North Central Accountable Community of Health

# Governing Board Meeting
## 1:00 PM–3:30 PM, November 5, 2018

| **Location** | **Call-in Details** |
|---|---|
| **Confluence Technology Center**<br>285 Technology Center Way #102<br>Wenatchee, WA 98801 | Conference Dial-in Number:<br>(408) 638-0968 or (646) 876-9923<br>Meeting ID: 429 968 472#<br>Join from PC, Mac, Linux, iOS or Android: https://zoom.us/j/429968472 |

| TIME | AGENDA ITEM | PROPOSED ACTIONS | ATTACHMENTS | PAGE |
|---|---|---|---|---|
| 1:00 PM | Introductions – **Barry Kling**<br>• Board Roll Call<br>• Review of Agenda & Declaration of Conflicts<br>• Public Comment | | • Agenda | *1* |
| 1:10 PM | Approval of October Minutes – **Barry Kling** | Motion:<br>• Approval of Minutes | • Minutes | *2-8* |
| 1:15 PM | Executive Director's Update – **Senator Parlette** | Information | • Executive Director's Report | *9-10* |
| 1:20 PM | Treasurer's Report – **Brooklyn Holton** | Motion:<br>• Approval of Monthly Financial Report<br>• Approval of Shared Domain 1 Investment Payments | • Monthly Financial Statement<br>• Board motion form | *11-14*<br>*15-23* |
| 1:30 PM | Presentation – Initiative 2<br>**Diane Tribble DSHS / AACWW** | Information | • Handouts | *24-28* |
| 2:00 PM | 2019 Budget Discussion – **John Schapman** | Information | • Budget Summary Sheet<br>*Separate attachment | * |
| 2:10 PM | WPCC – **Wendy Brzezny**<br>• Coaching Network | Motion:<br>• Approval of Coaching Network | • Board motion form | *29-30* |
| 2:40 PM | TCDI – John Schapman<br>• EMS Proposal | Motion:<br>• Approval of EMS Proposal | • Board motion form & Project Proposal | *31-65* |
| 3:00 PM | CHI Update – **CHI Board Seats** | Information | | |
| 3:15 PM | Other Staff Updates – **NCACH Staff**<br>• P4P Baseline Data<br>• Opioid<br>• Pathways HUB | Information | • P4P Baseline Data<br>• WPCC WG Update<br>• TCDI WG Update<br>• Opioid WG Update<br>• Pathways HUB Update | *66-70*<br>*71-72*<br>*73*<br>*74*<br>*75-76* |

| Location | Attendees |
|---|---|
| Confluence Technology Center | **Board Member Attendance**: Barry Kling, Rick Hourigan, Doug Wilson, David Olson, Carlene Anders, Bruce Buckles, Blake Edwards, Rosalinda Kibby<br>**Board Via Phone**: Senator Warnick, Michelle Price, Andrea Davis, Molly Morris, Ray Eickmeyer, Brooklyn Holton, Kyle Kellum<br>**Board Members Absent**: Scott Graham, Nancy Nash-Mendez, Mike Beaver<br><br>**Public Attendance**: Gail Goodwin, Ken Sterner, Dulcye Field. Jon Brumbach, Torrie Canda, Caitlin Safford, Courtney Ward, Kris Davis, Mike Lopez, Theresa Adkinson, Kelsey Gust, Laurel Lee, Laurel Turner, Shirley Wilbur, Deb Miller,<br>**Public Via Phone**: Laurie Bergren, Nicole VanBurkulo, Leah Becknell, Gerry Perez, Tracy Miller, Becky Corson, Chris DeVillenueve, Laina Mitchell<br>**Staff:** Linda Parlette, John Schapman, Wendy Brzezny, Caroline Tillier, Peter Morgan, Christal Eshelman, Sahara Suval, Tanya Gleason<br>Teresa Davis-Minutes |
| **Agenda Item** | **Minutes** |
| Introduction | No Conflicts of Interest Disclosed<br>Public Comment – None<br>❖ **Rosalinda Kibby moved, Doug Wilson seconded the motion to approve the September minutes, motion passed with one correction – note that the motion to approve the 2019 Opioid Workgroup plan was passed**. |
| ED Update | • Introduced Tanya Gleason – new Capacity Develop Specialist and Grant Manager for the NCACH<br>• Announcement of HCA Learning Symposium – Sahara will be sending agenda and registration information out. There is a small amount of money available from HCA for travel expenses<br>• Governor visiting area on October 12th at the CTC at 10:00 AM. He will also be visiting a few organizations. |
| Treasurer's Report | Brooklyn reviewed the monthly financial report and the proposed 2019 budget approval process and timeline.<br><br>**Upcoming Meetings/Key Dates**<br>October 18th Staff Meeting to review 2019 budget projections<br>October 26th NCACH Board Retreat to review 2019 budget recommendations<br>November 5th Board meeting to review 2019 budget<br>December 3rd Board meeting to approve 2019 budget.<br><br>We will be digging deep into the 2019 budget at the Board Retreat on October 26th 9:00 – 1:30 at the CTC in Wenatchee<br><br>❖ **Carlene Anders moved, Doug Wilson seconded the motion to approve the monthly financial report, no further discussion, motion passed** |

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| Budget Deviation Policy | Barry gave an overview of the proposed budget deviation policy. This policy was developed by Barry, Brooklyn, Rick, Blake and staff. Executive Director will still be responsible for reporting and monitoring any deviations. The numbers 10% or $100,000 (whichever is less) came from combined experience with grants and Brooklyn's experience with the City budget. These amounts would apply to the total period of the original approved allocation.<br>• Bruce feels that this is excessive without coming back to the Board for action. Feels that 2% or $10,000 would be better amount.<br>• Kyle said $50,000 is what he has always seen.<br>• Brooklyn has seen anywhere from 5-8% on city contracts. Felt comfortable with the amounts given the type of work that we are doing.<br>• Linda suggested having an e-vote option – Brooklyn said that if it requires board action, it negates that need for this new policy.<br>• Rosalinda – is not in favor of lowering the amount to $10K. She does not want to micro manage the organization.<br>• David said that he is comfortable with a max of $50K, we need to remain a policy board and trust the staff to do the work.<br>• Barry reminded the Board that we are trying to distinguish between being an operational board vs. policy board.<br><br>❖ **Rick Hourigan moved, Carlene Anders seconded the motion to approve the following budget deviation policy with the highlighted changes (10% or $50,000 and add "specific" before purpose)…**<br><br>The NCACH Executive Director (ED) is authorized to deviate up to 10% or $50,000, whichever is less, from any spending decision or budget allocation made by the Governing Board without further action by the Board, provided that any additional funds are used for the same specific purpose as the original allocation. The ED must approve such deviations in writing, and they must be reported (like any other expenditure) in NCACH monthly financial statements. The ED would be accountable to demonstrate that any additional spending of this sort is subjected by the staff to the same degree of oversight and accountability as any other NCACH spending.<br><br>**Motion passed – Bruce Buckles opposed** |
| Supported Employment and Supportive Housing Presentation | Jon Brumbach, HCA and Torri Canda, Amerigroup gave a presentation on Supportive Housing and Supported Employment.<br><br>**Supportive Housing Benefits**:<br>o Housing assessments and planning to find the home that's right for you<br>o Outreach to landlords to identify available housing in your community<br>o Connection with community resources to get you all of the help you need, when you need it<br>o Assistance with housing applications so you are accepted the first time<br>o Education, training and coaching to resolve disputes, advocate for your needs and keep you in your home<br>**Supported Employment Benefits**: |

- Employment assessments and planning to find the right job for you, whenever you're ready
- Outreach to employers to help build your network
- Connection with community resources to get you all of the help you need, when you need it
- Assistance with job applications so you can present your best self to employers
- Education, training and coaching to keep you in your job

**Who is eligible to receive FCS benefits?**

- Be enrolled in Medicaid
- Be at least 18 years old (Supportive Housing) or 16 years old (Supported Employment)
- Meet the requirements for complex needs
  - You have a medical necessity related to mental health, substance use disorder (SUD), activities of daily living, or complex physical health need(s) that prevents you from functioning successfully or living independently.
  - You meet specific risk factors that prevent you from finding or keeping a job or a safe home.

**Supportive Housing risk factors *One or more***

- Chronic homelessness
- Frequent or lengthy stays in an institutional setting (e.g. skilled nursing, inpatient hospital, psychiatric institution, prison or jail)
- Frequent stays in residential care settings
- Frequent turnover of in-home caregivers
- Predictive Risk Intelligence System (PRISM)1score of 1.5 or above

**Supported Employment risk factors *One or more***

- Housing & Essential Needs (HEN) and Aged Blind or Disabled (ABD) enrollees
- Difficulty obtaining or maintaining employment due to age, physical or mental impairment, or traumatic brain injury
- SUD with a history of multiple treatments
- Serious Mental Illness (SMI) or co-occurring mental and substance use disorders

Discussion:

- How do individuals access this? Through providers and Amerigroup.
- Amerigroup secured this through an RFP. All MCO's are working with Amerigroup to use this service.
- How do the Pathways with this program merge with the Pathways HUB? That is part of the reason that we are here so that we can work this out and come up with a referral process.
- Provider network – North Central has seven providers in the network
- To date, the program has nearly 17,000 enrollees
- This program only has 3 billing codes.

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| | • Anyone can refer someone to this program, they are happy to come and present to staff.<br>• They have a reference guide to determine eligibility<br>• Will be discussing ideas on how to incorporate and align with the projects that the ACH's are implementing at the Learning Symposium on October 24th.<br>• Laurel Turner from the Women's Resource Center has great confidence that this will have a big impact in our area. |
| HUB Update | Deb Miller announced that the Pathways Community HUB launched this morning and has their first client.<br>HUB Governance – Has formed "Action Health Partners Integrated Network, LLC"<br><br>Discussion:<br>How did Health Homes end up under Action Health Partners?<br>The Health Homes Lead program will remain as part of the Action Health Partners Community Care Coordination Network because the work of the program mirrors the work of the Pathways Community HUB. It is noted that the Health Home Lead program does not provide direct services to clients. Keeping both programs in the Community Care Coordination Network allows the opportunity for AHP HUB staff to receive a referral and make an initial assessment of Health Homes eligibility. All Health Homes identified clients would be directly referred on to the appropriate Health Home Lead program as mandated by HCA. It is important to note that Health Homes eligible clients are not eligible for the Pathways Community HUB.<br><br>The direct services for Health Homes clients are provided by a network of contracted Care Coordination Organizations. In 2015 Community Choice established an internal Care Coordination Organization program and began delivering care coordination services to Health Homes eligible clients. By establishing the new Community Choice Care Coordination Organizations Services, LLC, the direct services have been legally separated from the Action Health Partners Integrated Health Network as described in the Governance Overview HUB Neutrality document presented in the board packet.<br><br>Will provide an update on the MCO meetings at next Board meeting. |
| Staff Updates | **Christal Eshelman:**<br>• Community Partnership for Transition Solutions (CPTS) In the Medicaid Transformation, ACHs are being held accountable to a number of pay for performance measures. While most are healthcare metrics, two reflect the Health Care Authority's expectations that we address social determinants of health specific to homelessness and arrests. Based on workgroup feedback, NCACH did not select any of the evidence-based approaches linked to transitions from jail or law enforcement assisted diversion. However, regional data indicate underlying needs for individuals experiencing incarceration. |

- In May 2018, the North Central Accountable Community of Health and WorkSource partnered to bring stakeholders together to explore the Community Partnership for Transition Solutions (CPTS) model. There are currently 10 CPTSs around Washington State using a comprehensive approach that addresses all needs of an individual in order promote successful reentry into the community and reduce recidivism
- First official meeting happened in August. There is a lot of enthusiasm around this. The ACH has only provided some staff resource thus far, at this point it is not an emerging initiative as no funding is being requested. Next meeting is October 4th in Wenatchee.

Okanogan County FIMC Update – Continuing to meet monthly with Okanogan County providers.

- Next meetings are Nov 13th and Dec 11th
- Early Warning System – HCA is collecting a standard set of indicators for the entire state, Okanogan providers feel that this list is sufficient.
- HCA will hold weekly calls with the Okanogan County providers as well as daily statewide calls.
- Sahara made a media kit for Okanogan providers to use to let people know of the changes

Opioid Work Group – September meeting was cancelled.

- Working on putting the 2019 plan that was approved at the last Board meeting into action.
- We are doing Narcan training. Did a training on Narcan at the recovery event in Okanogan on September 22nd
- NCACH will now be taking over the Opioid Stakeholders group that Steve Clem has been running. Will bring this up at the next Opioid Workgroup meeting and decide how we want to proceed.
- Next Rapid Cycle Opioid Application will open this week and will remain open for a month.
- Barry noted that we just got to the point that we declared overdose as a reportable condition in Chelan and Douglas Counties. They are working the details out with those that we expect to report before we start doing press releases. The Center for Alcohol and Drug Treatment has agreed to receive the reports and conduct the follow up. They will fax the depersonalized information to CDHD.

**Wendy Brzezny:** WPCC Monthly meeting is moving to more of a strategic leadership meeting. Sites have gone from planning to implementation so not a lot of decisions will be made at the monthly meetings. We will be utilizing our Consultants to strategically guide these meetings.

- 16 out of 17 organizations have signed MOU's
- Stage 2 Funding is outlined in the MOU's there is a mixture of fixed and variable funding
- Will be submitting their MeHaf and/or PCMHA scores depending on which is required for their organization
- They will submit quarterly reports, be required to attend monthly leadership meetings as well as the Summit
- Hired Nicole Van Bokula to help lead our coaching network
- Learning activities will launch this week

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| | • Met with Roger Chaufournier regarding our budget and we are reconciling the contract.<br><br>**<u>John Schapman</u>**:<br>• TCDI Hospital application was due last Friday, received 7 applications. There is a two week scoring process and two week write back process.<br>• Developing a contract with Confluence to provide training and technical assistance for all hospitals that implement the TCM model.<br>• Emergency Department Diversion (Emergency Department Information Exchange (EDie) Training/Integration) – NCACH Staff has been working with Collective Medical Technologies to outline the process of EDie integration into hospital partner's EMRs and what a regional training schedule to better integrate EDie into clinical workflows would look like for organization's staff<br>• North Central Emergency Care Council has been working with EMS partners to better define how they quantify patient volumes of their providers. This will help create a funding model for the EMS proposal. A full proposal is expected to be presented in October to the TCDI Workgroup<br>• Staff submitted implementation plan. Both the SAR and Implementation Plans will be shared after they are scored |
| CHI Update | Chelan-Douglas Rides to Work forum to discuss solutions to employment related transportation challenges in Chelan and Douglas Counties. October 10, 4:00-6:00 PM at the Confluence Technology Center in Wenatchee (see meeting packet for flyer).<br><br><u>Community Feedback Survey:</u> Sahara Suval, Brooklyn Holton and Kyle Kellum went through the survey that went out to identify the accelerators and barriers to health.<br>• Received 215 total responses from 36 unique zip codes<br>• 19.5% of respondents are or someone in their household is insured through Medicaid<br>Conclusions:<br>• Data must be taken in context: Respondent demographics indicate that the majority of respondents *work* in clinical or social service settings (as opposed to being clients themselves)<br>• While each county has similar challenges and assets, they differ in prioritization of those challenges and assets<br>• Transportation is a shared challenge across all three CHIs and has significant potential to be addressed at a regional level<br>• To better reach Medicaid recipients, we must meet them where they are at and be more creative and inclusive with outreach efforts |

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| | Discussion:<br>• David Olson asked if there is a way of separating out the Medicaid recipients from providers. Sahara will work on that and report back.<br>• Carlene noted that Tran Go in Okanogan County and Link are having trouble connecting to get people to and from Wenatchee. |
| | Meeting adjourned at 3:18 PM |

## Executive Director's Report -- November 2018

October was another busy month for the North Central Accountable Community of Health! On October 12th, we were honored to welcome Governor Jay Inslee for a tour of the North Central region. Governor Inslee was on a statewide tour meeting with local legislators and providers to discuss state needs now that Eastern and Western State Hospitals in the near future will no longer be providing civil commitment services. Governor Inslee was particularly interested to explore more community-based mental health resources, and I was able to help facilitate connections with local providers in the North Central Region.

Governor Inslee and I started in Wenatchee with a tour of Parkside, the region's new crisis stabilization center, and met with Parkside Director, Dr. Julie Rickard. We then traveled to Central Washington Hospital to tour their Medical Unit 1 (MU1). After we visited MU1, we attended a discussion with local CEOs and behavioral health providers who shared a list of barriers on providing integrated care, including Medicaid rates; lengthy processing times for certain Department of Health licensures; and outdated Washington Administrative Codes (WACs).

Following the morning meeting with behavioral providers, I joined elected officials from Chelan, Douglas, Grant, and Okanogan Counties. Housing, transportation, and future siting issues of behavioral health facilities were discussed.

After Governor Inslee's visit, the team and I headed to Seattle for the Learning Symposium convened by the Health Care Authority on October 23rd and 24th. The first day's sessions were for ACH staff to come together, and included tracks for Executive Directors, Finance Leads, Program and Data Leads, and Community Engagement Leads. We then all gathered for a special dinner with one of the Symposium's keynote speakers, Dr. john powell [sic], who discussed the importance of belonging as a means of promoting health equity. The second day of the Symposium was open for ACH partners, and we were fortunate to have partners from Coulee Medical Center, Samaritan Healthcare, Family Health Centers, and Community Choice dba Action Health Partners join us.

In other NCACH updates, we received final remarks on our Implementation Plans, which were submitted to the Health Care Authority on October 1st. Read NCACH's Implementation Plan (https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents#north-central-ach)


**NCACH Staff at the HCA Fall Learning Symposium – October 24, 2018**

**L-R: John Schapman, Tanya Gleason, Linda Evans Parlette, Christal Eshelman, Caroline Tillier, Wendy Brzezny, Sahara Suval *(Photo, NCACH)***

For the remainder of this month, staff and I focused on finalizing the 2019 annual budget, which was presented to the NCACH Governing Board in a retreat on October 26th. Staff worked hard to develop comprehensive budgets, and I am proud of the work they put into the 2019 budget. The NCACH Governing Board will vote to approve the 2019 budget during the December 3rd Governing Board meeting.

