ACH Contact Information

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

ACH Name:	North Central Accountable Community of Health
Primary Contact Name **Phone Number** **E-mail Address**	John Schapman 509-886-6435 John.schapman@cdhd.wa.gov
Secondary Contact Name **Phone Number** **E-mail Address**	Linda Parlette 509-886-6438 Linda.parlette@cdhd.wa.gov

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

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

A. Milestone 1: Assessment of Current State Capacity

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

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

Yes	No
X	

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

   ACH Response:

   Not Applicable

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

   ACH Response:

   NCACH staff conducted a variety of assessment activities including administering online surveys, conducting individual interviews, utilizing workgroups, and holding focus groups. Some were project or domain specific and some crossed projects and domains. Listed below is a summary of the assessments NCACH has completed.

   <u>PCMH-A/MeHAF Assessment</u>

   Each member of the Whole Person Care Collaborative (WPCC) Learning Community completed the PCMH-A or MeHAF baseline assessment to establish the current operational state related to the PCMH model. The WPCC Learning Community is composed of all 17 outpatient primary care and behavioral health providers in the NCACH region. Completion of the PCMH-A or MeHAF was a requirement under the

Stage 1 Funding memorandums of understanding (MOUs) that were signed between the NCACH and each Learning Community member in February and March 2018. The assessments were either self-administered or facilitated by NCACH region's Practice Transformation Qualis Coach. For organizations with multiple sites, the assessment was sometimes completed for specific sites instead of the entire organization. Results from 12 organizations were summarized in a report in late 2017 and were used to understand the current state of the region's providers. These results guided the development of the change plan template, which is designed to touch on NCACH's entire project portfolio, with an emphasis on Bi-Directional Integration and Chronic Disease Management. Change plans completed by each Learning Community organization are due on July 31, 2018. A required element of the change plan is to report PCMH-A and/or MeHAF scores, and it is expected that the results of the assessment will guide the development of each organization's change plan.

Whole Person Care Collaborative Learning Community Assessment

NCACH staff recognized the need to gauge outpatient provider needs and gaps in other areas in addition to the PCMH-A/MeHAF. To accomplish this, NCACH staff developed a 52-question survey that covered areas such as quality improvement and practice coaching, workforce challenges, value-based payment (VBP) strategies, health information technology and exchanges including connection with the Washington Prescription Monitoring Program (PMP), access to care, and care coordination including coordination with the Pathways Community HUB. As of June 30, 15 of 17 Learning Community providers had completed this assessment. NCACH is still in the process of analyzing the abundance of information provided in the responses, but a few highlights are listed below:

- 80% of providers responded that they were or may be interested in practice coaching resources.
- The most frequently reported barriers to implementing and sustaining quality improvements are (1) time constraints/workload, (2) measurement capabilities, and (3) staff shortage/turnover.
- The largest workforce shortages involve (1) licensed mental health professionals (2) MDs/DOs (3) degreed nurses (4) substance abuse treatment professionals, and (5) medical assistants.
- The largest barrier where providers feel NCACH can play a role to assist them is in access to comprehensive data on patient populations.
- There are at least 11 different electronic health records (EHRs) currently being used by the 15 respondents in the NCACH region and one provider does not use an EHR.
- 71% of respondents said it would be very or extremely helpful to assist their organizations with using PreManage in order to receive notifications and track

data on patients who have been admitted to the hospital/emergency department (ED).

- 85% of respondents use EHRs that are not currently connected/integrated with the PMP. The two greatest barriers to using the PMP identified were lack of EHR interoperability and difficulty accessing the PMP.
- Substance abuse services and medication-assisted treatment (for those with opioid use disorder) ranked as the two hardest services to access.
- Two-thirds of respondents were interested in developing a Mobile Integrated Health team in partnership with emergency medical services (EMS).
- The biggest barrier to fully utilizing care coordinators was the lack of funding or reimbursement mechanisms to support the position.

Community-Based Care Coordination (Pathways Community HUB)

Last year, the NCACH Governing Board gave guidance that the NCACH did not want to serve as the Pathways Community HUB lead agency. This was in keeping with the mission of the NCACH to push resources out to community partners and build sustainable change in the community.

Several types of assessments were required for the planning of the Pathways Community HUB, which assessed the NCACH region for the following:

a. Agencies that were interested in serving as the Pathways Community HUB lead agency,
b. Care coordination activities that are currently taking place in the region, and
c. Agencies that are interested in becoming Care Coordination Agencies (CCAs) when the Pathways Community HUB is launched in their area.

