model.
- North Sound ACH supported tribal access to dental health aide technicians (DHAT). The tribe created a certification, and then the region partnered with a community college to have the curriculum development.
- Specific positions include: Recovery coach, Care coordinator, Acute Care Transitions Coach, Spoke Care Navigator, Population Health Coordinator, LPN Chronic Disease Coordinator, RN Complex Care Manager Outpatient, a pediatric specialist, PMG Ambulatory Care Social Worker and Behavioral Clinical Social Worker. Job descriptions for each were also included.

### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).* North Sound ACH identified that the region's gaps are similar to other regions. There currently is not a consistent platform being used across the region. Limited interoperability inhibits the ability to share



needed information across systems (sometimes within one's own organization) which creates challenges for effective care coordination. Potentially for that reason, North Sound ACH determined that HIE/HIT investments at a regional level should not be their focus and encouraged seeking change at the State level. However, examples of work in the region are as follows:

- One notable example of progress in this area impacts not only the North Sound region, but spans the state and crosses state borders. One partnering provider purchased a population health management tool with Medicaid Transformation funds that will be used to review key quality indicators through race/ethnicity and other demographic factors. The partner noted that although there has been a desire for this additional capability to monitor their patients pro-actively, the expense was cost prohibitive. This tool will now be utilized in five states because of the organization's nationwide reach.
- Other examples include the establishment of data sharing agreements, and screening and capture for social determinants of health and referrals.
- One concern a partner shared was the lack of progress related to performance measurement and the delay in its usage in behavioral health care systems. This partner was looking for direction and guidance from MCOs and commented that North Sound ACH is filling the void that the MCOs aren't filling with population health and community projects.

#### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* North Sound ACH's board chose to invest approximately \$6 million of their integrated incentives via a contracting arrangement with the behavioral health organization (BHO). As the BHO already maintains contracts with providers, the process to fund behavioral health agencies was expedited. Some BHO partners in addition to ACH change partners benefited.

ACH staff confirmed that transition dollars supported new EHR systems, upgrading network systems, computer parts and hardware. The BHO took on responsibility for partners meeting with the MCOs. One challenge reported specific to the transition was not having all the requirements of the behavioral health supplemental data. IMC change required behavioral health organizations to report in a certain way to MCO. Another comment from a partner regarding the transition was that the MCOs still require time to understand each of the communities.

#### **Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.*

Documentation submitted by North Sound ACH partners confirmed commitment to increasing access and to integrate behavioral health in primary care settings. Partners had adopted the standards of the Bree Collaborative, were trained on the collaborative care model of integration, and trained on screenings. Partner comments regarding progress include the following:

- The behavioral health integration work is "going great" and they have hired a psychiatrist.

- Another partner shared that although protocols and policies haven't been finalized, they're finishing getting the infrastructure in place by the end of the year, and then moving forward next year. The partner felt that the spring report to the ACH would reflect a greater degree of progress with policy work, as they transitioned to implementation and operating.
- The partner organization was very committed to the behavioral health integration work. The organization was building out their inpatient psychiatric unit and are focused on sustainability.

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* North Sound contracted with Compass Health as the Care Coordination Agency for North Sound Community HUB. Their MOU documents the following participant responsibilities:

- Have its community health workers and care coordinators attend all Pathways Community HUB model requested care coordination training sessions.
- Collaborate with the HUB and other CCAs on essential areas of work, including Consent and Release of Information agreements signed by clients to authorize sharing of personal health information (PHI) with the HUB and its affiliates.
- Collaborate in development of the HUB Policy and Procedures manual, CCA budget template and pro forma.
- Enter into a HIPAA Business Associate Agreement with the HUB, if the Participant is a "covered entity" as defined in HIPAA.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* North Sound ACH conducted a 2018 Current State Assessment (CSA) to assess the technical assistance and training needs for the region. It was determined by NSACH that it was an ongoing need and so they performed the 2019 CSA with results summarized in the CSA Executive Summary 2019. Partners confirmed their participation and/or receipt of the following TA:

- Trainings on topics critical to successful implementation (i.e. Trauma-informed Care, Adverse Childhood Experiences, supporting LGBTQ communities, etc.).
- Partner retreat.
- Equity and tribal learning.
- Partner portal and reporting orientation.
- May data webinar.
- IMC transition.
- Dentistlink.