## Charge on!

Linda Evans Parlette, Executive Director

## NCACH Funding & Expense Summary Sheet

| | SIM/DESIGN FUNDS (CDHD Account) | | | FINANCIAL EXECUTOR FUNDS | | |
|---|---|---|---|---|---|---|
| | SIM/Design Funds Received | SIM/Design Funds Expended | SIM/Design Funds Remaining | NCACH Funds @ FE | FE Funds Expended | FE Funds Remaining |
| **Original Grant Contract K1437** | $ 99,831.63 | $ 99,831.63 | $ - | | | |
| Amendment #1 | $ 150,000.00 | $ 150,000.00 | $ - | | | |
| Amendment #2 | $ 330,000.00 | $ 330,000.00 | $ - | | | |
| Amendment #3 ($50k Special Allocation) | $ 15,243.25 | $ 15,243.25 | $ - | | | |
| **Workshop Registration Fees/Misc Revenue** | $ 19,155.00 | $ 19,155.00 | $ - | | | |
| Amendment #4 (FIMC Advisory Comm. Spcl Allocation 2016) | $ 15,040.00 | $ 15,040.00 | $ - | | | |
| Amendment #5* | $ - | $ - | $ - | | | |
| Amendment #6** (FIMC Adv Comm Spcl Alloc 2017) | $ 30,300.45 | $ 30,300.45 | $ - | | | |
| **Interest Earned on SIM Funds*** ** | $ 3,223.39 | $ 3,223.39 | $ - | | | |
| **Original Grant Contract K2562** | $ 24,699.55 | $ 24,699.55 | $ - | | | |
| Amendment #1 | $ 70,629.00 | $ 72,430.46 | $ (1,801.46) | | | |
| **Original Contract K2296 - Demonstration Phase 1** | $ 1,000,000.00 | $ 1,000,000.00 | $ 0.00 | | | |
| **Original Contract K2296 - Demonstration Phase 2** | $ 5,226,961.23 | $ 134,322.96 | $ 5,092,638.27 | | | |
| **Interest Earned on Demo Funds** | $ 74,409.13 | $ - | $ 74,409.13 | | | |
| **Workshop Registration Fees/Misc Revenue** | $ 12,135.83 | $ 12,135.83 | $ - | | | |
| **Finacial Executor Funding - (As of Sept 2018)** | | | | | | |
| DY1 Project Incentive Funds (March 18) | | | | $ 3,922,723.01 | $ 2,204,323.23 | $ 1,718,399.78 |
| DY1 Integration Funds (March 18) | | | | $ 2,312,792.00 | $ 35,871.66 | $ 2,276,920.34 |
| DY1 Bonus Funds (March 18) | | | | $ 1,455,842.00 | | $ 1,455,842.00 |
| DY1 Project Incentive Funds (June 18) | | | | $ 1,228,827.00 | | $ 1,228,827.00 |
| DY1 Shared Domain 1 Funds (June 18)**** | | | | $ 2,048,045.00 | $ 2,048,045.00 | $ - |
| **Totals** | **$ 7,071,628.46** | **$ 1,906,382.51** | **$ 5,165,245.95** | **$ 10,968,229.01** | **$ 4,288,239.89** | **$ 6,679,989.12** |

** Funds allocated to NCACH but not yet in FE account*

*** Revenue outstanding. Funding is monthly cost reimbursement.*

**** Only $500 interest on SIM Grant per calendar year can be retained. The rest will be paid back to HCA when directed.*

$ 2,240,194.89

***** Automatically paid out through FE Portal from Health Care Authority and therefore not reflected on Financial Executor budget spreadsheet*

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| 2015-16 Report | 99,831.63 | $ 99,832.00 |
| 2016-17 Report | 480,000.00 | $ 76,736.40 |
| SIM Report | $ 178,290.64 | $ 583,355.34 |
| DEMO Report | $ 6,313,506.19 | $ 1,146,458.79 |
| | $ 7,071,628.46 | $ 1,906,382.52 |
| Variance | $ - | $ (0.01) |

## SIM Funds Report on NCACH Expenditures to Date

**Fiscal Year:** Feb 1, 2018 - Jan 31, 2019

| Budget Line Item | Budgeted Allocation | Sep-18 | Totals YTD | % Expended YTD to Budget |
|---|---|---|---|---|
| **Salary & Benefits** | **$ 80,313.00** | 11,315.88 | **$ 81,741.63** | **101.8%** |
| **Office Supplies** | | | $ - | |
| **Computer Hardware** | | | $ - | |
| **Legal Services** | | | $ - | |
| **Travel/Lodging/Meals** | | 104.64 | **$ 728.67** | |
| **Website Redesign** | | | $ - | |
| **Advertising** | | | $ - | |
| **Meeting Expense** | | | $ - | |
| **Other Expenditures** | | | $ - | |
| **Misc. Contracts (CORE)** | | | $ - | |
| **Misc. Contracts (CHIs)** | | | $ - | |
| **Subtotal** | **$ 80,313.00** | **$ 11,420.52** | **$ 82,470.30** | **102.7%** |
| **15% Hosting fee to CDHD** | **$ 12,046.95** | 1,713.08 | **$ 12,370.55** | **102.7%** |
| | | | $ - | |
| **Grand total** | **$ 92,359.95** | **$ 13,133.60** | **$ 94,840.85** | **102.7%** |

% of Fiscal Year 58%

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|---|---|---|
| Contract K2562 (FIMC Funding) | $ | 21,731 |
| Amendment #1 (SIM AY4 Funds) | $ | 70,629 |
| Retained Interest Earned to date | | |
| **Total SIM Funds** | **$** | **92,360** |
| | | |
| Budgeted Amount | $ | 92,359.95 |
| **Total Uncommitted Funds** | **$** | **0.21** |

## Demonstration Funds Report on NCACH Expenditures to Date

**Fiscal Year:** Jan 1, 2018 - Dec 31, 2018

| Budget Line Item | Original Budgeted Allocation | Budgeted Allocation | Sep-18 | Totals YTD | % Expended YTD to Budget |
|---|---|---|---|---|---|
| **Salary & Benefits** | **$610,857.72** | **$ 636,358.00** | 51,471.10 | **390,705.97** | **61.4%** |
| **Office Supplies** | **$ 18,000.00** | **$ 18,000.00** | 3,089.12 | **20,786.76** | **115.5%** |
| **Legal Services** | **$ 8,000.00** | **$ 8,000.00** | | **1,156.50** | **14.5%** |
| **Travel/Lodging/Meals** | **$ 7,000.00** | **$ 7,000.00** | 1,672.71 | **20,328.16** | **290.4%** |
| **Website** | **$ -** | **$ -** | | **737.77** | |
| **Admin (HR/Recruiting)** | **$ 7,500.00** | **$ 7,500.00** | | **330.86** | **4.4%** |
| **Advertising/Community Outreach** | | **$ -** | 1,029.50 | **4,518.54** | |
| **Insurance** | **$ 5,000.00** | **$ 5,000.00** | | **5,530.37** | **110.6%** |
| **Meeting Expense** | **$ 7,000.00** | **$ 7,000.00** | 14.46 | **1,599.96** | **22.9%** |
| **Events** | | **$ 52,000.00** | | **25,165.13** | **48.4%** |
| **Other Expenditures** | **$ 3,000.00** | **$ 3,000.00** | 2,236.80 | **14,674.19** | **489.1%** |
| **B&O Tax Payment** | | **$ 90,000.00** | | **90,000.00** | **100.0%** |
| **Integration Funds** | | **$ 21,731.16** | | **10,456.34** | **48.1%** |
| **Misc. Contracts (CHIs)** | **$ 120,000.00** | **$ 120,000.00** | 23,598.75 | **66,116.45** | **55.1%** |
| **Healthy Generations** | | **$ 75,000.00** | | **75,000.00** | **100.0%** |
| **OHSU** | | **$ 150,000.00** | 8,112.50 | **67,229.94** | **44.8%** |
| **CCMI, CSI*** | | **$ 151,961.23** | | **151,961.23** | **100.0%** |
| **Providence CORE** | | **$ 4,128.00** | | **17,888.00** | **433.3%** |
| **Subtotal** | | **$ 1,356,678.39** | **$ 91,224.94** | **964,186.17** | **71.1%** |
| | | | | - | |
| **15% Hosting fee to CDHD** | **$117,953.66** | **$ 146,338.37** | **$ 13,683.74** | **105,739.92** | **72.3%** |
| | | | | | |
| **Grand total** | **$904,311.38** | **$ 1,503,016.76** | **$ 104,908.68** | **$ 1,069,926.09** | **71.2%** |

% of Fiscal Year Complete 75%

| | |
|---|---|
| Funds remaining 8/31/2018 | $ 5,197,546.96 |
| Interest Earned to date | $ 65,783.77 |
| Budgeted Amount (2018) | $ 1,503,016.76 |
| **Total Uncommitted Dollars** | **$ 3,760,313.97** |

* Switched from $443,461 to $151,961.23 (YTD Total). Expenses to be paid through FE portal moving forward.

## Financial Executor Report on NCACH Expenditures to Date

**Fiscal Year:** Jan 1, 2018 - Dec 31, 2018

| Budget Line Item | Budgeted Allocation | Sep-18 | Totals YTD | % Expended YTD to Budget |
|---|---|---|---|---|
| WPCC Stage 1 | $ 1,665,000.00 | | 1,665,000.00 | 100.0% |
| WPCC Stage 2 Funding * | $ 580,000.00 | | - | 0.0% |
| Opioid Project | $ 100,000.00 | | 97,390.00 | 97.4% |
| TCDI - NCECC Project Funding | $ 70,000.00 | $ 50,000.00 | 70,000.00 | 100.0% |
| TCDI Hospital Application Funding | $ 312,500.00 | | - | 0.0% |
| Integration - IT Assistance | $ 42,700.00 | | 20,871.66 | 48.9% |
| Integration - Provider Contracting | $ 55,000.00 | | 15,000.00 | 27.3% |
| Pathways Hub Project | $ 380,000.00 | $ 40,000.00 | 70,000.00 | 18.4% |
| Asset Mapping (Board Approved 6.4.18) | $ 7,500.00 | | - | 0.0% |
| Program Evaluation | $ 7,000.00 | | - | 0.0% |
| CCMI, CSI | $ 291,499.77 | | 74,972.00 | 25.7% |
| UW AIMS Center | $ 48,000.00 | | - | 0.0% |
| WPCC Coaching Funds | $ 45,000.00 | | - | 0.0% |
| Emerging Initiatives - CCOW | $ 20,000.00 | | - | 0.0% |
| Payment to NCACH Demo Budget | $ 226,961.23 | | 226,961.23 | 100.0% |
| Grant Total | $ 3,851,161.00 | $ 90,000.00 | 2,240,194.89 | 58.2% |

| | |
|---|---|
| Funds Earned (Excludes Shared Domain 1 Funds) | $ 8,920,184.01 |
| Budgeted Amount (2018) | $ 3,851,161.00 |
| **Total Uncommitted Dollars** | **$ 5,069,023.01** |

% of Fiscal Year Complete 75%

# Board Decision Form

**TOPIC:** Payments to "Shared Domain 1 Partners as part of Washington State Intergovernmental Transfer payment mechanism

**PURPOSE:** Approve distribution of North Central Accountable Communities of Health Shared Domain 1 Incentive funding

**BOARD ACTION:**

☐ Information Only

☑ Board Motion to approve/disapprove

**BACKGROUND:**

*Summary of IGT Strategy:*

- The Centers for Medicaid and Medicare Services (CMS) approved 2 funding sources for the Transformation project: Designated State Health Programs (DSHP) and Intergovernmental Transfers (IGT). NCACH approved the current IGT strategy funding concept and is approving a second payment to IGT contributors and their partners.

Background on Distribution of Shared Domain 1 Investment Funds:

- Part of the IGT arrangement is that our region will approve money twice a year to IGT contributors and their partners.
- The approved $1,388,906 will flow through the Financial Executor in an account held for NCACH funding designated for Shared Domain 1 Investments.
- The Governing Board will approve release of these dollars in November 2018 which will be distributed to Shared Domain 1 Partners in December 2018 based on the following process:
    - Dollars will go into the account under the Shared Domain 1 Investment category from HCA
    - Once those dollars go into the account under the Shared Domain 1 Investment category, the pre-approval of the Governing Board will cause the Financial Executor to automatically release those dollars to the Share Domain 1 partners
- Board approval allows release of dollars from the Shared Domain 1 Investment category (Dollars in the NCACH Project Incentives, FIMC, VBP, and High Performance Pool categories will not be affected)
- If the release of dollars to Shared Domain 1 Partners is not approved, this will affect the Project Incentive Funds associated with the IGT strategy that is going to NCACH
- NCACH, IGT contributors, and HCA continue to work together on a plan to address Shared Domain 1 initiatives that is a mutually beneficial for all parties.

**PROPOSAL:**

Motion to approve the payment of $1,388,906 to partnering providers as allocated under the NCACH column of the Shared Domain 1 Investments worksheet to be distributed when the funding is placed in the NCACH account under the Shared Domain 1 Investment Category held by the Financial Executor.

| |
|---|
| **IMPACT/OPPORTUNITY (fiscal and programmatic):**<br>Intergovernmental Transfer payments is one way that the Washington State Medicaid Transformation Project is funded. Approval of these payments ensures that this process stays on track. If an ACH does not approve their portion of the payment, then all ACHs will see a decrease in total available funds available through the Medicaid Transformation Project. |
| **TIMELINE:**<br>• November 5th: NCACH Board approves payment to partnering providers<br>• December 14th: Shared Domain 1 incentives are distributed to partners in the Financial Executor portal. |
| **RECOMMENDATION:**<br>*Approve above motion* |

Submitted By: John Schapman
Submitted Date: 11/05/18

Attachments:

- Consolidated Partnering Provider Achievement Report
- HCA Intergovernmental Transfer Payment Presentation (January 2018)

## Consolidated Partnering Provider Achievement Report - Demonstration Year 2 (January 1, 2018 through June 30, 2018)

| ACH Name | Better Health Together | Cascade Pacific Action Alliance | Greater Columbia | HealthierHere | North Central | North Sound | Olympic Community of Health | Pierce County | SWACH | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Shared Domain 1 Incentives** | **$3,055,594** | **$2,777,813** | **$3,888,938** | **$6,111,188** | **$1,388,906** | **$4,166,719** | **$1,111,125** | **$3,333,375** | **$1,944,469** | **$27,778,125** |

| Partnering Provider | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Earned Funds | Total Earned Funds |
|---|---|---|---|---|---|---|---|---|---|---|
| EVERGREEN HEALTHCARE | $268,892 | $244,448 | $342,227 | $537,785 | $122,224 | $366,671 | $97,779 | $293,337 | $171,113 | $2,444,475 |
| VALLEY MEDICAL CENTER | $268,892 | $244,448 | $342,227 | $537,785 | $122,224 | $366,671 | $97,779 | $293,337 | $171,113 | $2,444,475 |
| ASSOCIATION OF WA PUBLIC HOSPITAL DISTRICTS - TRANSFORMATION POOL | $22,367 | $20,334 | $28,467 | $44,734 | $10,167 | $30,500 | $8,133 | $24,400 | $14,234 | $203,336 |
| PHD#1 DBA SKAGIT VALLEY HOSPITAL | $8,984 | $8,167 | $11,434 | $17,968 | $4,084 | $12,251 | $3,267 | $9,801 | $5,717 | $81,672 |
| OLYMPIC MEDICAL CENTER | $4,746 | $4,315 | $6,041 | $9,493 | $2,157 | $6,472 | $1,726 | $5,178 | $3,020 | $43,150 |
| GRAYS HARBOR COMMUNITY HOSPITAL | $2,900 | $2,637 | $3,692 | $5,801 | $1,318 | $3,955 | $1,055 | $3,164 | $1,846 | $26,368 |
| WHIDBEY GENERAL HOSPITAL | $2,833 | $2,575 | $3,605 | $5,665 | $1,288 | $3,863 | $1,030 | $3,090 | $1,803 | $25,750 |
| ISLAND HOSPITAL | $2,789 | $2,536 | $3,550 | $5,579 | $1,268 | $3,804 | $1,014 | $3,043 | $1,775 | $25,358 |
| JEFFERSON GENERAL HOSPITAL | $2,626 | $2,387 | $3,342 | $5,251 | $1,193 | $3,580 | $955 | $2,864 | $1,671 | $23,869 |
| MASON GENERAL HOSPITAL | $2,600 | $2,364 | $3,310 | $5,201 | $1,182 | $3,546 | $946 | $2,837 | $1,655 | $23,639 |
| SAMARITAN HOSPITAL | $2,167 | $1,970 | $2,758 | $4,335 | $985 | $2,955 | $788 | $2,364 | $1,379 | $19,703 |
| KITTITAS VALLEY COMMUNITY HOSPITAL | $2,100 | $1,909 | $2,672 | $4,199 | $954 | $2,863 | $764 | $2,291 | $1,336 | $19,088 |
| PULLMAN REGIONAL HOSPITAL | $1,785 | $1,622 | $2,271 | $3,569 | $811 | $2,434 | $649 | $1,947 | $1,136 | $16,224 |
| PROSSER MEMORIAL HOSPITAL | $1,333 | $1,212 | $1,697 | $2,667 | $606 | $1,818 | $485 | $1,455 | $849 | $12,122 |
| SNOQUALMIE VALLEY HOSPITAL | $968 | $880 | $1,232 | $1,936 | $440 | $1,320 | $352 | $1,056 | $616 | $8,800 |
| SUMMIT PACIFIC MEDICAL CENTER | $956 | $869 | $1,217 | $1,913 | $435 | $1,304 | $348 | $1,043 | $609 | $8,693 |
| WHITMAN HOSPITAL & MEDICAL CENTER | $844 | $767 | $1,074 | $1,688 | $384 | $1,151 | $307 | $921 | $537 | $7,671 |
| LAKE CHELAN COMMUNITY HOSPITAL | $765 | $696 | $974 | $1,531 | $348 | $1,044 | $278 | $835 | $487 | $6,958 |
| COULEE MEDICAL CENTER | $742 | $675 | $945 | $1,485 | $337 | $1,012 | $270 | $810 | $472 | $6,748 |
| FORKS COMMUNITY HOSPITAL | $720 | $655 | $917 | $1,440 | $327 | $982 | $262 | $786 | $458 | $6,546 |
| OCEAN BEACH HOSPITAL | $702 | $639 | $894 | $1,405 | $319 | $958 | $255 | $766 | $447 | $6,386 |
| MID-VALLEY HOSPITAL | $864 | $786 | $1,100 | $1,729 | $393 | $1,179 | $314 | $943 | $550 | $7,857 |
| MORTON GENERAL HOSPITAL | $652 | $592 | $829 | $1,303 | $296 | $889 | $237 | $711 | $415 | $5,925 |
| KLICKITAT VALLEY HEALTH | $635 | $577 | $808 | $1,270 | $289 | $866 | $231 | $692 | $404 | $5,771 |
| LINCOLN HOSPITAL | $626 | $569 | $796 | $1,252 | $284 | $853 | $228 | $683 | $398 | $5,689 |
| NEWPORT COMMUNITY HOSPITAL | $930 | $845 | $1,183 | $1,860 | $423 | $1,268 | $338 | $1,014 | $592 | $8,453 |
| WILLAPA HARBOR HOSPITAL | $569 | $517 | $724 | $1,138 | $259 | $776 | $207 | $621 | $362 | $5,175 |
| NORTH VALLEY HOSPITAL | $567 | $515 | $721 | $1,134 | $258 | $773 | $206 | $618 | $361 | $5,153 |
| SKYLINE HOSPITAL | $537 | $489 | $684 | $1,075 | $244 | $733 | $195 | $586 | $342 | $4,885 |
| COLUMBIA BASIN HOSPITAL | $481 | $437 | $612 | $961 | $218 | $655 | $175 | $524 | $306 | $4,369 |
| CASCADE MEDICAL CENTER | $399 | $363 | $508 | $799 | $182 | $545 | $145 | $436 | $254 | $3,630 |
| DAYTON GENERAL HOSPITAL | $397 | $361 | $506 | $794 | $181 | $542 | $144 | $433 | $253 | $3,611 |
| SNOHOMISH CO PHD (Verdant) | $362 | $330 | $461 | $725 | $165 | $494 | $132 | $395 | $231 | $3,295 |
| OTHELLO COMMUNITY HOSPITAL | $463 | $421 | $589 | $926 | $210 | $631 | $168 | $505 | $294 | $4,207 |
| FERRY COUNTY MEMORIAL HOSPITAL | $332 | $302 | $422 | $664 | $151 | $452 | $121 | $362 | $211 | $3,016 |
| THREE RIVERS HOSPITAL | $467 | $425 | $595 | $935 | $212 | $637 | $170 | $510 | $297 | $4,249 |
| ODESSA MEMORIAL HOSPITAL | $312 | $284 | $397 | $624 | $142 | $426 | $114 | $341 | $199 | $2,838 |
| QUINCY VALLEY MEDICAL CENTER | $359 | $326 | $457 | $718 | $163 | $489 | $131 | $392 | $228 | $3,263 |
| GARFIELD MEMORIAL HOSPITAL | $305 | $278 | $389 | $611 | $139 | $416 | $111 | $333 | $194 | $2,777 |
| EAST ADAMS RURAL HOSPITAL | $295 | $268 | $375 | $589 | $134 | $402 | $107 | $321 | $188 | $2,679 |
| SAN JUAN PHD (Peace Island) | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| GRANT COUNTY (McKay Rehab) | $357 | $325 | $455 | $715 | $162 | $487 | $130 | $390 | $228 | $3,250 |
| SKAGIT CO PHD (United General) | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| DOUGLAS CO. PHD # 2 | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| GRANT COUNTY PHD #5 | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| GRANT COUNTY PHD #7 | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| KITTITAS COUNTY PHD #2 | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| POINT ROBERTS CLINIC | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| SKAMANIA COUNTY PHD | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| SAN JUAN PHD (Lopez) | $55 | $50 | $70 | $110 | $25 | $75 | $20 | $60 | $35 | $500 |
| UNIVERSITY OF WASHINGTON | $2,444,475 | $2,222,250 | $3,111,150 | $4,888,950 | $1,111,125 | $3,333,375 | $888,900 | $2,666,700 | $1,555,575 | $22,222,500 |