To assess which agencies were interested in becoming the Pathways Community HUB Lead Agency, NCACH issued a Request for Proposals (RFP). The RFP was issued on March 28 and was closed on April 27. NCACH received one submission to this RFP. Despite only having one applicant, a rigorous scoring and review process was applied to the application. The applicant, Community Choice, was found to be competent and was approved as the Pathways Community HUB Lead Agency at the Governing Board meeting on June 4.

To understand care coordination activities that are currently happening in its region, NCACH took a couple of approaches. First, NCACH surveyed the Whole Peron Care Collaborative Learning Community members. Eight of the 52 questions in the survey sent to the WPCC Learning Community members were dedicated to understanding their current care coordination practices and to gauge interest in being a Pathways HUB CCA. Of note, four organizations responded that they were interested in becoming a CCA, four

were not interested, and five responded that they would need more information. NCACH will do further outreach to these potential CCAs.

In addition to surveying healthcare partners, NCACH worked with the Health Homes lead agency in the NCACH region to identify all the organizations that they contract with to serve as care coordination organizations for the Health Homes program. Given the similarities between the Health Homes model and Pathways Community HUB model and potential overlap between the target populations of each of these programs, NCACH believes it is critical to work closely with all the care coordination organizations providing Health Homes services.

NCACH is also partnering with the Nursing Director from Chelan-Douglas Health District, who is the Regional Care Facilitator as part of the P-TCPi initiative, which involves surveying the NCACH region for pediatric care coordinators. This sharing of information is very valuable as she has made contact with each of the schools in the region to learn what care coordination activities are taking place and who the contacts are. As NCACH expands its programs, a key strategy is to more closely partner with school districts in the NCACH region.

Opioid Current State Assessment

To assess regional capacity for opioid work, NCACH staff conducted key informant interviews with community leaders, used an online survey, and presented at community meetings to collect information about community opioid initiatives and programs that were currently happening, planned to happen, or were considered in need. Fourteen key informant interviews were conducted, 19 online surveys were received, and NCACH staff presented at five community meetings. All initiatives were related to opioid prevention, treatment, opioid overdose prevention, and long-term recovery were asked about. This information was synthesized into a Current State Assessment Matrix by county.

There was a strong need for the following interventions:

- Public and youth education on opioid use and misuse
- Increased number and awareness of medication take-back boxes
- Improved opioid prescribing practices
- Drug Court
- Increased medication-assisted treatment providers and increased access to treatment
- Improved access and distribution of naloxone (law enforcement, schools, community partners, general public)
- Improved real-time data collection of fatal and non-fatal opioid-related overdoses

- Increased long-term treatment and recovery and supportive housing options

Diversion Interventions Assessment

Since selecting ED diversion and community paramedicine as NCACH's two initial evidence-based approaches (as outlined in preliminary project plans applications), NCACH completed assessments as part of the Transitional Care and Diversion Interventions (TCDI) Workgroup activities to fine-tune the exact approach the region will take. Each of these approaches was assessed with the relevant community partners and stakeholders, since the approaches would require buy-in and support from different sectors. Some of the assessment findings are listed below.

L.E.A.D.

Although NCACH did not select this approach in its preliminary project plans, NCACH believed it was important to further evaluate the potential to implement the Law Enforcement Assisted Diversion (L.E.A.D.) approach. NCACH held interviews with three key law enforcement agencies in the area (Grant County Sherriff's Office, Wenatchee Police Department, and Chelan County Sherriff's Office) to exploring two primary questions:

1. Do you believe this approach would be feasible to complete if there was funding to support implementation?

2. If yes, would law enforcement in the region be interested in exploring this option further?

Each law enforcement agency acknowledged that the L.E.A.D. program was a very worthy program. At this time, they felt it was not the appropriate program to implement in the region.

Emergency Department Diversion

For ED Diversion, initial assessments were sent to partnering hospitals to learn which hospitals were currently implementing principles of the "ER is for Emergency Best Practices Principles."

NCACH had 80% of local hospitals complete the survey. The survey demonstrated that 75% to 90% of partners were implementing the majority of the ER is for Emergency Seven Best Practices. The only approach that fell below 70% was *use of feedback information* (37.5%).

The survey results highlighted the following key takeaways:

1. The majority of hospitals wanted to focus on patient education as a way to decrease inappropriate use of emergency departments.

2. A majority of emergency departments utilize the EDie system, but primarily to retrieve information about their patient.

After the initial ED assessment, NCACH set up monthly meetings of ED managers, directors, and chief nursing officers to review the data and develop a plan for ED Diversion.