- TA to organize or expand syringe exchange programs.

### **Project Implementation.**

For each project selected, North Sound ACH was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress, however partners are at varying levels of implementing initiatives in the region.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* North Sound ACH intends to use the Collaborative Care model to normalize integration of physical and behavioral health services. Both behavioral and physical health outpatient care settings will use the five core model elements: creating a patient-centered care team, measuring symptoms and treating to target, using population-based care tools, accountable care, and using evidence-based treatment.

*Implementation Plan Progress.* Every partner committed to the bi-directional project is required and has completed a MeHAF survey. The ACH leadership reviews these for themes to try to identify needs. The ACH team noted that the survey assists partners to self-identify issues through the recognition of a baseline status and then with incremental changes being captured.

For this project, policies are a requirement in the change plan and there is a reporting mechanism to capture completion of this requirement in the CSI reporting portal by each partner. The ACH anticipates that further progress will be seen in 2020 and during the next set of site visits.

### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* North Sound ACH will build upon the North Sound BHO Opioid Reduction Plan (ORP), a comprehensive regional plan developed to mirror the State's plan, with regional, county-level and tribal coordination activities designed to support State-level strategies and help further the four goals of prevention, treatment, reduction of overdose deaths, and enhanced data capacity. The North Sound ACH plans to partner with the BHO and other partners to execute the ORP and implement collaborative strategies beyond the current scope of the BHO's efforts. Building on the ORP, the North Sound ACH indicates it will implement community-prioritized strategies based on evidence-based approaches and the recommended resources for identifying promising practices as outlined in the Medicaid Transformation Toolkit: Prevention: Prevent Opioid Use and Misuse; Treatment: Link Individuals with Opioid Use Disorder (OUD) with Treatment Services; Overdose Prevention: Intervene in Opioid Overdoses to Prevent Death;

Recovery: Promote Long-Term Stabilization and Whole-Person Care. They also align with the 2017 Washington State Interagency Opioid Working Plan.

*Implementation Plan Progress.* The Opioid prescribing practice work has made concrete progress making education materials available, and holding a clinical excellence learning collaborative at the system level with the intent of impacting opioid prescribing policies. Submitted documentation outlines a change in the policies and procedures to implement Naloxone prescriptions and treatments.

One partner confirmed that their MAT clinics are up and running and have policies and procedures in place to replicate if needed. If this program were to be duplicated, the partner recommend that organizations be prepare for workforce challenges due to the difficulty of finding prescribers for the resulting volume. The partner warned that the volume can be underestimated.

## Summary Findings for Olympic Community of Health

Olympic Community of Health

- **Counties:**
  - Clallam
  - Jefferson
  - Kitsap
  
- **Tribal Reservation/Trust Land:** The Hoh, Jamestown S’Klallam, Lower Elwha Klallam, Makah, Port Gamble S’Klallam, Quileute and Suquamish Tribes are located in this region.
  
- **Medicaid Population Size (2018 Client Count):** 82,661

HCA 62-008 (2/18) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2D: Diversions Interventions
  - 3B: Reproductive and Maternal and Child Health
  - 3C: Access to Oral Health Services
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor’s MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	■ <i>Continuation – with monitoring</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

**Findings.** Although documentation was provided to confirm that progress is being made for each project, after careful review of all submitted documents, including those received as a result of a request for

information, and in consideration of comments shared during interviews, we have confirmed that Olympic Community Health is notably delayed in conducting work steps to meet select project milestones.

Olympic Community Health was transparent and forthcoming regarding this delay. The ACH indicated that their focus, as well as the focus of partnering providers, has been on efforts to support integrated managed care by the January 1, 2020 deadline. Interviewees stressed the importance of this focus due to factors in the region that have created additional burden in transitioning to IMC that other regions may not have experienced. As a result, progress was not moving forward at the same pace or scope as originally planned. The ACH noted that they have already developed plans to remediate the delay and stay on track in 2020. They anticipate starting to do so by Spring 2020.