Final incentive amounts are contingent upon all nine ACHs providing final approval for their portion of the shared domain 1 incentives and full IGT contribution.

# Medicaid Transformation Funding Overview – North Central

Marc Provence
Savannah Parker
Health Care Authority
January 19, 2018

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## Delivery System Reform Incentive Payment (DSRIP) Program

- Provides federal expenditure authority for up to **$1.125B** (total computable) over five years.
- Funding available for Medicaid Transformation under Initiative 1
  - Incentive-based
    - Not a grant
    - Must be earned through achievement of milestones and outcomes
- Administered by Washington's Accountable Communities of Health.

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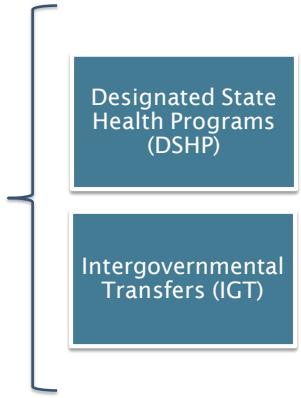
# DSRIP Funding

- Two CMS approved funding sources: DSHP and IGT
- DSHP and IGT financing creates one DSRIP pool, not region-specific
- DSRIP pool is more DSHP-driven in Years 1-2; IGT dependence grows significantly starting in Year 3

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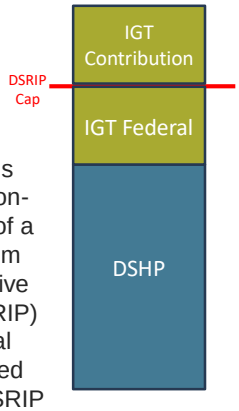
3

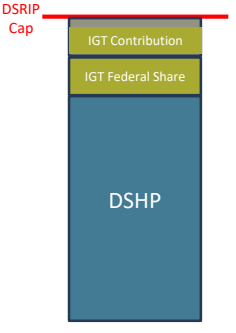
# How IGT counts towards the DSRIP Cap

**Original Understanding**




When an IGT is used for the non-federal share of a Delivery System Reform Incentive Payment (DSRIP) only the federal share is counted against the DSRIP budget cap.

**CMS Clarification**




When an IGT contribution is being paid through DSRIP both the federal and non-federal share (IGT contribution) will be counted against the DSRIP budget cap.

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4


## What is an Intergovernmental Transfer (IGT)?

- A transfer of public funds between governmental entities, such as from a county or a public hospital to the state.
- The source of funding for each IGT that is proposed by a governmental entity must be reviewed to ensure that it meets state and federal requirements for permissible transfers.

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6

## DSRIP IGT Funding Assumptions

- ACHs do not need to find IGT contributors. The state has identified IGT contributors and will handle the contractual requirements to operationalize the IGT financing mechanism.
- IGT contributors, like other provider partners, must have an opportunity to earn incentives
- IGT contributors are well-positioned to provide Domain 1 services across all 9 ACHs
- All incentive distributions must be approved by ACHs prior to payment
- Less than full participation by ACHs in an IGT strategy reduces the total DSRIP incentive pool proportionally

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7

## DSRIP IGT Approach
## Shared Domain 1 Investments

- **"Shared Domain 1 Investments"** is a term representing pooled incentive funds for specific (to be defined) Domain 1 services from designated providers across all nine regions.
- Shared Domain 1 Investments neither preclude nor replace other ACH allocations for Domain 1.
- ACHs must still approve incentive payments made from the Shared Domain 1 Investment pool
- Shared Domain 1 Investments supports the use of intergovernmental transfers as a funding mechanism for DSRIP.

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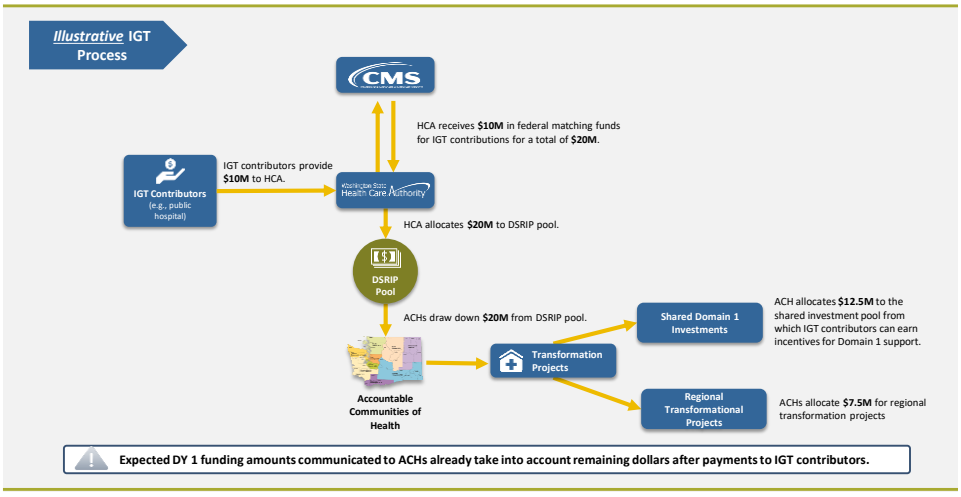
8

# How IGT works




**Note:** Rounded funding amounts are provided as examples.

**Source:** 42 CFR 433.51 - Public Funds as the State share of financial participation.

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# What this means for North Central ACH incentives?

| ACH Design Funds | ACH Project Incentives (funded by DSHP) | ACH Project Incentives (funded by IGT) | VBP Incentives (Reinvestment Pool) | Behavioral Health Integration Incentives | Total Regional Incentives |
|---|---|---|---|---|---|
| $6,000,000 | $14,612,000 | $11,091,000 | $2,200,000 | $5,779,000 | $39,682,000 |

| Shared Domain 1 Investments (Optional) |
|---|
| $20,927,000 |

- ACH approval of Shared Domain 1 Investments funds $20.9m in regional project incentives over the five years.
- The Shared Domain1 Investments are separate from the ACH regional project incentives.
- If one or more ACHs select to not participate in the Shared Domain 1 Investments this will reduce the total available funding available for ACH project incentives.

***Estimated Incentives Projected as of December 14, 2017***

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# ACH's Role

- Register and approve Shared Domain 1 Partnering Providers
- Authorize disbursements to Shared Domain 1 Partnering Providers

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## Questions?

# Medicaid Alternative Care

## The "One-Pager" Fact Sheet

- **Purpose**
  - Provide for unpaid caregivers who support individuals who are Medicaid eligible, but who do not currently access traditional LTSS services (like Community First Choice).

- **Eligibility**
  - Age 55 or older
  - NFLOC
  - Resident
  - Live at home
  - Have a qualified unpaid caregiver
  - Eligible for CN/ABP (using spousal impoverishment if married)

- **Examples of waived financial rules**
  - No home equity limit
  - No estate recovery
  - No transfer penalties
  - No Co-pay (aka Participation)
  - No disability requirement

- **Services**
  - Caregiver assistance
    - Help with housework
    - Home safety evaluations
    - Respite
    - Essential shopping
    - Home-delivered meals
  - Training, education, and consultation
  - Specialized equipment and supplies
  - Health maintenance and therapy support

- **Financial rules**
  - The specific WACs under which the care receiver is eligible for CN/ABP
  - WAC 182-513-1600 through WAC 182-513-1605

# Tailored Supports for Older Adults

## The "One-Pager" Fact Sheet

- **Purpose**
  - A new eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria.
- **Eligibility**
  - Need to apply (HCA 18-008)
  - Age 55 or older
  - NFLOC
  - Resident, citizen (or meets immigration status)
  - Possess SSN
  - Live at home
  - Resources <$53,100 & $108,647 if married)
  - Income < $2,250 for 2018
  - Spouse's income is not factored into eligibility
- **Waived financial rules**
  - No home equity limit
  - No estate recovery
  - No transfer penalties
  - No Co-pay (aka Participation)
  - Don't need to be disabled if under age 65
  - Don't need to obtain all sources of income
  - Don't need to sign away rights to settlements/subrogation
- **Presumptive eligibility (PE)**
  - A person can be determined PE by DSHS social services or AAA after a pre-screening interview determining: NFLOC, income eligibility, resource eligibility.
  - One PE period every 24 months; PE ends within a month to two months unless application submitted (See specific PE rules); if application submitted, PE continues until financial decision made.
- **Services**
  - Caregiver assistance
    - Help with housework
    - Home safety evaluations
    - Respite
    - Essential shopping
    - Home-delivered meals
  - Training, education, and consultation
  - Specialized equipment and supplies
  - Health maintenance and therapy support
  - Personal care (in place of caregiver assistance)
- **Financial rules**
  - WAC 182-513-1610 through WAC 182-513-1660

# Examples of Services

- **Caregiver Assistance** (Care receivers with a caregiver-MAC & TSOA): respite, housework & errands
- **Personal Assistance** (TSOA individual only): personal care, home delivered meals, nurse delegation
- **Specialized Medical Equipment & Supplies**: durable medical equipment, Personal Emergency Response System, incontinence supplies
- **Training & Education**: support groups, consultation (LTC planning, OT, PT, dementia, fall prevention)
- **Health Maintenance & Therapy**: evidence based exercise programs

# Services by Step & Program

| PROGRAM<br><br>Tool | STEP 1:<br>Based on demographics and program eligibility; may receive under presumptive eligibility | STEP 2:<br>Based on results of a screening; may receive under presumptive eligibility | STEP 3:<br>Based on results of assessment; may receive under presumptive eligibility |
|---|---|---|---|
| MAC or TSOA Dyad<br><br>TCARE | $250 one time limit | $500 annual limit (minus any expenditures for Step 1) | Average of $573/month up to $3,438 for 6 months |
| TSOA without caregiver<br><br>GetCare | $250 one time limit | $500 annual limit (minus any expenditures for Step 1) | $573/month – capped with no ability to average expenditures over a 6 month period |

# Services by Step & Program

| PROGRAM<br><br>Tool | STEP 1:<br>Based on demographics and program eligibility; may receive under presumptive eligibility | STEP 2:<br>Based on results of a screening; may receive under presumptive eligibility | STEP 3:<br>Based on results of assessment; may receive under presumptive eligibility |
|---|---|---|---|
| MAC or TSOA Dyad<br><br>TCARE | $250 one time limit | $500 annual limit (minus any expenditures for Step 1) | Average of $573/month up to $3,438 for 6 months |
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# Board Decision Form

**TOPIC:** WPCC Coaching Network

*PURPOSE***:** To approve the formation of a centralized coaching network that would assist our funded partners.

**BOARD ACTION:**

☐ Information Only

☑ Board Motion to approve/disapprove

**BACKGROUND:** NCACH originally assumed that **s**upport of quality improvement and practice transformation efforts across our WPCC Learning Community would be based primarily on participation in uniform learning activities. Given the diversity of our Learning Community in terms of size, scope of services offered, and level of sophistication with quality improvement, NCACH is adjusting its technical assistance model to incorporate more hands on coaching support in addition to smaller and more targeted learning activities. This shift is consistent with and responsive to needs identified through an assessment of our WPCC provider community in July, as well as needs identified through the change plan process.

In September 2018, staff asked for authorization to shift some of the spending during Q4 of 2018 to allow more coaching resources to be deployed. NCACH subsequently entered into a short-term contract with Shift Consulting LLC. While we intended to engage Nicole Van Borkulo as an additional practice coach to support the learning community through the end of 2018, her work was adjusted to solely focus on ensuring quality assurance amongst the current coaches, inventorying coaching needs and helping develop NCACH's coaching plan for 2019, which includes developing job description, recruiting, interviewing and participating in the training of the future coaches. This shift was informed by recent conversations and planning meetings with the current coaches from CCMI/CSI, Qualis and Shift Consulting, as well as conversations with Greater Columbia ACH.

Current assumptions informing our recommended approach to developing a coaching network include:

- Coaching resources are more effective when there is a good match between the client and coach and when this coach remains *consistent* – developing a trusting relationship with a coach takes time.
- "Meta coaching" from CCMI/CSI current is built into the learning activities, but in-person or more hands-on coaching was not part of their contract given desire to develop local capacity.
- Some WPCC member organizations may need more hands on support in the short run to implement their change plans, apply what they learn from learning activities, and ultimately sustain improvement efforts over the long run.
- Some WPCC member organizations may not need as much coaching, but may benefit from partnering with a coach to help interpret the change ideas in the change plan and dovetail them with existing organizational efforts.
- Building a cohesive coaching network allows for standardization of process and promotes peer sharing and improvement work among the coaches and across the WPCC community.

**PROPOSAL:** *Approve the formation of centralized coaching network which would involve the hiring of 2 FTE practice coaches employed and managed by NCACH.*

**IMPACT/OPPORTUNITY (fiscal and programmatic):**

Given the need for coaching to help our providers with practice transformation efforts, NCACH can either invest in a patchwork of external consultants or build internal NCACH capacity.

NCACH staff are recommending building internal capacity in order to build more intensive capacity at a lower cost. The current coaching structure allows for 70-100 coaching hours for 14 organizations a month at a cost of approximately $30,000. By building internal coaching capacity, we can increase the number of coaching hours to 200-300 a month (number has been discounted due to travel and other meetings) while reducing the cost to approximately $20,000 a month.

There are value adds to the WPCC by having internal rather than peripheral coaching. In addition to the cost savings, these include:

- Consistent messaging and approach to this work for all organizations including, but not limited to implementation of change plans, reporting, meetings and learning activities
- Shared learning (of best practices and innovative ideas) across sites happens more naturally and consistently in a network of coaches
- Linkages between the work of the WPCC, other NCACH workgroups, and other initiatives in the region will be easier to make and maintain and provides for more seamless process improvements for the overall NCACH Medicaid Transformation Project
- Local coaches will be viewed as 'part of the community' and can more intentionally create sustainable relationships with the organizations and their practices
- Local coaches will be more agile and flexible in their ability to provide in-person, on the ground support to sites
- Provides for more natural feedback loops between coaches and the WPCC Manager to continue to shape learning activities and processes that better meet the evolving needs of our providers
- WPCC Manager will have a better view of the work coaches are doing in the field and the types of support the coaches need for their own professional development

**TIMELINE:**

- Post positions and start hiring process as soon as possible so that we may engage coaches as early in 2019 as possible

**RECOMMENDATION:**

See proposed motion above.

Submitted By: Whole Person Care Collaborative
Submitted Date: 11/5/2018
Staff Sponsor: Wendy Brzezny

# Board Decision Form

**TOPIC:** Emergency Medical Service (EMS) proposal

**PURPOSE:** Approve the proposed scope of work and funding for EMS partners to participate in Diversion Intervention Strategies as part of the Medicaid Transformation Project

**BOARD ACTION:**

☐ Information Only

☑ Board Motion to approve/disapprove

**BACKGROUND:**

The North Central Emergency Care Council in partnership with Aero Methow Rescue Services worked with the 10 participating EMS transport agencies to evaluate the current state of EMS providers in the North Central region, identify their capabilities and barriers to reduce non-emergent transports to the Emergency Department (Diversion), support patient's post-hospital discharge to prevent readmission (transitional care), and determine what scope of work those partners would like to achieve. This work was done in three stages:

- Stage 1: Evaluate EMS providers and gain a baseline understanding of the current state of EMS services and reporting methodologies
- Stage 2: Review survey results with EMS partners and discuss potential process improvement approaches to reduce ED utilization by ambulance or follow up care
- Stage 3: Take feedback from EMS partners, review current priorities of both the region and its partners, and develop a project proposal

Based on Data and information gathered, EMS partners selected the following priorities:

1. Treat and release/referral for patients
2. Documentation consistency and data collection
3. Work with payers to establish a reimbursement mechanism for costs associated with non-transport of patients who are treated by EMS and patients who do not need to be treated at the Emergency Department but are transported to alternate destinations.

Agencies determined to take an incremental approach to the priorities listed above. Patient follow up after discharge would not be possible for them at this time without the addition of personnel, contracts with healthcare organizations, and Medical Program Director oversight. Therefore 2019 will focus on enhancing the data systems needed to collect valid data and establishing a protocol to align with treat and referral initiatives occurring at the state level. The agencies, NCECC, and NCACH will evaluate the effectiveness of the work done concerning treat and release or referral of patients, documentation and data collection throughout 2019 and determine how it can assist in expanding Mobile Integrated Health programs across the region in 2020 and 2021.

**PROPOSAL:**

Motion to approve the EMS project proposal and up to $300,000 of funding for project management and EMS agencies to complete the scope of work outlined in the proposal.

**IMPACT/OPPORTUNITY (fiscal and programmatic):**
Approving the EMS proposal as outlined in the attached document will allow NCACH Staff and the North Central Emergency Care Council to work with EMS partners to establish mechanisms in 2019 to support EMS partners in establishing stronger data collection systems and develop the protocols necessary for EMS partners to established treat and refer programs. This will help build a foundation for EMS partners to continue expanding Mobile Integrated Health services in 2020 and 2021.

**TIMELINE:**
October 25th: TCDI Workgroup approved the EMS proposal
November 5th: EMS proposal submitted to NCACH Governing Board for approval
November – December: NCACH develops an MOU and signs MOU with EMS partners for completion of work
January 2019: EMS work under the proposal is initiated.

**RECOMMENDATION:**
*Approve above recommendation*

| | |
|---|---|
| Submitted By: | Transitional Care and Diversion Intervention Workgroup |
| Submitted Date: | 11/05/18 |
| Staff Sponsor: | John Schapman |

Attachment:

- North Central Emergency Care Council EMS Proposal

NORTH CENTRAL
EMERGENCY CARE COUNCIL
ADVOCACY & EDUCATION

**EMS PROJECT PROPOSAL OUTLINE**

The North Central Emergency Care Council would continue to be the convening agency that would coordinate the work of the Emergency Medical Providers in the North Central Region. The North Central Region will work with the Transitional Care and Diversion Intervention Workgroup, EMS transport agencies, Medical Program Directors, receiving facilities, Local County Councils, regional referral resources, and the WA State Department of Health to achieve the goals and tactics outlined in the proposal for Emergency Medical Service engagement in the Medicaid Transformation Project

The North Central Emergency Care Council brings value to this project in the established relationships with the aforementioned parties and the existing resources to develop, implement, and provide the training needed to EMS agencies and the providers.

North Central Emergency Care Council works with the WA State Department of Health, EMS Agencies, and County Medical Program Directors on development of Regional Patient Care Procedures, County Operating Procedures, and Patient Care Procedures. (Definitions page 32)

The Goals and Tactics listed below are lofty in development, implementation, and training with the numerous partners needed for participation and the steps involved for completion, many of those listed, once completed, will span into already existing programs supported by the ACH.

The North Central Emergency Care Council is requesting the span of the project to be from October 2018 – December 2019. Training costs may carry-over to 2020. This can be evaluated for extension prior to the end of December 2019.

**SUMMARY OF PHASE 1 COMPLETED AUGUST 2018**

The North Central Emergency Care Council in partnership with Aero Methow Rescue Services worked with the 10 participating EMS transport agencies to evaluate the current state of EMS providers in the North Central region (**attachment A page 7**), identify their capabilities and barriers to reduce non-emergent transports to the Emergency Department (Diversion), support patient's post-hospital discharge to prevent readmission (transitional care), and determine what scope of work those partners would like to achieve. This work was done in three stages:

- Stage 1: Evaluate EMS providers and gain a baseline understanding of the current state of EMS services and reporting methodologies
- Stage 2: Review survey results with EMS partners and discuss potential process improvement approaches to reduce ED utilization by ambulance or follow up care
- Stage 3: Take feedback from EMS partners, review current priorities of both the region and its partners, and develop a project proposal

Based on the above stage some key data issues associated with our EMS partners rose to the top:

- Of the EMS calls that are Medical, Trauma, or Behavioral Health in nature: Medical calls are the highest at 85%, Trauma calls are 38%, and Behavioral health is the lowest at no greater than 20%.
- Specific to the kind of medical transport:
    - Up to 30% call volume was classified as not medically necessary transports,
    - 30% of the call volume were non-transports.
    - Reasons for non-transport decisions are as follows: No medical attention needed, assess with no treatment, assess with Treatment and Release, assess with treatment and patient refuses transport, and patient refuses all treatment and transport.

Non-transport of patients whom EMS agencies respond to as a 911 call cost EMS agencies a significant amount of money with no reimbursement to offset cost [estimate cost of a call]. This adds a financial strain to partners and encourages EMS partners to choose transportation over treat and release due to sustainability models.

Based on Data and information gather, EMS partners selected the following priorities:

1. Treat and release/referral for patients
2. Documentation consistency and data collection
3. Work with payers to establish a reimbursement mechanism for costs associated with non-transport of patients who are treated by EMS and patients who do not need to be treated at the Emergency Department but are transported to alternate destinations.

Agencies determined to take an incremental approach to the priorities listed above. Patient follow up after discharge would not be possible for them at this time without the addition of personnel, contracts with healthcare organizations, and Medical Program Director oversight. Beginning January 2020, the agencies, NCECC, and NCACH will evaluate the effectiveness of the work done concerning treat and release or referral of patients, documentation and data collection, and determine the next area of focus for EMS.

The above tactics align with the work currently occurring at the state level. The Washington State Senate passed House Bill 1358 in April 2017. This bill allows those agencies classified as “fire departments” to get paid for treat and referral programs. Within the North Central region, 5 of the 10 transport agencies qualify for this reimbursement model, which is to take effect in 2019. This will help support 50% of our agencies or [up to 30% of our Medicaid clients] transported by partners in our region. However, NCACH recognizes that leaving out the non-profit and private entities in our region will leave a large gap in services areas. Therefore, NCACH has chosen to support both private and public entities in moving this direction. NCACH is working closely with the State partners implementing reimbursable Treat and Referral programs to ensure the processes we put in place for NCACH partners are in alignment with State programs.

The above survey lead to the following work plan outlined below. The work plan outlines how the funding will be spent by the partners, which partners will be involved in the work and to what level, and the reporting and measurement requirements of both partners and regional entities in this work.

**SCOPE OF WORK**

The below scope of work outlines the timeline to complete tasks, deliverables, and agencies responsible for completion of work.

**TACTIC #1: Develop and initiate protocols for non-acute patients who come into encounter with EMS Agencies including**

1. Alternative transport protocols to non-ED sites
2. Treat and release (Referral) Protocols [see **attachment B** (page 31) for details on Treat and Referral program]

| Action Item (s) | Responsible Party | Deliverable | Completion Date | | | | |
|---|---|---|---|---|---|---|---|
| | | | Q4 2018 | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 |
| **Analyze current statewide standards with Treat and Referral (HB 1358)** | | | | | | | |
| Review current standards for treat and refer as it pertains to reimbursement in 2019 | NCECC | Review completed, training plan established | | | | | |
| Provide training to partners (Private and Public) on treat and referral programs that are in alignment in statewide efforts | NCECC | Training provider to partners (educational) | | | | | |
| Promote policy changes to enhance transport work | NCACH, NCECC | Policy promotion established | | | | | |
| **Develop protocols for Non-Acute Patients who come into encounter with EMS** | | | | | | | |
| Meet with EMS, MPDs, County Councils, and Department of Health, and applicable partners to develop model **[see attachment C (page 32) for more information]** | NCECC | Regional Protocols developed | | | | | |
| Submit Protocols to Regional Council and Department of Health for approval | NCECC | Protocols submitted to DOH | | | | | |
| Training EMS transport agencies on how to implement protocols approved by DOH | EMS Agencies | Trainings completed | | | | | |
| Implement protocols with EMS Staff | EMS Agencies | Protocols implemented in clinics. Utilized in patient care | | | | | |
| Track number of patients who are diverted through treat and referral programs | EMS Agencies | Data submitted to NCACH. Data evaluated | | | | | |
| **Establish systems to allow EMS agencies to refer patients to alternative care destinations** | | | | | | | |
| Determine key referral needs of EMS partners | NCECC | Documented needs completed | | | | | |
| Hold meetings to connect partners in referral process | NCECC | Meeting minutes, agendas documented | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Establish process needed to transit referral data | NCECC | Referral system established with agencies | | | | | |
| Patient notifications to Primary Care Providers or other referral partners | EMS Partners | Patient notifications sent by partners | | | | | |

- **See process for Protocol, PCP, and COP development following definitions on page 32**

**TACTIC #2: Enhance data standardization and health information exchange to address population health**

| Action Item (s) | Responsible Party | Deliverable | Completion Date | | | | |
|---|---|---|---|---|---|---|---|
| | | | Q4 2018 | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 |
| **Standardize EMS encounter definitions across region** | | | | | | | |
| Defining non-transport, non-acute transport, and other EMS Classifications with County Councils | NCECC | Definitions established and implemented by partners | | | | | |
| **Coordinate Certified Ambulance Documentation Specialist Training** (*Long distance travel for education specialist, training to EMS Providers).* | NCECC | Certified Ambulance Documentation training provided | | | | | |
| Develop standardize data points with each agency to track and report EMS encounter data | EMS Partners | Data points identified, Tracking mechanism established | | | | | |
| *Analyze Data and share reports to partners Semi-Annually* | EMS Partners; NCACH | Semi- Annual report submitted | | | | | |
| Review initial data collected, provide recommendations on next steps if applicable | NCECC NCACH | Data collected, recommendations provided to regional partners | | | | | |
| **Ensure partners are connected with WEMSIS system** | | | | | | | |
| *Identify regional data to be collected and evaluated through WEMSIS* | NCECC; NCACH; EMS Agencies | Data points identified and tracked | | | | | |
| *Provide WEMSIS/EMIR training to partners* | NCECC; NCACH | Training completed | | | | | |
| Partners will link EMR systems to upload data to WEMSIS system | EMS Partners | Data submitted to WEMSIS, Report provided | | | | | |

## Funds Allocation:

### Regional training and support cost:

Funding provided to the Regional council to support EMS agencies in achieving a reduction in non-acute transports to the Emergency Department. Not to exceed $60,000 for training.

- **Protocol Rollout/Training: Region wide (3 County Councils, $3,000 ea.) $9,000**
    - Coordination of Protocol development by NCECC
    - Protocol printed materials to EMS Agencies
    - Protocol rollout agency participation and training session each council location
        - Compensation for travel and attendance
- **Three Certified Ambulance Documentation Specialist training sessions for up to $36,000 ($12,000 each)**
    - Page Wolfberg & Wirth, LLC (Pennsylvania)
    - Printed materials
    - Training Session/Location
- **WEMSIS/EMIR training up to $15,000 ($1,000 per each participating agency; $5,000 to NCECC for coordination).**
    - NCECC Coordination of training provided by:
        - Image Trend
        - DOH Representative
        - Regional Coordination of trainings

### Partner Specific Funding:

Agency specific funding for instituting protocols for non-transport of patients is based on the below formula

| Category | Medicaid Patient Volume (2017) | Dollar Amount |
|---|---|---|
| **1** | <200 | $15,000 |
| **2** | 200 – 500 | $20,000 |
| **3** | 500 – 750 | $25,000 |
| **4** | 750 – 1,000 | $30,000 |
| **5** | 1,000+ | $35,000 |

**Funding will go to support agencies completing the following:**

1. Agencies  staff time to participate in trainings
2. Adjustments in Agencies EMIRs to accommodate data tracking in system and create electronic processes for referral submission
3. Implementing referral processes to partners
4. Providing treat and referral process to patients as outlined in Attachment B
5. Participating in regional shared learning activities

## Payment Cycle:

**Training Payments:**

- Training payments will be paid directly from NCACH to the vendor through the Washington State Financial Executor portal (Public Consulting Group)

**Agency Payments:**

- Payments are made quarterly for 25% of the total amount an organization can earn based on the above equation. Payment cycle will be as follows:
    - Q1 (January – March): Payment in April
    - Q2 (April –June): Payment in July
    - Q3 (July – September ) Payment in October
    - Q4 (October – December) Payment in January 2020
- Any funding that goes to NCECC to assist in project management of this work will be paid out following the amount distribution method listed above

## Reporting Requirements:

**Quarterly Reports:** Agencies must submit a quarterly report to NCACH and NCECC be eligible for the quarterly payment

- NCACH and NCECC will partner to develop a reporting template for partners. Templates will be released to partners Q4 of 2018

**Monitoring and Evaluation:** Semi-annually, partners will have performance metrics they need to submit as part of their quarterly reporting to receive funding. Metrics are specific to Medicaid patients and will be defined as follows:

- Total number of 911 calls
- Number of transport calls
- Number of transport calls that are not medically necessary
- Non-Transport calls
- Number of Medicaid patients
- Number of Medicaid patients transported
- Number of Patients referred to alternative services

# NCACH and NCECC EMS Survey Summary Report

**Date:** August 31, 2018

**Authors**

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## Summary

This Phase I project was a collaborative effort between the North Central Emergency Care Council (NCECC) and the North Central Accountable Community of Health (NCACH). The goal of the project was to determine how our regional EMS agencies could address Diversion and Transition Care Services. This survey provided important demographic information concerning the 10 EMS services in this region. These EMS providers are diverse and are comprised of fire-based services, non-profits, hospital-based services and for-profit EMS organizations; yet this diverse group of organizations share a number of common concerns. In addition to base-line demographic information the survey results suggest several potential focus areas that could be pursued under Phase II and III.

Potential Focus Areas Include:

- Treat & release in the field
- EMS telemedicine
- Improving compensation for EMS services (including non-transport/field treatment)
- Community Health Gaps including-
    - ER discharge follow-up
    - Hospice partnering
    - Patient home evaluation
    - Geriatric care & issues
    - Urgent care transport
    - Improved PCP communication

In conclusion, the results of this survey provide useful demographic information for the EMS agencies that work in our region. The overarching goal is to utilize these survey results to help the agencies identify potential focus areas for Phase II and III development and implementation.

***Background***

As part of the North Central Emergency Care Council (NCECC) strategy in collaboration with the North Central Accountable Community of Health (NCACH) a **Phase I** project was initiated to evaluate and plan tactics for how EMS agencies could address Diversion and Transition Care Services. A key component of this initial Phase was to conduct a survey of regional EMS providers with a goal of using the survey results to help the agencies identify potential focus areas for Phase II and III development and implementation.

Aero Methow Rescue Service (AMRS) was tasked with developing, administering and analyzing the survey. The survey was developed in June 2018 using SurveyMonkey (https://www.surveymonkey.com/) as the assessment tool. Agencies were given approximately 2-weeks to complete the on-line survey and results were analyzed in late July 2018, and an initial draft shared with the participating agencies in early August 2018. This final report was subsequently completed and delivered to NCACH (project end date: August 31, 2018). The report includes a summary of findings and individual agency survey responses are included as an addendum.

**Agency Participation:** The following Agencies Participated in the Survey.

| #1 | #2 | #3 | #4 | #5 | #6 | #7 | #8 | #9 | #10 |
|---|---|---|---|---|---|---|---|---|---|
| Douglas County Fire District #15 | Waterville Ambulance Service | Cascade Medical | Aero Methow Rescue Service | Ballard Services Inc. | Lifeline Ambulance Inc. | Moses Lake Fire Department | Lake Chelan Community Hospital EMS | AMR Grant County | Protection-1 LLC |

***Organization Demographics:***

The 10 EMS services in this region are diverse and are comprised of fire-based services, non-profits, hospital-based services and for-profit EMS organizations (see **Figure 10B**). **Table 1A and B** provide a breakdown on each agencies' staff size and staff distribution (ex. Full-, Part-time, Volunteers etc.) and EMS vehicle resources. Across these organizations, staffing ranges from **8** to **81** total staff, with the two fire departments having the largest contingency (#1-**81** and #7-**44.5** total). In this regard, it is important to remember that staffing for these fire departments includes both fireman and EMS providers. Across all agencies the distribution of full time, part-time and volunteer EMS providers were **70%**, **26%** and **12.7%**. Full-time and volunteer fire accounted for **9** and **19%,** respectively. Across agencies vehicle resources ranged from a minimum of **2** to a maximum of **20** with the majority of vehicles being ambulances.

***Medical Response Demographics:***

**Figure 1** is a breakdown in percentages of calls that are medical, trauma or behavioral (mental health, dementia etc.) in nature for each agency. Medical calls predominate and range from **~50-87%**, Trauma was considerably more variable across agencies and ranged from **10-38%**, whereas, behavioral only represents between **<5-20%** across agencies. For all 911 calls (medical/trauma/behavioral), the patient age distribution is presented in **Figure 2**, and as might be anticipated the number of calls generally goes up as a function of age with the greatest number involving individuals who are 46 years old or greater. For most agencies there is a predominance of responses involving geriatric patients.