**Recommendation.** Because progress was confirmed and the ACH has a plan in place to remediate delays upon implementation of IMC, the IA recommends that the ACH be allowed to continue with their projects as planned without modification, or discontinuance, but with additional monitoring. We recommend that HCA meet to discuss the delay with the ACH, and request that Olympic Community Health provide routine updates to the State to ensure continued progress. If future SAR reports, including SAR4 and SAR5, indicate that delays are increasing and progress is deteriorating, we recommend that HCA consider formalizing remediation through a corrective action plan.

## **2. Regional Insights:**

ACH leadership and partnering providers were asked about successes and challenges identified to date.

Table 13. Olympic Successes and Challenges

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>The Medicaid Transformation has been a catalyst for providers in each county to meet and to engage across regions and within the individual service region. It has prompted convening across functions which has allowed for cross pollination and understanding of ideas.</li> <li>A unique strength is that six of the eight tribes in the region actively participate in the MTP with OCH. It has been a great win to have this level of engagement.</li> </ul>	<ul style="list-style-type: none"> <li>The magnitude of the change of shifting to financially integrated managed care (IMC) at the same time as Medicaid Transformation is a challenge.</li> <li>OCH staff retracted the intermediary metrics in March of 2019 due to partner concerns about feasibility. A revised set of metrics are expected to be approved by the OCH Board of Directors and re-released to partners in September 2019.</li> </ul>
<ul style="list-style-type: none"> <li>OCH leadership has been phenomenal and has helped partners to get to where they are. OCH also conducted very helpful site visits to discuss partner change plans. Outside consulting for contract reviews was very helpful, as their expertise allowed for recommendations for contract negotiations.</li> </ul>	<ul style="list-style-type: none"> <li>A concern was raised that integrated care focuses more on integration from the physical health side than behavioral health. This concern has been raised to the OCH board for focus.</li> </ul>
<ul style="list-style-type: none"> <li>Culture change occurring through the financial incentive and outcomes focus of Medicaid Transformation has brought medical professionals to the table.</li> <li>The Opioid Summit has been a very large accomplishment.</li> <li>PCPs are doing more screenings because now they know there are resources and know where to send their patients.</li> </ul>	<ul style="list-style-type: none"> <li>Concern was raised about variations in systems. A partner stated they wish the ACH would invest in a centralized EHR to allow connectivity. It was noted that the ACH has started down the path of developing a system that will not talk with other systems.</li> <li>The workforce needs more education about whole person care, but this issue keeps getting moved to the bottom of the list. There was a recommendation to have an Integrated Care Academy.</li> </ul>
	<ul style="list-style-type: none"> <li>A challenge is that community partners sometimes change. Different people coming into the role without having the history of the work being done requires getting them up to speed to assure things continue.</li> </ul>

**3. Review Components:**

### **ACH Organization & Compliance Representation.**

*Representation.* Documentation confirmed that the Board of Trustee includes twenty (20) members which represent the three-county Olympic Community of Health (OCH) regions. Representation includes community partners, primary care, behavioral health provider, health plan, hospital or health system, public health jurisdiction, and tribes, IHS facilities, and UIHPs sectors. Currently, two seats are vacant for the sectors of housing/homelessness and chronic disease prevention.

*Communication methods.* Board members are responsible to communicate with other members of their sector or tribe to ensure effective information flow to and strong engagement on matters related to the OCH. Additionally, Board meeting materials are posted on the ACH public-facing website.

*ACH partner support.* Partners report that OCH leadership in the MTP has been very strong. One partner noted that OCH has been very engaging and always willing to assist and provide resources they request or clarity around the process. This partner noted that OCH has also been clear about their obligations as an ACH.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* OCH submitted documentation that supports they have teamed with partnering providers to advance the goals and objectives of the MTP. OCH and partners have signed Medicaid Transformation Project Partner agreements. The agreement requires the partnering provider to complete the requirements under the Change Plan, also referred to as the Project Plan. Additional requirements include collaborating with the ACH and other partnering providers in good faith to implement DSRIP and the Project Plan; complying with Project Plan and Project-Specific Agreement (PSA) requirements, including but not limited to timely and accurate reporting in accordance with the performance measures, project milestones, and timelines specified in the Project Plan and the PSA; and providing such other information as reasonably requested by the ACH.

### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted indicates by type of incentive (PH/BH Implementation Partner and CBOSS Implementation Partner) the partner name and dollars disbursed to date.

*Partnering provider usage of funds for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for Medicaid Transformation activities. Funding was used by some partners, for example, for one-time costs such as EHR Implementation, training or operational costs such as the hiring of staff.

### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* The region is impacted by the urban core areas where pay is higher. Interviewees noted that they are competing with the giant of



Seattle and salaries have increased significantly along the I-5 corridor. The quality of life in the region is a benefit for the region, but workforce challenges exist for rural areas. One partner discussed their progress through the use of Community Health Workers (CHWs). CHWs are being used in the Emergency Department to link patients to a patient-centered medical home and also the criminal justice setting to link individuals to primary care, behavioral health, and/or other community services.

#### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).*

Particular progress in this area noted by OCH was Board approval to move forward with Digital Health Commons, a cloud based system that helps non-traditional providers to receive information. HIPAA considerations are being worked on prior to launch. Additionally, OCH is creating dashboards that are shared individually with providers during site visits. OCH has shared P4R measures at regional and county levels.

#### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* One partner noted this change marks a shift that impacts their entire financial system and it took a full year to complete. An OCH focus group noted the MCOs have been great, but the push for value-based payment (VBP) should have been included at the beginning of the project rather than later. Another partnering provider stated they have weekly calls with their Behavioral Health Organization (BHO) to share lessons learned and to ask for assistance on how to better serve patients.

#### **Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.*

The focus group interviewed noted that their region was already doing some integrated care prior to the MTP, but those efforts have been moving forward more easily. The process has helped to break down the silos. Participants have been looking at integration of behavioral health providing whole person care.

One behavioral health partnering provider stated bi-directional integration has been more about making it work for primary care. This provider noted that it isn't possible to be fully integrated because the state treats behavioral health so differently. The partnering provider further stated that there have been challenges in the understanding that a primary care provider is not necessarily the primary provider in a patient's life as a patient may see a primary care provider 1-2 times a year while seeing an SUD provider nine hours per week.

#### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* One of the outcomes found on several Change Plans was the addition of a standard assessment of social determinants of health (SDOH). These included, but may not have been limited to:

- Housing status/needs.

- Employment status/needs.
- Food status/needs.
- Transportation status/needs.

One partner noted that Care coordination has improved as providers built relationships that did not previously exist.

### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* OCH provided several examples of how they have provided training and technical assistance. Examples include:

- Epic users convening.
- SUD partner convening.
- Qualis contract for practice coaching.
- Clallam County Natural Community of Care convening.
- Tribal sovereignty training.

OCH brings the full region together annually, each county together annually, and sometimes each sector when there are particular needs or trainings.

### **Project Implementation.**

For each project selected, OCH was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* The goal is to provide the right level of whole person care at the right place and right time. For most people, behavioral health concerns are identified in the primary care setting, where early intervention, treatments or referral can occur. For persons experiencing behavioral health problems, it means creating avenues so that there is no wrong door to prevention, early intervention, treatment, and recovery. For some, specialty behavioral health care, whether mental health or substance use disorder treatment, or both, is the path to recovery. OCH's approach to bi-directional integration facilitates a patient-centered approach to recovery.

*Implementation Plan Progress.*

Documentation provided included a copy of the physical health and behavioral health change plan which lists the outcomes and tactics for the project. The ACH has offered partnering providers engaged in this initiative the opportunity to select the Collaborative Care Model, Bree Collaborative, or to utilize the Milbank Report approaches. Through documentation review, variation in the selected model and extent of progress was observed. Documentation from one partner confirmed that co-location of primary care and behavioral health is expected by Fall 2019. Standard of practice procedures for PH/BH were submitted by another partner confirming that integrated behavioral health services are operational.

**Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* OCH and its partners have been working on the region's opioid response for nearly 18 months, pioneering an approach that reflects our values, goals and collaborative focus. OCH will incorporate many of the processes and strategies developed in response to the opioid crisis to inform our approach to other projects in our portfolio.

Our vision is a region that engages all partners to practice region-wide safe opioid prescribing practices, improve care for chronic pain, improve access to the full spectrum of best practices for the treatment of opioid use disorder, prevent fatal opioid related overdoses, and ensure that our community is informed and educated.

*Implementation Plan Progress.* OCH reported the opioid project is one of their biggest strengths. They noted that even though partners are taxed for time, there is still a commitment to participate. One partner noted the opioid project has achieved wonderful progress and is fairly advanced. One challenge of the program is a lack of capacity to address SDOHs (transportation, housing, etc.). This requires a long-term engagement and collaboration, and it can be hard for small agencies to sustain involvement. The partner further noted that there is a need to identify strategies to bring in these agencies to support transformation. The focus group reported their region had prescribers and providers who had not come together, but now have done so. These providers have had in-person meetings and are learning to "speak the same language and to communicate". This improvement in communication has led to differing provider types finding common ground on how to work together on complex issues.

## Summary Findings for SWACH

SWACH

- **Counties:**
  - Clark
  - Skamania
  - Klickitat
- **Tribal Reservation/Trust Land:** Part of the Cowlitz Indian Tribe is located in the region.
- **Medicaid Population Size (2018 Client Count):** 131,932

ACH Regions Map

HCA 92-009 (2/15) Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

- **Medicaid Transformation Toolkit Projects:**
  - 2A: Bi-directional Integration of Care
  - 3A: Addressing the Opioid Use Crisis
  - 2B: Community-Based Care Coordination
  - 3D: Chronic Disease Prevention and Control

### 1. Overview and Findings

Below is a high-level overview of the Independent Assessor's MPA findings.

Objective	Review Procedures	Recommendation
<b>Objective 1:</b> Demonstrate compliance with the STCs and approved protocols	Met	■ <i>Continuation</i>
<b>Objective 2:</b> Assess project health to provide final recommendations of continuation, modification, correction action or discontinuation		

### 2. Regional Insights:

ACH leadership and partnering providers were asked about successes and challenges identified to date.

Table 14. SWACH Successes and Challenges

Successes and Challenges Identified by ACH and Partnering Providers	
Successes	Challenges
<ul style="list-style-type: none"> <li>Medicaid Transformation created a venue for necessary conversations that had not previously happened. There is integration occurring not only between physical health and behavioral health, but inclusive of the social determinants of health.</li> </ul>	<ul style="list-style-type: none"> <li>Bringing primary care providers into behavioral health settings has been challenging. PCPs are more likely to bring behavioral health consultant into their practice.</li> </ul>
<ul style="list-style-type: none"> <li>MTP has provided scaffolding, structure, education and training. The providers aren’t left to innovate on their own and SWACH has brought medical providers to participate at the community level.</li> </ul>	<ul style="list-style-type: none"> <li>There is a lack of buy-in and reluctance of some providers to get involved. Opportunities remain to discuss why integration is better for clients.</li> <li>This helps primary care providers see the benefit and bridge to behavioral health.</li> </ul>
<ul style="list-style-type: none"> <li>There has been a culture shift occurring as a result of Medicaid Transformation that reinforces the understanding of the mind/body connection.</li> </ul>	<ul style="list-style-type: none"> <li>It is not clear how to utilize aggregate data or share data. There are too many systems across providers that are dealing with SDOH. There have also been challenges with software and CCS platform.</li> </ul>
<ul style="list-style-type: none"> <li>The Health Improvement Council provides useful, specific guidance, advice and support. It is highly organized and the pace of activities is reasonable.</li> </ul>	<ul style="list-style-type: none"> <li>There has been lack of alignment or agreement with the MCOs. At this time, MCOs are not investing in care coordination like they could to see a return on investment.</li> </ul>
<ul style="list-style-type: none"> <li>Partners are describing optimism regarding the success attainable through Medicaid Transformation and feel that the region is heading in the right direction.</li> </ul>	<ul style="list-style-type: none"> <li>There has been difficulty in developing the scope of work as this process was much different than grants.</li> </ul>

**3. Review Components:**

**ACH Organization & Compliance Representation.**

*Representation.* Documentation confirmed that the Board of Trustees has thirteen (13) positions and include representatives from the community, healthcare, social services, tribes, managed care organizations, FQHCs, public health, and higher education sectors.