For each agency the distribution of transports based upon EMS expertise (ex. BLS, ALS or Inter-facility) is presented in **Figure 3**. These data are a bit more variable across agencies. For 8 out of the 10 agencies surveyed, ALS transports predominated ranging from **45-74%** of the EMS responses; whereas, for this same group BLS ranged from **25-48%**. For the other two agencies, BLS accounted for **30** and **70%** of the responses while ALS ranged from **12-25%**, Inter-facility transports were considerably more variable across agencies ranging from **<5%** to **35%**. The ranking of the top medical, trauma and behavioral emergencies are presented in **Figures 4, 5, and 6**. For medical emergencies across all agencies, chest pain (**18%**), breathing difficulty (**18%**), unconscious/fainting (**11%**) and diabetic emergency (**9%**) were the consistent top priorities; whereas for trauma, motor vehicle accidents (MVA) and falls accounted for **20** and **15%** of the trauma priority response, respectively. The other trauma priorities were well distributed at **7%** or less. The top behavioral emergency priorities were categorized as: general behavioral problems (**17%**), suicide (**17%**) and anxiety (**14%**) with dementia, depression and drug/alcohol abuse each accounting for **11%** across agencies. With the exception of two agencies ($^{\#}$2 & $^{\#}$4) **47-75%** of the 911 responses did involve transport to a hospital, for agencies $^{\#}$2 and $^{\#}$4 transports accounted for **<10%** and **47%**; respectively (see **Figure 7**). Across agencies the percentage of calls that resulted in non-transports ranged from **12- 52**%. Of the transports, the percentage that did not meet medical transport (as defined by Medicare/Medicaid) were less than **10%** for seven agencies, while the remaining three agencies ranged from **15-30%**. **Table 2** further breaks down the details concerning the reasons for non-transports. **Figure 8** identifies a list of medical procedures that could be done in the field which would result in a reduction in unnecessary transports. In general, there was a fairly consistent response across agencies concerning the types of procedures that could be addressed by EMS providers. The highest priority procedures

included treatment for: hypoglycemia (**17%**), respiratory emergencies-albuterol (**13%**), and allergic reactions (**12%**). However, with the exception of one category (urinary tract infection – **3%**), responses for other noted procedures ranged from **8-10%**.

***Reporting and Communication Demographics:***

For Patient Care Reporting (PCR) both electronic (**75%**) and non-electronic (**25%**) reporting are utilized (see **Figure 9A**) and of the electronic PCR systems **50%** of the agencies utilize Wemsis-Image Trend, Wemsis-3 or Wemsis-elite, the remaining electronic PCR systems are equally distributed between: Med 4 and Rescue Net (**13%** each). A large percentage (**56%**) of reports are physically provided to hospitals, while **33%** are transmitted via Fax and only **11%** are shared by other electronic media (see **Figure 9B**). **Table 10** provides information on dispatch fees for Public Service Answering Points (PSAP) and in-house 24/7 dispatch services in our region, with the majority of agencies paying dispatch fees (**80%**) and not having their own in-house dispatch service (**70%**).

***Reimbursement and Cost Demographics:***

Across all agencies, Medicare is the predominant payer accounting for **45-55%** of the reimbursements for EMS responses. Whereas, Medicaid and commercial insurance account for **10-25%** and **10-30%**, respectively. Private payers are the smallest contributor only accounting for **5-15%** of the reimbursements (see **Figure 11A**). **Figure 10B** provides perspective on all the agencies' core funding-base where the distribution was: For-Profits (**40%**), Hospital-based (**30%**), Fire-based (**20%**) and Non-Profits (**11%**). Public funding sources range from EMS and Fire District levies, to hospital-based levies (**Figure 11C**). For these agencies, EMS District Funding accounted for **50%** whereas Fire District Funding was **10%** and other sources (i.e. hospital based & others) accounted for **40%** of the agencies' operating budget.

***Gaps, Opportunities and Community Engagement:***

**The survey explored a number of potential gaps and opportunities (see Table 3**). **90%** of the agencies surveyed indicated that if there was reimbursement for the use of telemedicine they would consider using it; whereas, only **60%** thought the inclusion of a 24-hr nurse-patient hotline could help relieve EMS burden. When asked if there was any follow-up between agencies and primary care physicians (PCP) **60%** indicated yes, but the majority of these (5 out of 6) indicated that communication only occurred "sometimes"; in addition, the methods by which agencies communicated with PCPs was variable (ex. writing, FAX, EPCR system). With regard to social services, **70%** of the agencies were both aware of potential resources in their community and

actively worked to connect patients with these services. Only **30%** of the agencies were aware of the Medicaid Health Homes program.

As noted in **Figure 5**, 15% of trauma responses involved falls, representing the 2nd highest trauma response across all agencies. However, only 5 agencies (50%) indicated that fall prevention programs were available in their community and only 2 of these indicated that they are actively engaged in these programs.

Finally, each agency identified a number of in-community health care opportunities that they felt could readily be accommodated by EMS agencies if funded. The list of opportunities are included in **Tables 3**. In addition, the agencies provided a number of very informative comments concerning opportunities and concerns that are presented in **Tables 4** and **5**. In brief, the agencies were very enthusiastic about new opportunities to contribute to patient care through follow-up visitations and transitions as well as strategies to enable EMS "treat and release". Although it is well recognized that these services are highly beneficial to the community, an overarching concern expressed by all agencies is lack of adequate reimbursement for these services.

In conclusion, the results of this survey provide useful demographic information for the 10 EMS agencies that work in our region. The EMS services are diverse and are comprised of fire-based services, non-profits, hospital-based services and for-profit EMS organizations. Although this is a diverse group of organizations there share a number of significant common concerns and it is anticipated that the survey results will help facilitate the agencies to identify potential focus areas for Phase II and III development and implementation.

**Table 1:** Agency staff (A) and vehicle (B) resource demographics.

**A.**

| Agency | Paid FT EMT-P | Paid FT AEMT | Paid FT EMT | Paid PT EMT-P | Paid PT AEMT | Paid PT EMT | Paid Fire Only | Paid Office | Volunteer EMT-P | Volunteer AEMT | Volunteer EMT | Volunteer EMR | Volunteer Fire Only | Volunteer Office | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0 | 5 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 3 | 10 | 0 | 61 | 0 | 81 |
| 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 4 | 1 | 0 | 0 | 8 |
| 3 | 6 | 1 | 3 | 7 | 0 | 10 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| 4 | 2 | 1 | 1 | 4 | 4 | 0 | 0 | 3 | 0 | 1 | 21 | 4 | 0 | 0 | 41 |
| 5 | 11 | 6 | 2 | 1 | 2 | 9 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| 6 | 21 | 0 | 30 | 2 | 0 | 12 | 0 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 71 |
| 7 | 13 | 0 | 15 | 0 | 0 | 0 | 28 | 1.5 | 0 | 0 | 0 | 0 | 0 | 0 | 57.5 |
| 8 | 9 | 0 | 5 | 6 | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| 9 | 12 | 0 | 12 | 0 | 0 | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 29 |
| 10 | 2 | 0 | 2 | 4 | 1 | 10 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| **Total** | 76 | 13 | 70 | 24 | 7 | 53 | 29 | 18.5 | 2 | 4 | 35 | 5 | 61 | 0 | 397.5 |

**B.**

| Agency | Aid Vehicles | Quick Response Aid Vehicles | Ambulances | Total |
|---|---|---|---|---|
| **1** | 0 | 2 | 4 | **6** |
| **2** | 0 | 0 | 2 | **2** |
| **3** | 1 | 1 | 4 | **6** |
| **4** | 0 | 7 | 5 | **12** |
| **5** | 0 | 0 | 9 | **9** |
| **6** | 0 | 4 | 16 | **20** |
| **7** | 0 | 3 | 5 | **8** |
| **8** | 0 | 1 | 5 | **6** |
| **9** | 1 | 0 | 6 | **7** |
| **10** | | | | |

**Figure 1.** percentages of calls that are Medical, Trauma or Behavioral (mental health, dementia etc) in nature for each agency.