*Communication methods.* Documentation confirmed that the ACH is communicating with partners through multiple methods including e-newsletters, a website calendar and resources section, social media, and videos. Partners indicated there are weekly meetings/communications with a SWACH team member and SWACH sends minutes shortly after each meeting.

*ACH partner support.* Partners report that SWACH has been helpful with giving support and structure. Early meetings with different members helped conceptualize goals, mission statement, milestones, etc. It helped bring community partners to the table.

*Partnering provider engagement with ACH in support of MTP efforts.*

*Status of Contracts.* Documentation and site visit interviews confirmed that SWACH and partnering providers are engaged in efforts to support Medicaid Transformation. Most SWACH and partnering providers have signed Medicaid Transformation Project Partner Agreements in 2019. Sample provisions of the agreements require the partner to:

- Complete the project milestones and submit deliverables set forth in the Scope of Work and Partner Reporting Guidance.
- Notify SWACH if the partner intends to change their legal status, organizational structure, or fiscal reporting structure.
- Submit all reports required by and in accordance with the Scope of Work or Partner reporting Guidance and submit all additional information requested by SWACH.

The agreement outlined the procedure for payment of funds, including the basis for payment, frequency and amount of payments, payment contingencies, and allowable costs.

#### **Distribution of Earned Incentive Funds.**

*Distribution of funds without duplication of federal funds.* Documentation indicates the funding methodology, but does not discretely refer to non-duplication of federal funds.

*Distribution of funds to partnering providers.* Documentation submitted confirms the interviewed partners have received funding and the methodology.

*Partnering provider usage of fund for transformation efforts (Local Health Initiative Efforts).* Partnering providers confirmed usage of funds for Medicaid Transformation activities. For example, funds were used to hire new staff and consultants, workforce training, MAT services, increased screening and outreach, among others.

#### **Workforce Transformation.**

*Address identified workforce gaps. (ACH & Local Health Initiative Efforts).* SWACH documentation provides an overview of steps taken to identify and fill workforce gaps. Some partners reported no issues in addressing any gaps in their workforce but others expressed the following concerns:

- MTP is a temporary project, so some of those positions can be difficult to fill due to their finite nature.
- Behavioral health positions are consistently difficult to fill but MTP funding has helped in recruitment.
- Differences in hiring policy across partners has created barriers to sharing the workforce.

### **Population Health Management through Data Exchange & Usage.**

*Address identified HIT/HIE infrastructure and/or point of care gaps. (ACH & Local Health Initiative Efforts).*

SWACH's current state assessment found that while a lot of information is being shared across the region, data exchange is mostly occurring manually (e.g. fax or paper-based). No organizations reported as part of the assessment any electronic exchange occurring with either community paramedicine or law enforcement / criminal justice organizations. SWACH noted that these findings are only reflective of clinical perspectives, as CBOs did not participate in the assessment.

Examples of work SWACH has conducted specific to HIT/HIE infrastructure and data exchange are as follows:

- SWACH is the Pathways Community Hub lead entity and is responsible for ensuring the Pathways Community Hub operations manual meets all certification requirements, e.g., HIPAA protection policies, as well as data governance and processes to manage HUB data. SWACH contracted Care Coordination Systems (CCS) to build a platform for data exchange and to track care coordination.
- SWACH has worked with clinical partners, suggesting strategies such as the following to include in their agreed-upon Medicaid Transformation scopes of work related to improving HIT/HIE:
  - Utilize data systems to track outcomes and population health.
  - Support robust EHR systems with registry functionality, and collection of SDOH data.
  - Support implementation of HIE solutions and protocols (e.g., OneHealthPort, EDIE®, PreManage).
  - Support the integration of EHR and HIE.
  - EHR supports.
  - Utilize telehealth to support partnerships between physical health, behavioral health and community agencies for integrated care approaches.

As an example, in review of one provider's scope of work, the provider plans to use funding to establish a closed loop referral process, which includes building EHR tracking mechanisms for referrals. They also shared a sample dashboard that will be used to monitor progress. Another provider has the goal to gain sponsorship from an MCO to connect with PreManage. The care management tool has been tested successfully in the region as a pilot project with several behavioral health agencies.