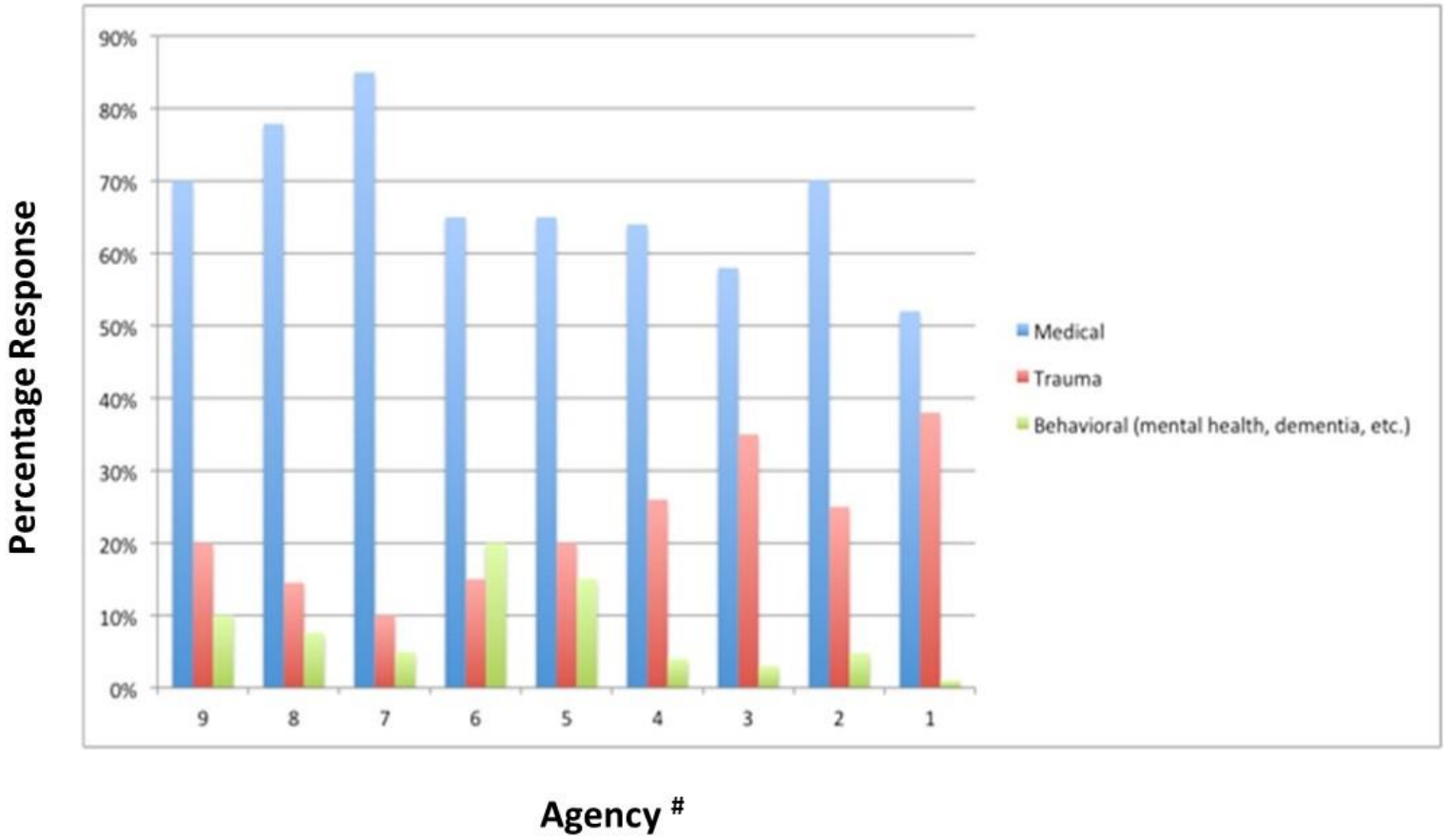


**Figure 2.** Age distribution for 911 calls across each agency.

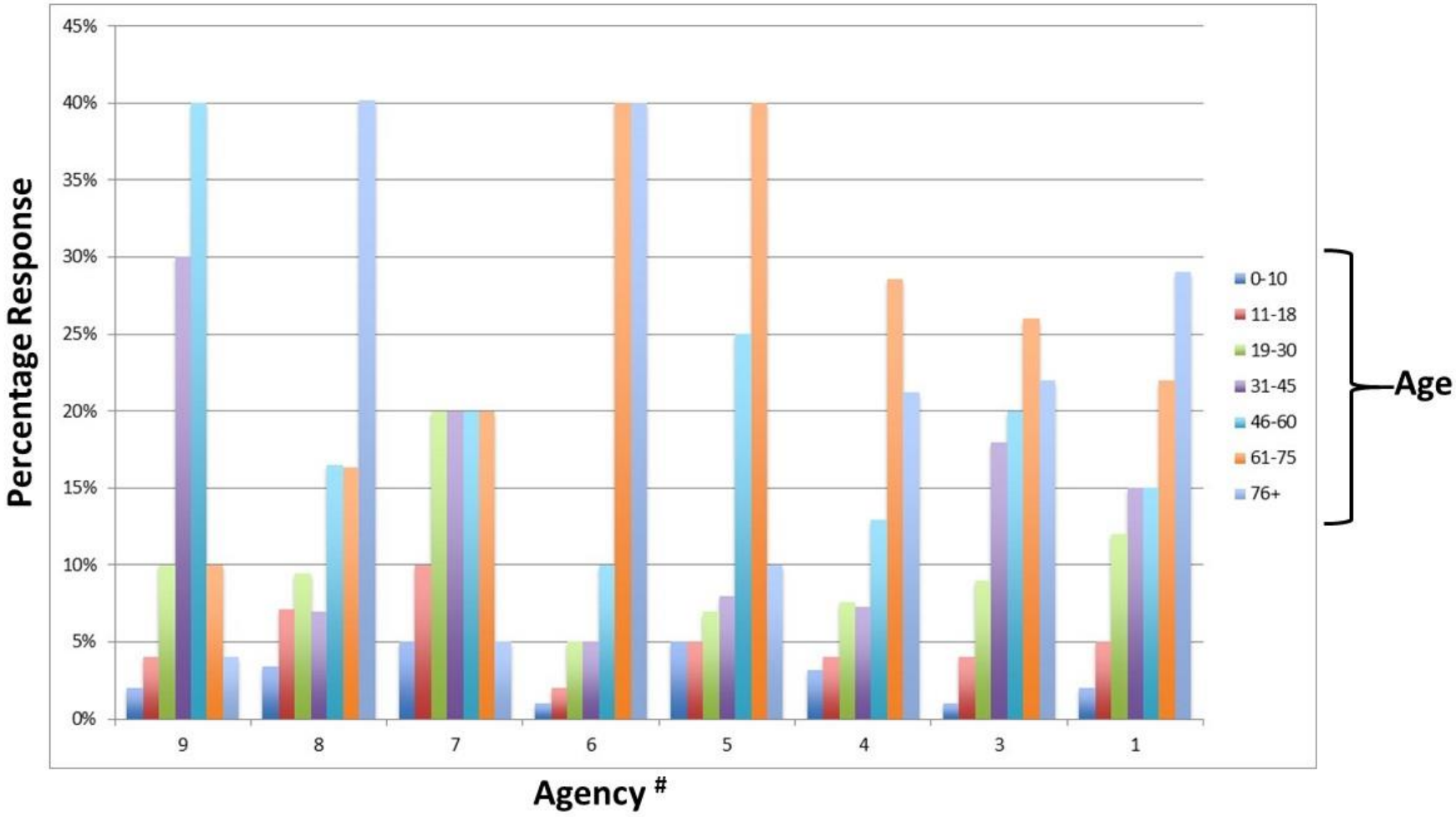


**Figure 3.** Distribution of call response types (BLS, ALS, inter-facility transport )across each agency.

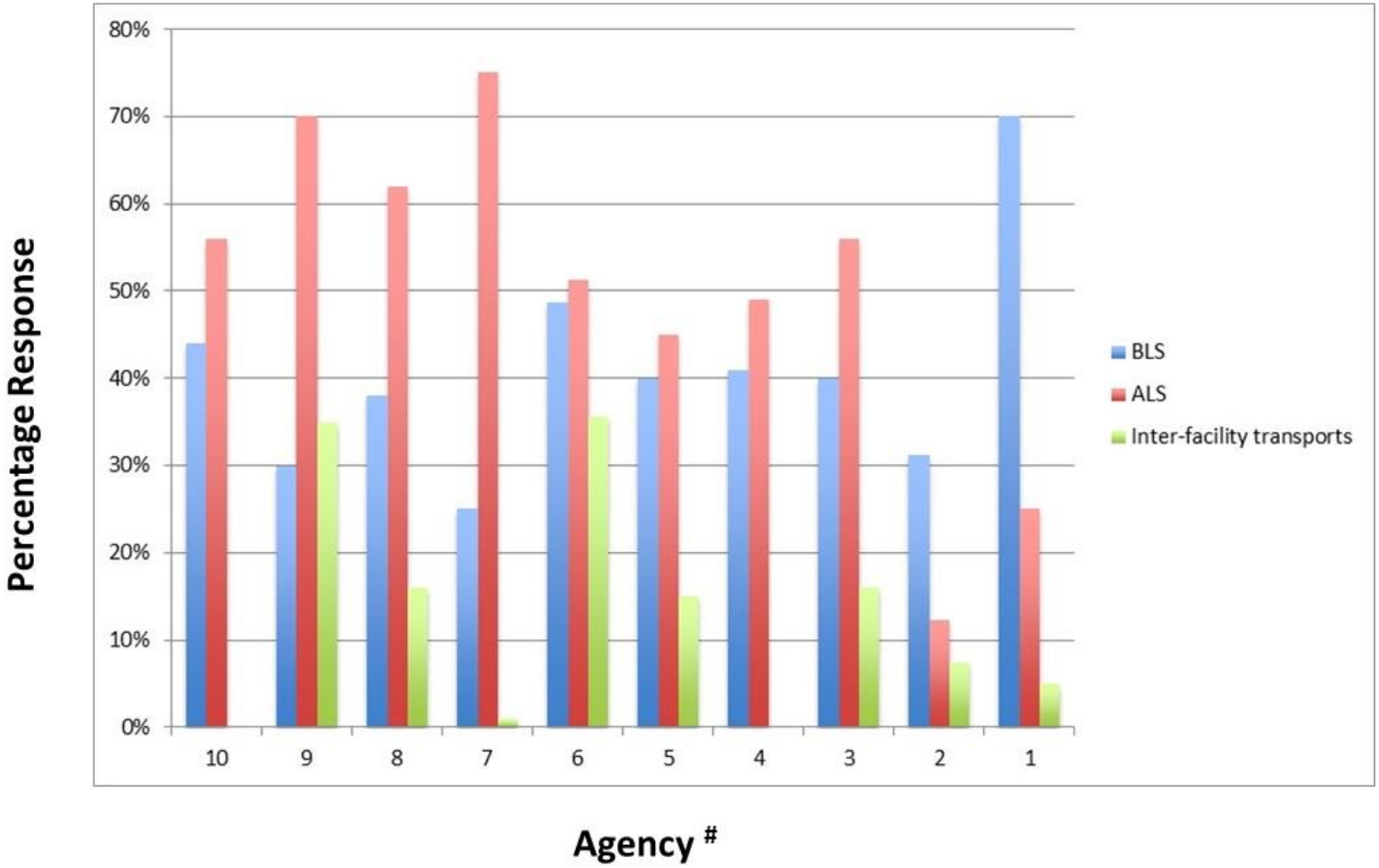


**Figure 4.** Distribution of priority medical responses across each agency.

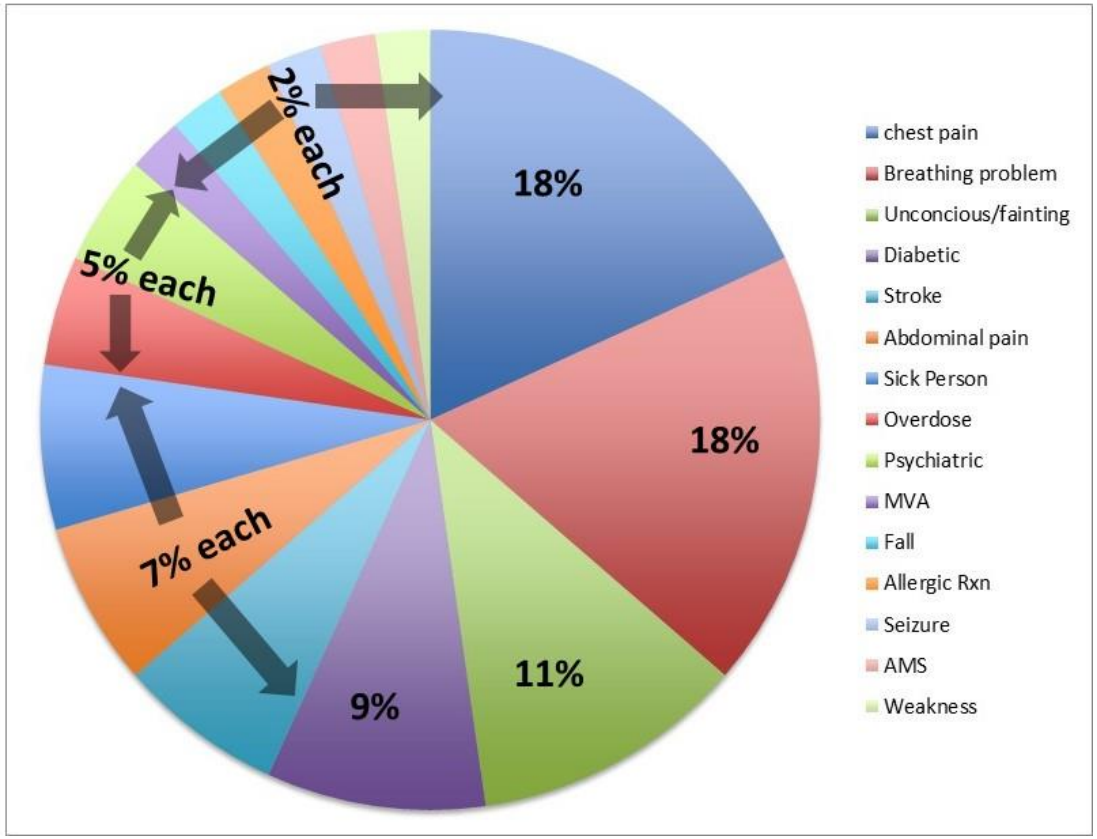


**Figure 5.** Distribution of priority trauma responses across each agency.

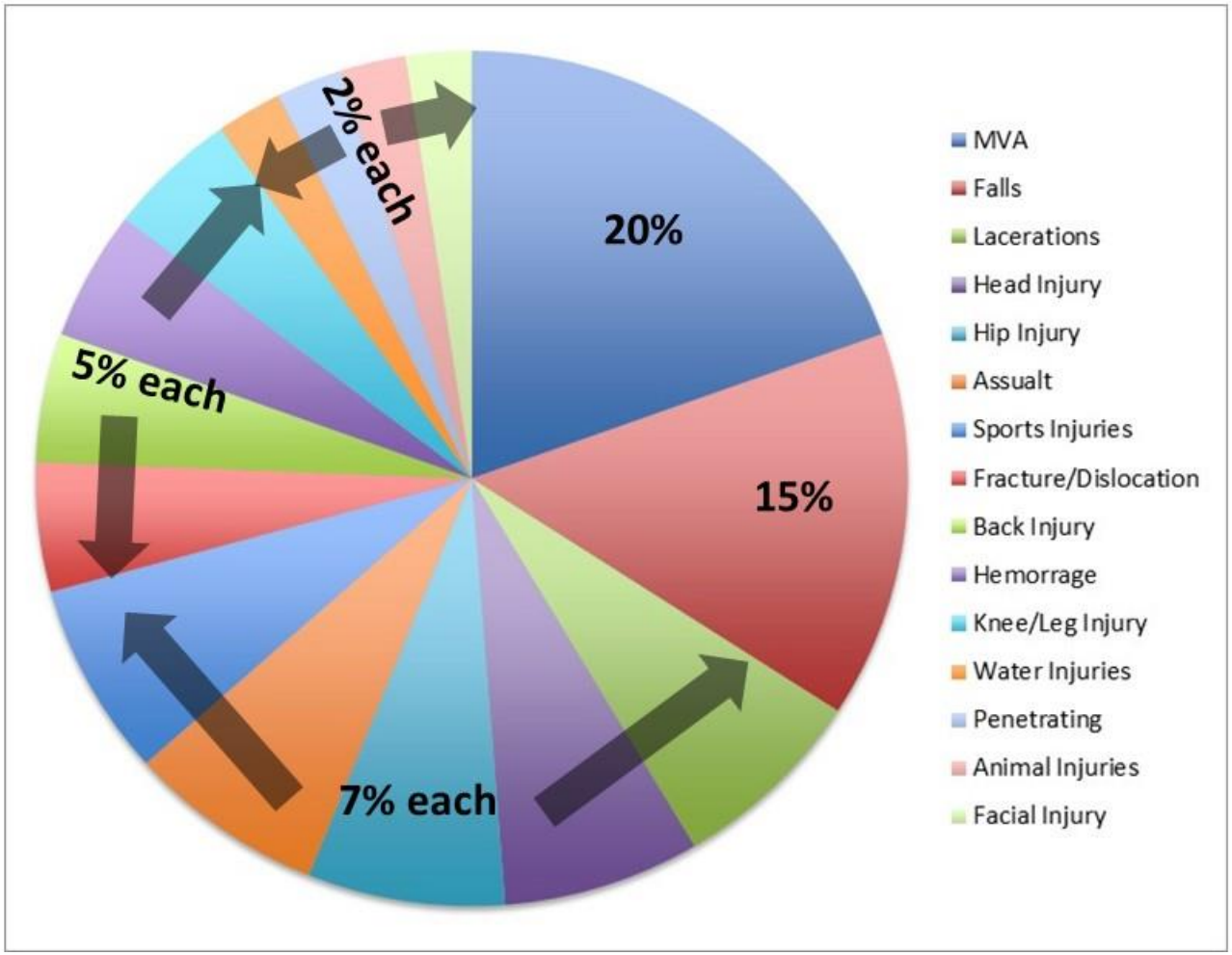


**Figure 6.** Distribution of priority behavioral responses across each agency.

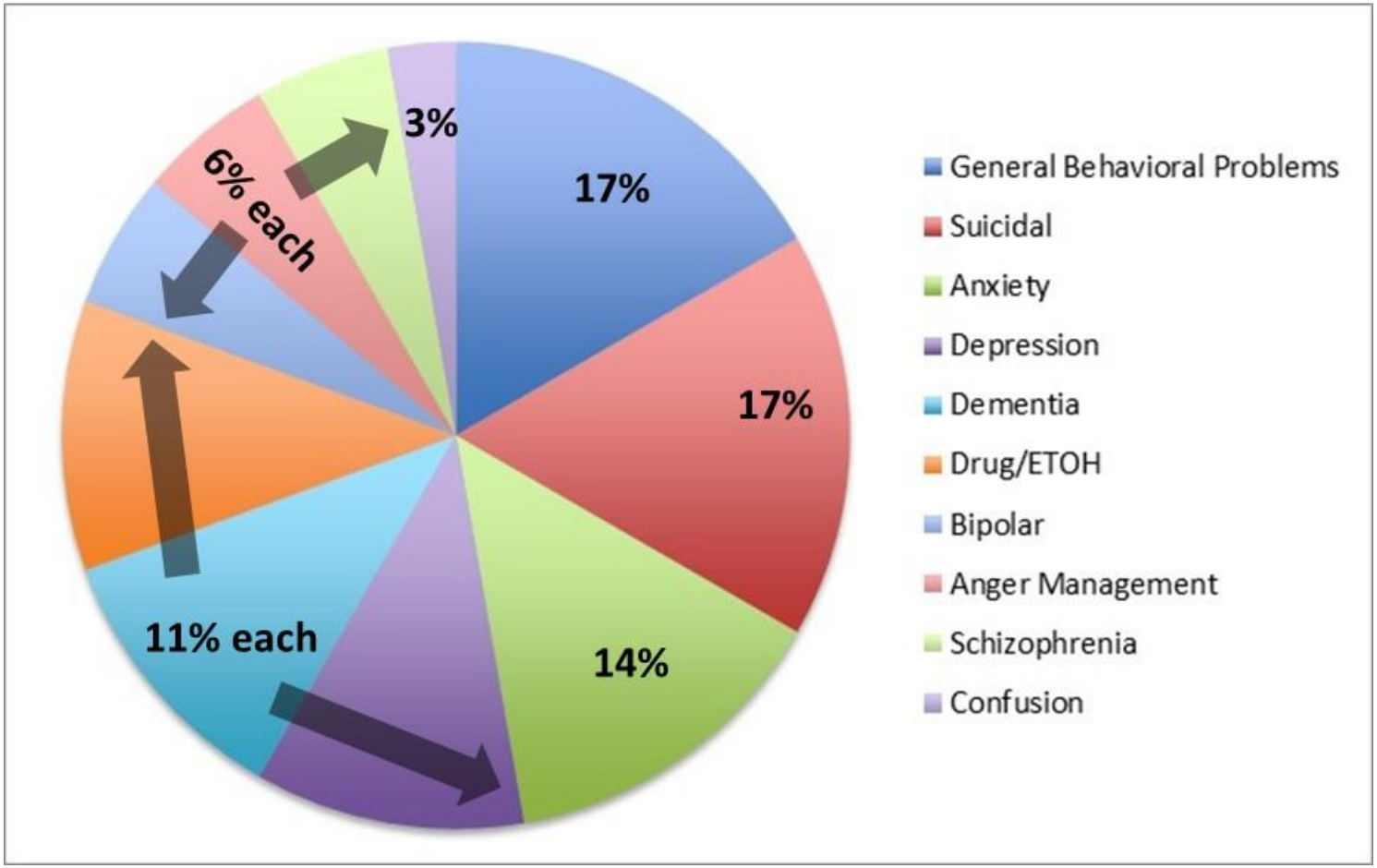
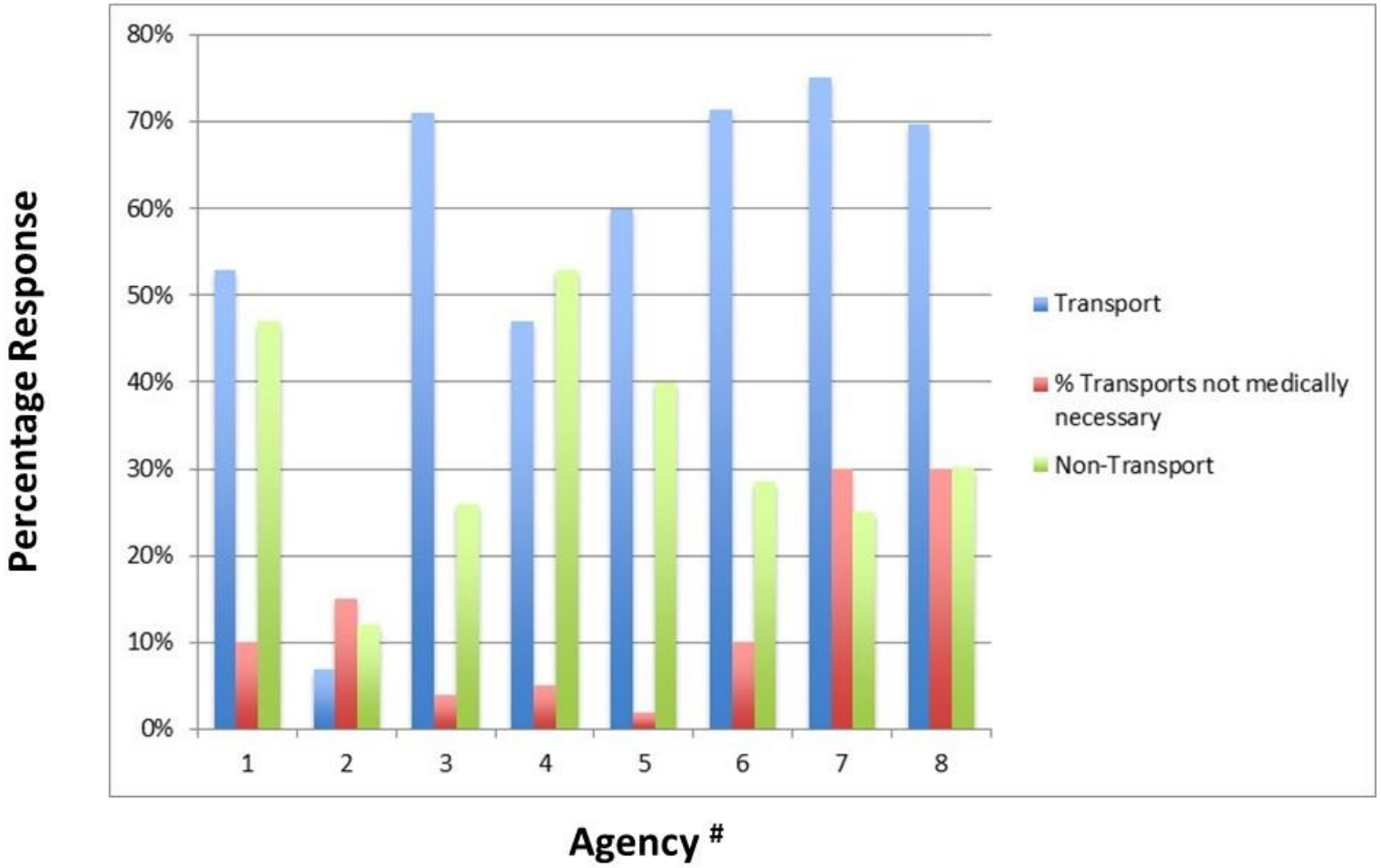


**Figure 7.** Distribution of transports vs. non-transports across each agency.




C

**Table 2:** Reasons for non-transport decision.

| Agency | No Medical Attention Needed | Assess, No Treatment | Assess, Treat, Release | Ases, Treat, Pt Refuses Transport | Patient Refuses Assessment, Treatment and Transport | Total |
|---|---|---|---|---|---|---|
| **1** | 2% | 46% | 5% | 20% | 27% | **100%** |
| **2** | 6% | 0% | 0% | 0% | 11% | **17%** |
| **3** | 10% | 6% | 2% | 27% | 55% | **100%** |
| **4** | 6.20% | 8% | 1.80% | 1% | 2% | **19%** |
| **5** | 10% | 68% | 12% | 5% | 5% | **100%** |
| **6** | 7.50% | 5.00% | 0.00% | 5.00% | 10.00% | **27.50%** |
| **7** | 10% | 15% | 15% | 20% | 5% | **65%** |
| **8** | 13% | 3% | 20% | 51% | 13% | **100%** |
| **9** | 10% | 15% | 9% | 4% | 5% | **43%** |

**Figure 8.** Distribution of potential procedures that could be done in the field by EMS to prevent unnecessary transports.

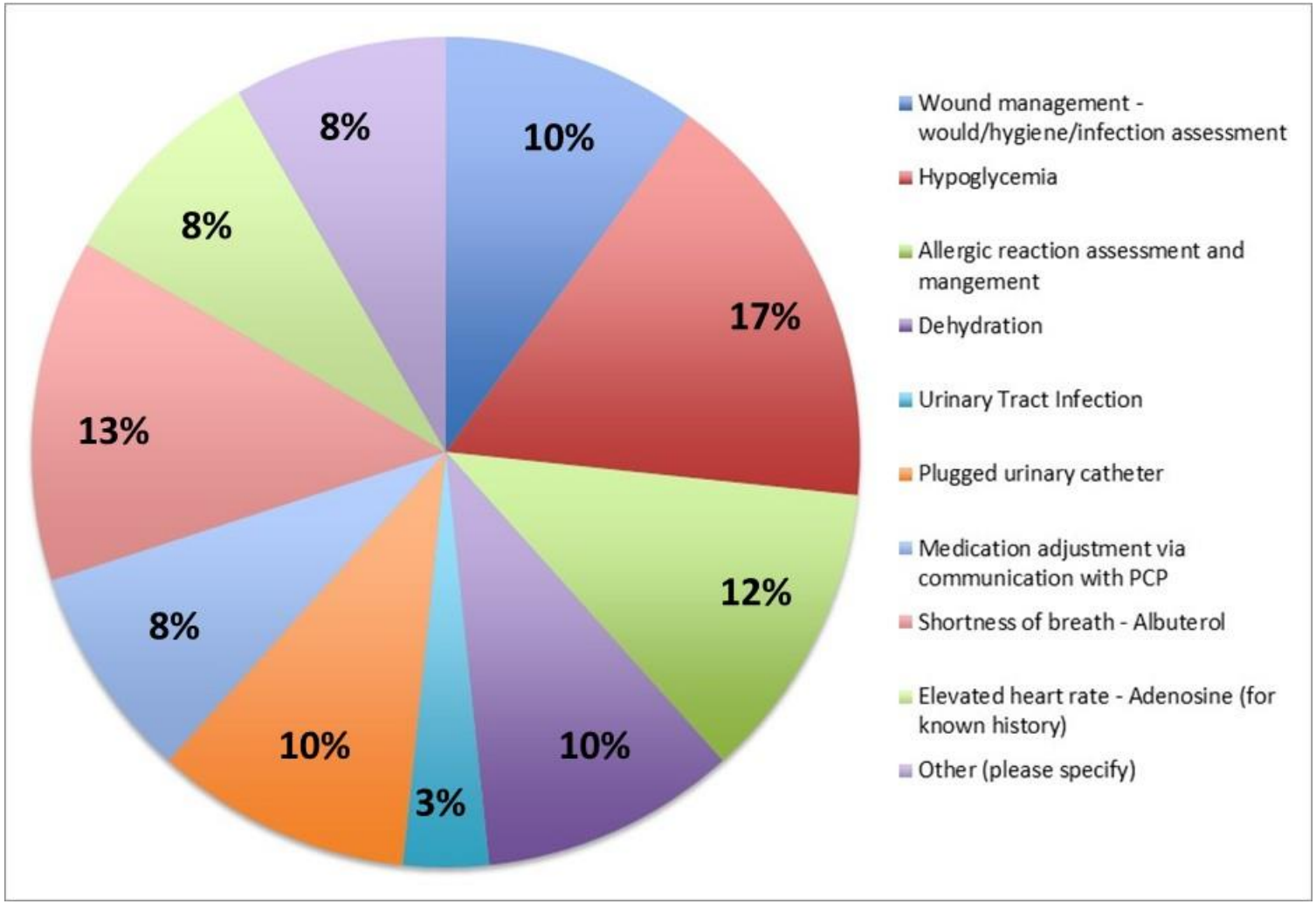


**Figure 9.** (A) Patient Care Reporting (PCR) systems and (B) communication method for sharing reports with hospitals and primary care physicians.

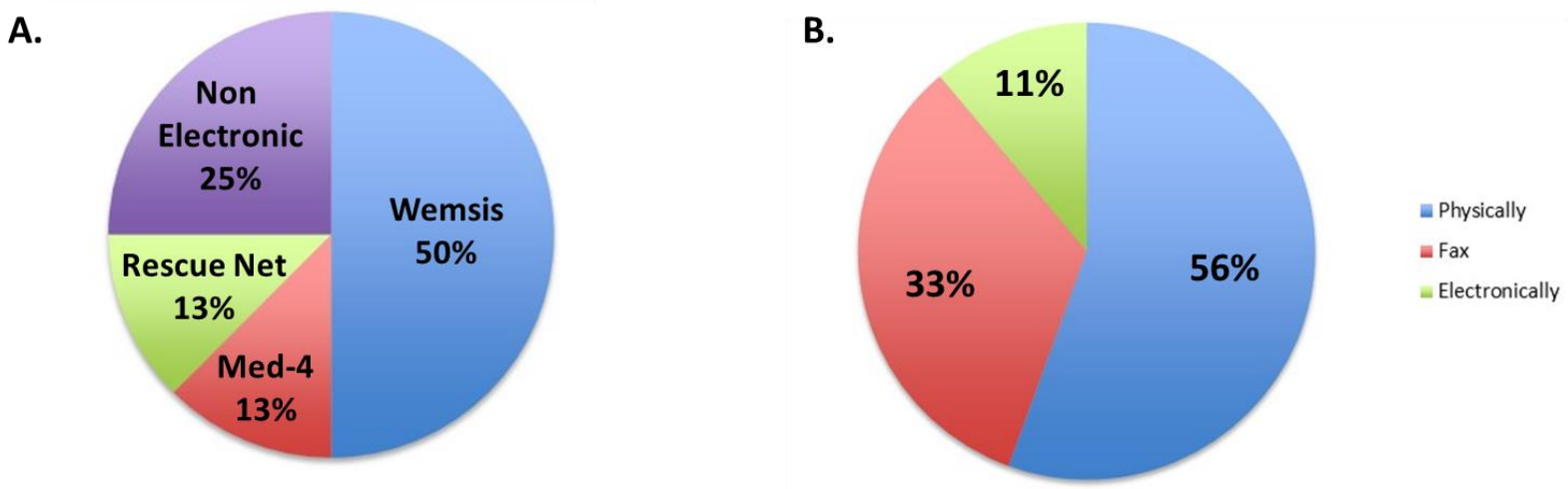
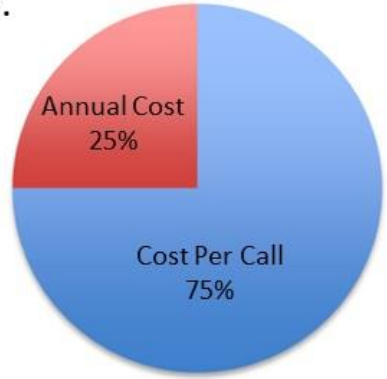


**Figure 10.** (A) Distribution of agencies paying for Public Service Answering Point (PSAP); (B) How agencies are billed for PSAP; (C) 24/7 in-house service; and (D) Primary role of in-house service

A.

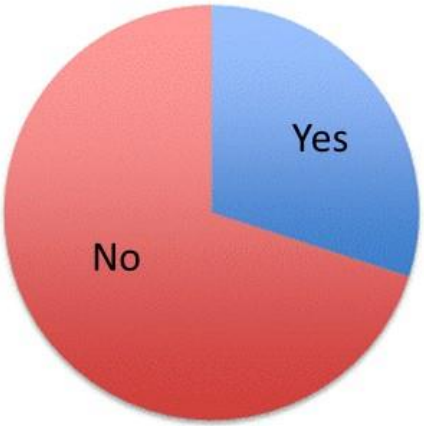

B.




Distribution of billing for agencies that pay a fee for PSAP

C.

**Distribution of agencies that have a 24/7 in house dispatch service?**




D.

**Primary role of in house dispatch service**

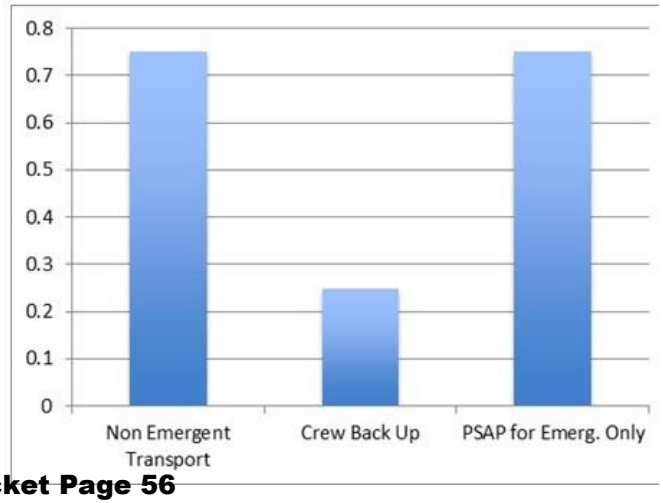
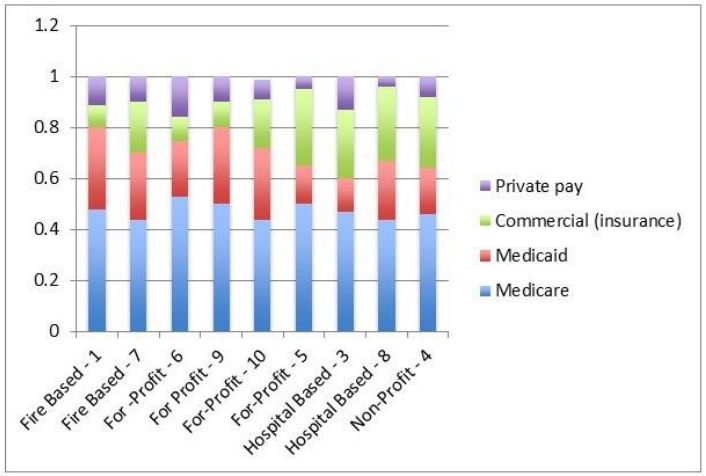
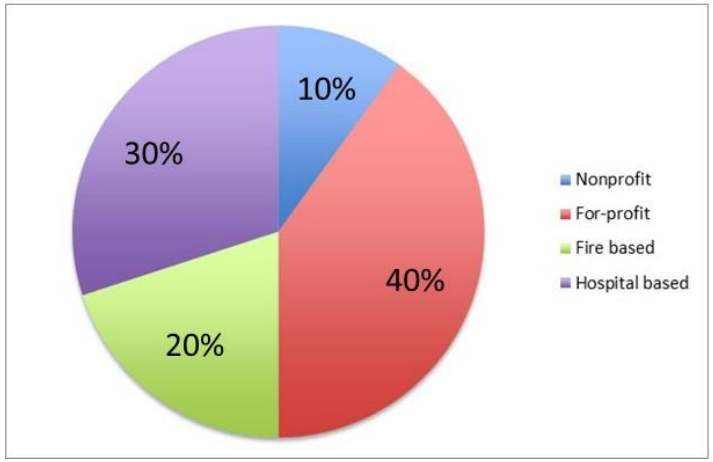


**Figure 11.** (A) Current insurance based support for services; (B) distribution of EMS organizational base; and (C) base-line infrastructure funding support.

**A.**




**B.**




**C.**

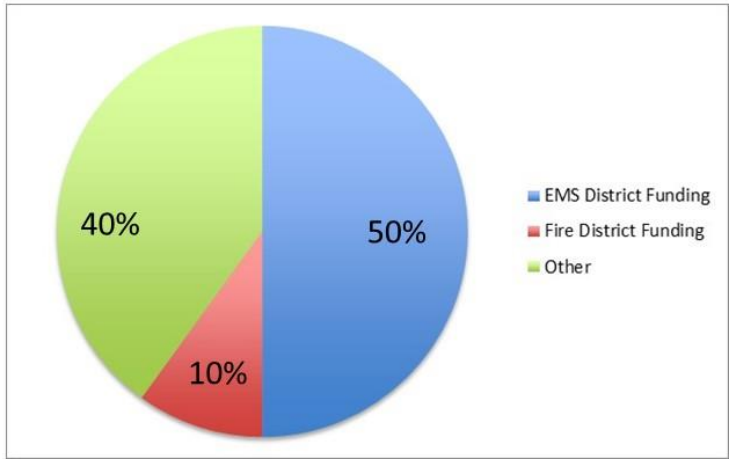


**Table 3:** Gaps, 0pportunities and community engagement.

| | Reimbursed Telemedicine | 24hr Nurse-Patient Hotline | What gaps in Community Healthcare could you fill if funded | Do you connect patients with PCP | How do you transmit PCR to PCP | Aware of social service resources in community for patients | Do you connect patients with social service resources | Which social services to you connect patients to most frequently | Are you familiar with Medicaid's Health Homes program | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency 1 | Yes | Yes | Surgery follow up, ER discharge follow up | No | N/A | No | No | N/A | No | | |
| Agency 2 | Yes | Yes | Medication change follow up, ER discharge follow up | Sometimes | in writing | No | No | N/A | No | | |
| Agency 3 | Yes | No | ER discharge follow up, follow up with repeat patients for chronic care | Sometimes | EPCR system | Yes | Yes | Done through local hospital | Yes | | |
| Agency 4 | Yes | Yes | Urgent care, ER discharge follow up, Lift assist, Hospice partnering, | Sometimes | Fax | Yes | Yes | Room One | Yes | | |
| Agency 5 | Yes | Yes | Urgent care, Home to facility transitions, Doctor appt follow ups | Sometimes | Fax | Yes | Yes | No | N/A | | |
| Agency 6 | Yes | No | Not a gap this agency can fill but a need in the community | Sometimes | in writing | Yes | No | N/A | No | | |
| Agency 7 | Yes | No | Transporting to urgent care, increasing PCP availability | No | N/A | Yes | Yes | Aging and Adult Care | No | | |
| Agency 8 | Yes | No | Any gap that is needed: ER discharge follow up, Home care management | Yes | EPCR system | Yes | Yes | Catholic charities, The sacntuary, Chelan Vally Hope, CARE services | Yes | | |
| Agency 9 | No | Yes | Alternative care, Transport facility | No | EPCR system | Yes | Yes | unknown | No | | |
| Agency 10 | Yes | Yes | Ugent care, ER discharge follow up, Transportation to medical appts, Telemedicine, Fall Risk Assessment, Patient Home evaluation | No | N/A | No | Yes | APS, Hospital social worker | No | | |

**Table 4:** Potential Opportunities

| What gaps in community healthcare system could be filled by your agency, if funded….? |
|---|
| • There is a lot that we are already doing, however it is all uncompensated…. |
| • We could do surgery follow-up, or an hospital/ER discharge, or anything that their PCP would want as long as we are not abused by the system and there is some type of reimbursement for time and/or supplies… |
| • Following up with medication changes especially with our elderly population. A fail safe to make sure patients are following discharge instructions either from PCP or ED… |
| • Follow-up post hospital discharge, within 48 hours. This would be for medical, trauma or surgical patients… |
| • 24/7 urgent care; hospital discharge follow-up. Reimbursement for frequent lift assist that are not transported and a patient care management plan developed for future calls to the same residence; partnering with Hospice and including Hospice in the patient care management plan so all services are better coordinated and EMS responses to Hospice patients are reimbursed. |
| • Post doctor appointment follow-up (not necessarily surgery follow-up), more urgent care, more behavioral health, assistance in transitioning people at home to some sort of facility. |

**Table 4:** Potential Opportunities (continued…)

| What gaps in community healthcare system could be filled by your agency, if funded? (continued…) |
|---|
| • Our community needs longer urgent care hours and clinics should look to adjusting hours to meet the needs of their customers. When it cost a person sick leave, lost wages and they have to pay to go to the doctor they are less likely to want to go. Many insurer and Washington State Medicaid already have nurse hotlines in place and have for many years. |
| • Transition to urgent care….increasing PCP so patients don't need to wait 3 months to see doctor when sick… |
| • Hospital discharge follow-up….home care management… |
| • Alternative care…transport facility… |
| • Urgent care, hospital post-discharge visit, transportation to medical appointment, telemedicine, fall risk assessment, patient home evaluation before discharge for patient safety mainly injuries sustained from falls or home preventable injuries. |

**Table 5:** Additional Considerations

| Final Key Points…. |
| --- |
| • Increasing difficulty to get EMS volunteers which many agency rely upon… Reimbursements have taken a steady decline and Medicaid/Medicare have never been the money makers, but biggest payers…EMS provides a lot to the community, nice to be considered part of the medical field and medical providers…EMS has a lot to offer the community, but cannot be uncompensated… |
| • Programs where we follow-up with the patients after their ED or PCP visit to confirm they're following discharge instructions would be beneficial… |
| • We want to be a contributor to the healthcare system and help getting patients to the right place when care in needed. Help alleviate repeat visits for those issues that can be dealt with in the home…Help reduce the overall cost and burden to healthcare system…. |
| • Underfunding from Medicare/Medicaid makes it hard to stay competitive with other industries fighting for paramedics and EMTs. Some government based EMS systems receive some sort of public funding and bill for their services which also contribute to "unfair playing field"…. Fewer young people entering the EMS field…Government red-tape makes it very expensive to operate in the healthcare field. |

**Table 5:** Additional Considerations (Continued…)

| Final Key Points…. |
| --- |
| • EMS can play a major role in improving community health and reducing the cost. EMS is trusted and can assess patients homes better than anyone… EMS is severely underfunded, but has capability to have a big impact on patient health….EMS less expensive than other healthcare organizations, funding EMS is most fiscally responsible mean to improve access to healthcare. |
| • EMS can play a major role in improving community health and reducing the cost. EMS is trusted and can assess patients homes better than anyone… EMS is severely underfunded, but has capability to have a big impact on patient health….EMS less expensive than other healthcare organizations, funding EMS is most fiscally responsible mean to improve access to healthcare. |
| • Transport patients to physician's office or clinic to help start and IV/rehydrate/sugar or nausea medicine and help them fill their medicine. More in-home services, fall assist, wound care, assisted living facility response, ability to assess and leave them there, assist hospice, assist health department during flu season to provide vaccinations at home…. |

**Details for Treat and Refer Services: Associated with WAC 182-546-0550**

(1) The purpose of treat and refer services is to reduce the number of avoidable emergency room transports, i.e. transports that are nonemergency or nonurgent.

(2) Treat and refer services are covered health care services for a client who has accessed 911 or a similar public dispatch number, and whose condition does not require ambulance transport to an emergency department based on the clinical information available at the time of service.

(3) Treat and refer services can be provided by any city and town fire department, fire protection district organized under Title 52 RCW, regional fire protection service authority organized under chapter 52.26 RCW, provider of emergency medical services that levy a tax under RCW 84.52.069, and federally recognized Indian tribe.

(4) To receive payment for covered health care services provided to clients under this section, an entity that meets the criteria in subsection (3) of this section must be an enrolled medicaid provider and have an established community assistance referral and education services program under RCW 35.21.930.

(5) Treat and refer services must be documented in a standard medical incident report that includes a clinical or mental health assessment.

(6) The health care professionals providing treat and refer services must:

a. Be state-certified emergency medical technicians, state-certified advanced emergency medical technicians, or state-certified paramedics under RCW 18.71 and RCW 18.73;
b. Be under the supervision and direction of an approved medical director according to RCW 35.21.930(1); and
c. Not perform medical procedures they are not trained and certified to perform, according to RCW 35.21.930(1).

(7) Entities that meet the criteria in subsections (3) and (4) of this section must:

a. Retain the standard medical incident report in subsection (5) of this section according to WAC 182-502-0020; and
b. Annually send the medicaid agency an estimate of the medicaid dollars saved by fewer avoidable emergency room trips, as described in RCW 35.21.930(4).

(8) Payments under this section are subject to review and audit under chapter 182-502A WAC.

**WAC 246-976-010 Definitions**

**County Operating Procedure (COP)**

(22) "County operating procedures" or "COPS" means the written operational procedures adopted by the county MPD and the local EMS council specific to county needs.

**Patient Care Protocols (Protocols)**

(59) "Prehospital patient care protocols" means the department-approved, written orders adopted by the MPD under RCW 18.73.030(15) and 70.168.015(27) which direct the out-of-hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment. The protocols meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter 70.168 RCW.

**Regional Patient Care Procedure (PCP)**

(66) "Regional patient care procedures" means department-approved written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter 70.170 RCW. Patient care procedures do not relate to direct patient care.

**Process for developing County Operating Procedures, Patient Care Protocols, and Regional PCPs**

EMS Providers are credentialed with the State of Washington for prehospital services. All EMS providers work under the license of a physician who provides medical oversight in each county. The North Central Region has three Medical Program Directors (two of them split Douglas County due to transport patterns). EMS providers must have Regional PCPs, COPs, and MPD approved Patient Care Protocols for treatment, transport, and non-transport of all patients.

- Regional and local council requests MPD to draft or approve draft of any COP, PCP, Protocol
- MPD drafts, reviews, makes recommendations
- Regional and local council updates document with recommendations
- Regional and local council approves document
- Regional and local council submits document to Department of Health, Office of Community Health Systems, for review and comment
- DOH provides recommendations and/or approves document for submission to the WA State EMS and Trauma Care Steering Committee for approval

The process of development and approval can at times take as long as 12 months to accomplish. Regional and local councils, and Steering Committee, meet on a bi-monthly basis making the process lengthy.