### **Transition to Integrated Managed Care.**

*Support provided to help transition to Integrated Managed Care.* SWACH reported as part of its SAR 3.0 submission that it has provided approximately \$1.3 million and projects \$3.5 million in incentives to support implementation of integrated managed care. SWACH counties have implemented at different times with Clark and Skamania counties implementing in April 2016 and Klickitat County in January 2019. SWACH reports the following activities to support transition:

- IMC Core Group. SWACH established this group in 2018 for stakeholders to meet every other month in preparation for the January 2019 implementation.

- Post-Implementation Support. SWACH supported the region's transition through one-on-one meetings, facilitation of connections, and convening of stakeholders as needed. They also helped behavioral health providers with development of a contracting structure.

SWACH indicated transition has mostly gone well, but with expected challenges with administrative and business changes, such as:

- Conversion of crisis services to the Administrative Services Organization (ASO) led to some challenges with data submission and developing a better understanding of the credentialing process for the ASO.
- Submission of fee-for-service claims to MCO partners influenced changes in business practices and administrative workflows.
- Challenges with residential treatment authorizations has created loss of administrative time.

SWACH has supported providers through transition challenges by serving in several roles, acting as a connector and convener when needed, and connecting partners with payers or other partners for peer-to-peer learning. To help address the structural changes needed, SWACH developed an exclusive contract with the behavioral health providers to invest in administrative and infrastructure needs.

### **Bi-directional integration.**

*Activities to increase access to mental health and substance use treatment; bi-directional integration; implementation of registries, development of relationships; culture change.* SWACH has developed two workgroups that focus directly on bi-directional integration.

- Clark County Opioid Taskforce brings together multiple sectors across Clark County to focus on policy, system, and environmental change that decrease opioid overdose and increase engagement in prevention, availability, and access to treatment and recovery.
- Partners participating in the Integrated Care Collaborative will conduct integration improvement projects using tactics developed from SAMHSA's Six Levels of Integration. Education and coaching around integration and the IHI Model for Improvement will be provided to participating providers to support implementation.

Partnering providers participating in the Bi-directional Integration project have indicated that there is limited access to behavioral health services for clients who are not in crisis. There is an increase in MAT in primary care, but they are still working on how to operationalize these services.

### **Community-Based Care Coordination.**

*Address identified care coordination gaps. (ACH & Local Health Initiative Efforts).* Review confirmed that care coordination activities and workflows are being developed and implemented between partnering providers. The ACH is working with clinicians to understand the work of peer support and the value peer support staff bring to the patient's treatment. Medicaid Transformation has resulted in expansion of staff.



### **Training & Technical Assistance.**

*Training resources, tools and principles in use. (ACH & Local Health Initiative Efforts).* SWACH through the Medicaid Transformation has pursued and conducted multiple methods to offer partner training and technical assistance. Training topics include, but are not limited to:

- Motivational Interviewing Training.
- Crisis Response Training.
- Chronic Disease Self-Management Lay Leader Training.
- Pathways Framework, CCS CHR Training, CHW Fundamentals.
- Medication Assisted Treatment Waiver Training.
- Leading for Social Justice and Equity.

### **Project Implementation.**

For each project selected, SWACH was asked to submit documentation as proof of completion for at least one Key Deliverable from Stage 2 Milestone of the ACH Implementation Plan: "Develop guidelines, policies, procedures and protocols." The procedure compared the submitted documentation to the Implementation Plan for corroboration. As a result, the IA identified that there are no areas of concern that would impede continued progress.

For the required projects, "Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation" and "Project 3A: Addressing the Opioid Use Public Health Crisis" the original approach that was described in the submitted project plan, and the progress gathered from the mid-point assessment is summarized to substantiate implementation activities.

#### **Project 2A: Bi-directional Integration of Physical and Behavioral Health Through Care Transformation**

*General Approach.* The project is built upon five core concepts of integration that are fundamental to the Collaborative Care Model and the Bree Collaborative. Providers are allowed to develop practical models of integration that align with their strategic goals and the variety of clinical settings in which they operate. SWACH's plan is to invest in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes.

*Implementation Plan Progress.* SWACH indicated progress through submission of learning material and collaborative curriculum. SWACH's Integrated Care Collaborative Agenda outlines the curriculum established and focuses on many aspects of care coordination.

#### **Project 3A: Addressing the Opioid Use Public Health Crisis**

*General Approach.* SWACH will use AMDG and CDC prescribing guidelines for this project. SWACH proposed in its Project Plan to leverage school and community-based prevention and education initiatives, increased access to treatment and peer support services in Clark County, and programs distributing

Naloxone publicly and to law enforcement. SWACH indicated it would support partners through the following:

- Collaborative workshops.
- Shared learning forums.
- Dissemination of evidence-based guidelines and best practices.
- Setting-specific advisory workgroups.
- Data monitoring guidelines.
- Technical assistance from consultants and staff.

Strategies are expected to advance HIT through enhanced utilization of the prescription monitoring program, adoption of evidence-based approaches, increased access to treatment through capacity building (e.g., peer support, identification/referral for OUD, increased number of MAT providers, etc.), and increased enrollment and engagement of persons with OUD who are not receiving MAT.

*Implementation Plan Progress.* SWACH demonstrated progress on this project by submitting the Clark County Opioid Taskforce Charter and a collaboration presentation. Both documents outline useful information about opioids and the Charter specifically details how the Taskforce contributes to collaborative efforts to combat the opioid epidemic.

## Acronym List

Acronym	Term
ACEs	Adverse Childhood Experiences
ACHs	Accountable Communities of Health
AMDG	Washington State Agency Medical Directors Group
BHO	Behavioral Health Organization
BHT	Better Health Together
CBHA	Community Behavioral Health Agency
CBO	Community-Based Organization
CCA	Care Coordination Agencies
CCI	Care Coordination Inventory
CCV	Community/Consumer Voice Committee
CFO	Chief Financial Officer
CHC	Community Health Care
CITO	Chief Information and Technology Officer
CLC	Community Leadership Council
CMS	Centers for Medicare and Medicaid Services
CORE	Center for Outcomes Research and Education
COT	Chronic Opioid Therapy
CPAA	Cascade Pacific Action Alliance
CPAS	Collaboration, Performance, and Analytics System
CVC	Community Voices Council
DHAT	Dental Health Aide Therapist
DLT	Data and Learning Team
DPPs	Diabetes Prevention Programs
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Department
EH	Elevate Health
EHR	Electronic Health Record
EMS	Emergency Medicaid Service
EPR-3	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
FQHCs	Federally-Qualified Health Center
GCACH	Greater Columbia Accountable Community of Health
HCA	Washington State Health Care Authority
HIE	Health Information Exchange
HIS	Health System Inventory
HIT	Health Information Technology
HSAC	Health Systems Advisory Coalitions
IHCP	Indian Health Care Provider

Acronym	Term
INTERACT	Interventions to Reduce Acute Care Transfers
KCACH	King County Accountable Community of Health
LARC	Long-Acting Reversible Contraception
LHINs	Local Health Improvement Networks
LOI	Letter of Intent
MAT	Mediated Assisted Treatment
MCOs	Managed Care Organizations
MED	Morphine Equivalents Doses
MTP	Medicaid Transformation Project
NCACH	North Central Accountable Community of Health
NCCs	Natural Community of Care
OCH	Olympic Community of Health
ORP	Opioid Reduction Plan
ODU	Opioid Use Disorder
PCACH	Pierce County Accountable Community of Health
PCP	Primary Care Provider
PHSKC	Public Health – Seattle and King County
PMEC	Performance, Measurement, and Evaluation Committee
PPS	Performing Provider System
P4P	Pay for Performance
P4R	Pay for Reporting
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
RMCH	Reproductive and Maternal & Child Health
SC	3CCORP Steering Committee
SIM	State Innovation Model
SMEs	Subject Matter Experts
SMI	Serious Mental Illness
STCs	Special Terms and Conditions
SUD	Substance Use Disorder
SWACH	Southwest Washington Accountable Community of Health
VBP	Value-Based Payment
WHAP	Whole Health Action Management
WPCC	Whole-Person Care Collaborative
WSHA	Washington State Hospital Association