## Breakdown of Emergency Medical Service Funding by Agency

| Agency | Medicaid Encounters (Total for 2017) | Funding Range |
|---|---|---|
| Ballard | (Estimated >1,000) | $35,000 |
| Lifeline | (Estimated > 1,000) | $35,000 |
| Moses Lake Fire | 1211 | $35,000 |
| AMR | (Estimated 200 – 500) | $20,000 |
| LCCH EMS | 372 | $20,000 |
| Cascade Medical Center | (Estimated 200 – 500) | $20,000 |
| Protection 1 Ambulance | 209 | $20,000 |
| Aero Methow EMS | (Estimated <200) | $15,000 |
| Okanogan County Fire District #15 – Brewster EMS | 155 | $15,000 |
| Waterville Ambulance | (Estimated <200) | $15,000 |
| Total | | $230,000 |

**Highlighted =** Agencies that provided specific numbers on total Medicaid Encounters. Those who have ranges in () did not. An agency cannot receive funding until numbers are provided.

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

October 26, 2018

**RE: Pay for Performance Baseline Metrics**

Dear Senator Parlette,

On behalf of Washington State Health Care Authority (HCA), I am pleased to present North Central Accountable Community of Health the region's pay for performance (P4P) metric results for the first baseline measurement period and improvement targets associated with the first performance year. These metric results set the goals for improvements for 2019.

By selecting projects from the Project Toolkit, the ACH region is accountable for demonstrating regional improvement in outcomes over the course of Medicaid Transformation. The measures of health and social outcomes associated with the ACH's Project Plan, known as P4P metrics, determine the proportion of earned Project Incentives year over year.

This report contains North Central Accountable Community of Health's P4P metric baseline results based on data from 2017 (01/01/2017 – 12/31/2017, and the resulting P4P metric improvement targets that set the performance expectation for DY 3 (01/01/2019 – 12/31/2019). The report contains Category 1 data, to be used to communicate with your partnering providers, other partners and stakeholders. Additional materials are included to assist with communicating these results with your partners and stakeholders. Please use them at your discretion.

In order to allow time for ACHs to review and share their results locally, HCA will wait until November 5 to conduct a more comprehensive public rollout of ACH P4P baseline results, including the release of the expanded Healthier Washington Dashboard.

We will use time on a Transformation Alignment Call (TAC) in November to answer questions about the baseline report. In the meantime, if you have any questions about this report or related materials, please send to the Medicaid Transformation inbox (medicaidtransformation@hca.wa.gov).

Sincerely,

Michi'l Needham

Mich'l Needham
Chief Policy Officer
Health Care Authority

# Executive Summary: ACH Baseline Report

| | |
|---|---|
| *Baseline measurement year* | DY 1 (01/01/2017 – 12/31/2017) |
| *Associated performance year* | DY 3 (01/01/2019 – 12/31/2019) |

## What is the purpose of the ACH Baseline Report?

This report is specific to each ACH's approved portfolio of transformation projects. The ACH Baseline Report contains baseline results for the pay for performance (P4P) metrics connected with performance in demonstration year (DY) 3. Improvement targets are determined based on prior ACH performance on the metric. Based on the ACH's baseline results, the report includes the ACH-specific improvement targets that the ACH is accountable for in DY 3, or 2019.

## How did the state arrive at these results and targets?

Data required for ACH project P4P is collected and results are calculated by the state for each ACH region. ACHs are accountable for all the Medicaid beneficiaries that reside in their region that meet the criteria of the P4P metrics (e.g., age, Medicaid coverage criteria) and regional attribution criteria. The calculation of P4P metrics is not limited to the Medicaid beneficiaries treated by partnering providers, nor is it limited to the scope of project activities ACHs implement within selected project areas. For more information about how P4P metrics are calculated, refer to the Measurement Guide.[1]

## What is the significance of the ACH Baseline Report?

The ACH Baseline Report notifies the ACH of the targets for regional improvement in health outcomes among Medicaid beneficiaries for the upcoming performance period (DY 3). Essentially, this report outlines the magnitude of regional progress that the ACH will need to demonstrate to earn full credit for achievement for DY 3. The report is tailored to the P4P metrics associated with the ACH's approved portfolio of projects, and specific to the P4P metrics that are active for DY 3 performance. ACHs are only responsible for the metrics connected to the projects selected in the approved Project Plans.

Baseline results and improvement targets produced by the state on behalf of ACH regions are the "source of truth".[2] HCA acknowledges that other concurrent measurement efforts (e.g., data dashboards) may contain results for the same or similar metrics. However, the state defined a measurement methodology and metric specifications expressly to meet the parameters of the DSRIP program.

## What happens next?

*Communication of ACH Baseline Report with partners.* ACHs may use this report as a communication tool with engaged partners and stakeholders. The ACH Baseline Report is a Category 1 data product, and appropriate for public dissemination.

*Healthier Washington Measures Report.* By mid-November, ACHs will receive a detailed measures report that includes full P4P metric information (e.g., numerator, denominator, county results), and includes

[1] https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

[2] For more information on how the state produces the results and improvement targets, please see the Measurement Guide: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

results for all ACH regions, as well as additional metrics. The detailed measures report is provided under the ACH's data sharing agreement with HCA, and will contain Category 2 data.

*Healthier Washington Dashboard***.** The Healthier Washington Dashboard is a publicly available data resource that allows users to explore data on populations, health indicators and HEDIS measures for Washington State. To support DSRIP project activities, the state invested in enhanced dashboard functionality, and will include all DSRIP ACH Project P4P metric results. The expanded HW Dashboard is scheduled for public release early November 2018.

*Public posting of ACH Improvement targets for DY 3.* To promote transparency and support communication among stakeholders and partners, HCA will publish a summary table that displays all ACH improvement targets by P4P metric for the DY 3 performance year. The summary table will be posted publicly on the Medicaid Transformation Resources webpage by mid-November 2018.

*Assessment of regional ACH performance for DY 3 (2019).* The measurement year for DY 3 performance is 01/01/2019 -12/01/2019. After allowing a 6-month period for the data to mature, the state will calculate DY 3 performance in the fall of 2020. The resulting ACH-level improvement and achievement are converted into achievement values (AVs) that determine what share of potential total Project Incentives were earned by each project.

## Questions?

Please send questions to the Medicaid Transformation inbox (medicaidtransformation@hca.wa.gov).

## Frequently Asked Questions

- *What do baseline and improvement targets represent?*
    - ACH baseline results represent historical ACH performance.
    - Improvement targets are set using prior ACH performance, and are specific to the region. Once baseline results are calculated, improvement targets can be defined for the upcoming performance year. This process repeats for each performance cycle, and is defined in more detail in the DSRIP Measurement Guide.
    - For each metric, the ACH will receive full or partial achievement value, based on the amount of progress toward (or achievement of) the improvement target. The AVs are used to determine earned incentive payments based on performance.
- *Why do P4P metric improvement targets matter?*
    - ACHs are rewarded for demonstrating progress towards pre-established performance targets for key health indicators, as defined by the Project Toolkit and DSRIP Measurement Guide.
    - It is by demonstrating progress that the ACH can earn Project Incentives associated with performance.
- *I don't see all 31 P4P metrics in the ACH Baseline Report. Where did they go?*
    - The ACH Baseline Report is specific to the metrics affiliated with the selected projects in the individual ACH Project Plan.
    - Note that P4P metrics phase in over time to allow for ACH project implementation to take place. Therefore, not all P4P metrics are "active" for the DY 3 performance year. The metrics appendix in the Project Toolkit defines the performance years for which each metric is active. [3]
- *How were these metrics calculated?*
    - The state is responsible for calculating ACH-specific performance goals for each P4P metric, known as an improvement target.
    - Improvement targets are reset for each performance year, according to the ACH's performance in the reference baseline year.
    - Improvement targets are established for each metric based on one of two methods: gap to goal (GTG), or improvement over self (IOS).
    - Resources for more information:
        - Measurement Guide (*Chapter 7: ACH Project Incentives – Pay for performance; Appendix H: ACH Project P4P improvement target and AV methodology; Appendix C: DSRIP measurement and payment timing*).
- *How will performance in 2019 be compared to these baseline results?*
    - Within each performance cycle, a point value, or achievement value (AV), is calculated for each ACH for each metric. AVs drive payments from ACH Project Incentives. In the context of P4P, the maximum value of an AV is one (1.0), in the instance in which an ACH meets or exceeds the designated improvement target. The amount of ACH Project Incentive P4P funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each P4P metric.

[3] https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf

- *How do these improvement target values relate to the achievement values? Do improvement targets factor into how the region earns incentives?*
    - For P4P metrics, an ACH may earn AVs at various magnitudes based on meeting a minimum threshold of 25 percent of its improvement target in the performance year. If this performance threshold is not achieved, an ACH will forfeit the ACH Project Incentive P4P payment associated with that metric. Project P4P incentives that are left unearned during the performance period can then be earned through the ACH High Performance Incentive process.
- *How does this affect how ACHs will carry out their transformation project activities?*
    - ACHs can use baseline information to understand where the region is starting from across the required P4P metrics, and the magnitude of change that is required to earn the full amount of potential Project Incentives for the performance period.
    - Demonstrating improvement in the P4P metrics is not only a mechanism for earning Project P4P Incentives, but performance relative to the metrics can also can give a better sense of how transformation project activities are improving the health and wellness of Medicaid beneficiaries residing in the ACH region, with the aim of true population health improvement.
    - The state knows that ACHs and partnering providers will likely have supplementary measures of success that they will be monitoring on a more frequent basis to stay abreast of implementation progress, areas for adjustment and/or opportunities for scaling transformation efforts for delivery system reform.
- *Where can I find more information?*
    - For more information about the Medicaid Project Toolkit and metric associations with project areas, see Project toolkit and metrics appendix.
    - For information about how performance is measured and the broader DSRIP accountability framework, see DSRIP Measurement Guide.[4]
    - Full specifications for Project P4P metrics are found on the Medicaid Transformation metrics webpage.[5]
- *Will ACH baseline results be posted publicly? If so, where can the results be found?*
    - A summary table that displays individual ACH DY 3 P4P improvement targets by metric will be posted on the Medicaid Transformation Resources webpage.[6]
    - The Healthier Washington Dashboard released in November 2018 will contain P4P metrics results and improvement targets for all ACH regions, including results by geographic region (e.g., ACH region, county) and demographics (e.g., age group, gender, race, and ethnicity). Users have the ability to combine filters to see metric results for specific populations for a more in-depth exploration across demographic dimensions and geography where there is sufficient data to do so (considering small numbers/suppression rules).

[4] https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf
[5] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics
[6] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

# NCACH Project Workgroup Update

## Whole Person Care Collaborative

*October 2018*

## Key Meeting Outcomes

**Broader WPCC Stakeholder Group (10/1/2018)**

- Reviewed upcoming learning activities including Bi-Directional Integration LANs due to start that week. Also shared information about SUD Consent Management guidance that HCA has drafted and that BH providers may want to review and provide feedback on.
- Provided an update on status of Stage 2 MOUs as well as change plan and measurement logistics in portal (including reporting expectations).
- Updated the group on current coaching activities that are designed to support change plan implementation. Kathy Reims shared reflections from recent coaching activities that have been specific to measure specifications, while also helping teams think through their change plan ideas.
- Roger Chaufournier led a leadership discussion specific to aligning change plan with internal priorities as well as external factors, including what we know about our collective performance on certain measures. Discussion focused on areas where we might strengthen alignment which ended up including asthma management and follow-up after ED/hospitalization for behavioral health issues (measures where we are not performing as well as a region.)
- Ended with a roundtable, giving leaders at the table a chance to share their current reflections.

**WPCC Workgroup *(*10/11/2018*)***

- Reviewed learning activity schedule as well as role of coaching network and ways to promote peer sharing.
- Brainstormed options for WPCC participants completing the Motivational Interviewing Train the Trainer track to offer trainings to broader NCACH community.
- Solicited feedback on best way for NCACH to communicate with WPCC community (method, content, frequency) given fast-paced and evolving nature of communications.
- Discussed pros and cons around measures being reported for entire patient panel versus Medicaid only. Generally agreed that panel level data minimizes reporting burden and more in line with improvement perspective, though acknowledged that will be harder to connect dots to data from HCA.
- Reviewed draft summary of SDOH screening tools and reiterated that goal is not to prescribe one tool for all WPCC members, but rather to encourage alignment of core domains across different tools. NCACH will update summary to include a cross walk to HUB intake questions, and post to portal as a resource.
- Discussed ways to synchronize efforts of partners being funded through various NCACH

workgroups. Incorporating updates into broader WPCC meetings will promote better information sharing, but queuing up shared learning activities between different workgroup providers may be more effective for synchronizing the work.

## Upcoming Meetings

| | |
|---|---|
| 11/5/2018 | WPCC Meeting (open to the public) |
| 11/8/2018 | WPCC Workgroup Meeting |
| 12/3/2018 | WPCC Meeting (open to the public) |
| 12/13/2018 | WPCC Workgroup Meeting |

North Central Accountable Community of Health

# CACH Project Workgroup Update

## Transitional Care and Diversion Intervention Workgroup

*November, 2018*

## October Key Meeting Outcomes

- NCACH staff have been working with the North Central Emergency Care Council (NCECC) Board to finalize the EMS proposal to present to the Transitional Care and Diversion Intervention Workgroup. NCECC board members met on Thursday October 18th for final review. The EMS proposal was approved at the TCDI workgroup on 10.25.18
- Hospital applications are in final review with partner scores to be provided November 5th. Seven out of ten hospitals applied and are planning on completing the following projects outlined below:

| Organization | Requested Funds | Transitional Care* | ED Diversion | EDie Integration | EDie Training | CBI |
|---|---|---|---|---|---|---|
| Lake Chelan Community Hospital | $ 71,000.00 | 1 | 1 | 1 | 1 | 1 |
| Mid Valley | $ 39,975.00 | 1 | 1 | | | |
| Three Rivers Hospital | $ 26,000.00 | 1 | | | | |
| Samaritan Healthcare | $ 71,000.00 | 1 | 1 | 1 | 1 | 1 |
| Columbia Basin Hospital | $ 71,000.00 | 1 | 1 | 1 | 1 | 1 |
| Coulee Medical Center | $ 71,000.00 | 1 | 1 | 1 | 1 | 1 |
| North Valley | $ 55,044.00 | 1 | 1 | 1 | 1 | 1 |
| **Total Review** | **$ 405,019.00** | **7** | **6** | **5** | **5** | **5** |

## Upcoming Meetings

| | |
|---|---|
| November 15th | TCDI Workgroup Meeting |
| December 20th | TCDI Workgroup Meeting |

North Central Accountable Community of Health

# NCACH Project Workgroup Update

## Regional Opioid Stakeholders Workgroup

*November, 2018*

## October Key Meeting Outcomes

- The first round of the 2019 Rapid Cycle Opioid Application is due on November 2nd. The application is available at: https://ncach.org/opioid-project/. A total of $50,000 is available for organizations (up to $10,000 per organization) to implement opioid initiatives January-June 2019.
- The Workgroup is forming a planning committee for the March 2019 Opioid Response Conference (which will use a distributed conference model). If you would like to join the committee, contact Christal Eshelman (christal.eshelman@cdhd.wa.gov).
- The Workgroup received two presentations in October by 2018 Rapid Cycle Opioid Application awardees – the Syringe Service Program in Grant County and the Regional Opioid Communications Plan.
- With Steve's retirement at the end of this year the NCW Opioid Stakeholders Group (aka. Steve Clem's group) has requested to be facilitated in conjunction with the Regional Opioid Stakeholders Workgroup. Both sets of stakeholders will be invited to the Regional Opioid Stakeholders Workgroup meetings, starting in December. Since both group and experienced declining attendance this seems like a good opportunity to maintain attendance and reduce duplication of meetings.

## Upcoming Meetings

| | |
|---|---|
| November 16th | Regional Opioid Stakeholders Workgroup |
| December 21st | Regional Opioid Stakeholders Workgroup |

# NCACH Project Workgroup Update

## Pathways Community HUB

*October 2018*

## [Date] Key Meeting Outcomes

- Pathways Community HUB successfully launched on October 1, 2018. In the first 20 days of the program launch the HUB received 113 Active Referrals; 22 of those referrals were triaged to another community care coordination program; 9 referrals declined services; 79 remaining clients have been assigned to CSSA/PCS; and 3 clients are actively enrolled. Health Insurance, Medical Referral, Social Service Referral, and Tobacco Cessation are the current active pathways PCS are working on with the three enrolled clients.
- A monthly dashboard report will be created for reports moving forward.
- Pathways Community Specialists (PCS) and their supervisors participated in the Skillsource Partner Resource Van Tour on October 16th visiting numerous social service partners in the Moses Lake area. PCS reported this tour to be very informative and they gained a lot of information about resources available for HUB clients.
- Two of the PCS have also enrolled in the WSDOH Community Health Worker training as part of an ongoing continuing education for their work.
- Action Health Partners staff held a Pathways Community HUB Informational meeting in Moses Lake on October 19th. The meeting objectives were to Understand the Pathways Community HUB project (>76% reported increased knowledge/understanding); Identify Intersections Across Care Coordination Programs; Identify Next Steps to Collaboration. There were 39 participants representing 25 agencies were in attendance. The group collectively

identified three next steps and prioritized based on impact and effort. These solutions include:
    - 1. Schedule regular care coordination networking opportunities for all programs
    - 2. Being personable to clients and peers across programs/don't assume client comprehension.
    - Increase communication via data base or other IT system
- HUB Advisory Board met on October 18th. The group reviewed the initial metrics of the first two weeks of HUB services. Outreach and engagement challenges were discussed and a workgroup will form to assess the current target criteria and will work with staff on quality improvement processes to address the challenges.
- MCO conversations continue and to date the team has had initial conversations with all three NCACH regional MCOs.
- HUB staff is working with CCS CHW Trainers on scheduling/planning the 2019 PCS/CHW trainings. The goal will be to have HUB Clinical Director certified as a Pathways Community HUB Clinical Master Trainer no later than Q2 2019.

## Upcoming Meetings

| | |
|---|---|
| TBD-November | Pathways Community HUB Advisory Board |
| TBD-November | PCS/Supervisor Monthly meeting |
| TBD-Nov-Dec | Chelan Douglas Pathways Community HUB Informational Meeting |
| | |