Through these meeting discussions, NCACH identified strategies that ED partners could implement to support the ER is for Emergency Seven Best Practices. Based on a follow-up survey for partners, the top three strategies were incorporated into the NCACH application process for interested hospital partners:

A. Reduce inappropriate ED visits by encouraging prompt visits to primary care physicians and improving access to care

B. Patient education on how to access appropriate care

C. Training staff to better utilize the EDie system and promote better information exchange across NCACH's region

Community Paramedicine

NCACH held initial meetings with EMS partners of the North Central Emergency Care Council (NCECC) to determine the following:

1. Who are the appropriate partners within the EMS community to complete this work?

2. Are these partners interested in participating in a community paramedicine model?

3. What further information would be needed to progress?

NCACH had 50% of the EMS transport agencies present in the initial meeting including a mix of public and private EMS agencies. In those conversations, it was determined that community paramedicine should focus on transport agencies. It was also determined that agencies are willing to adopt components of community paramedicine (as defined by the region) but are not willing to develop a full-blown community paramedicine model in their agency. The major concern that was voiced by every agency is the lack of a reimbursement model for community paramedicine for all EMS providers.

NCACH and the NCECC continued to meet with EMS partners for a couple of months to outline basic strategies that partners would be willing to address. These discussions led to the development of a proposal that was submitted to NCACH, which will result in a detailed plan for EMS partners to implement and address the following goals:

1. Reduce non-acute ED visits originating from ambulance transports

2. Reduce 30-day hospital readmissions of chronic disease and high-risk patients

3. Enhance collection of EMS data and standardize how data is reported across the region

NCECC is now moving forward with in-depth assessments of the 10 identified EMS transport agencies. The plan NCECC is developing will outline how each EMS agency will contribute to the regional attainment of the above goals.

Transitional Care Assessment

For transitional care management, an initial survey was sent to hospital partners that asked basic questions on transitional care/care coordination services (i.e., nurse case management, community-based care coordination). Concurrent with the survey, NCACH staff scheduled individual conversations with each of the hospital entities on the current process they are using for transitional care. These two processes helped NCACH gain a better understanding of its partner's current state, willingness to move to a regional model, and ability to implement a transitional care model in their organization

Coalitions for Health Improvement (CHI) Stakeholder Surveys

In June 2018, the CHIs released an online survey to gather community feedback on opportunities and barriers to health and healthcare across NCACH's four-county region. Compared to the more targeted assessments described above, this survey is being shared with a much broader set of stakeholders. Survey respondents to date represent over 20 sectors and include community members interested in improving the health and well-being of their communities, tribal partners, elected officials, agricultural representatives, and public services like libraries. The survey is being widely distributed until July 31, 2018, and will be used to create a working strategic plan for the three CHIs for the length of the Medicaid Transformation. NCACH also plans to use this feedback to identify areas of overlap, regional assets, and opportunities to address health equity through its Medicaid Transformation work.

Social Determinants of Health Facilitated Discussions

NCACH recognizes that whole-person health cannot be achieved strictly within the clinic. As a central tenet of all six selected Medicaid Transformation projects, NCACH is incentivizing clinical-community linkages and strengthening the ability of providers and community organizations to support the population through social determinants of health that are causing barriers to achieving one's full health potential. Through various meetings and reports, transportation and housing have consistently been identified as two of the greatest barriers to health within the NCACH region.

To further understand the needs of the community and providers and identify concrete steps the NCACH can take to mitigate these barriers, NCACH staff teamed with its Oregon Health & Science University contractor to hold a series of facilitated discussions in April 2018 focused on social determinants of health, specifically transportation and housing.

NCACH utilized a five-step process to collect and analyze information that resulted in formal recommendations for the NCACH Governing Board to adopt.

1. Facilitated discussions with representatives from four counties (April 3 and 4)
2. Synthesized results and ideas
3. Reviewed the results and ideas at the NCACH Annual Summit and requested feedback (April 20)
4. Processed feedback from NCACH Annual Summit participants
5. Formulated recommendations and submitted to the Governing Board for approval (June 4)

On April 3 and 4, NCACH held three facilitated discussions in Wenatchee, Moses Lake, and Omak. NCACH wanted to ensure that local variation and unique challenges were captured in the results and ideas. Community partners with knowledge of the barriers faced by providers and clients were invited to participate, with a range of seven to 10 participants per group.

Each facilitated discussion began by asking participants to identify strengths in their local community and in the region. After spending some time discussing strengths, NCACH partners discussed some misconceptions that they frequently encounter. This naturally led, as planned, to identifying the greatest challenges the people housing and transportation partners serve face including the biggest unmet needs and most important obstacles that people encounter. NCACH staff followed that up by examining what challenges organizations face in terms of unmet needs and obstacles. Lastly, and most importantly, NCACH staff finished the session by asking participants what opportunities they saw for the NCACH to help with these misconceptions and challenges that people and organizations are facing. Below are key results from each of the sessions.

Strengths across the region:

- ★ Strong spirit of collaboration and pulling together; resourcefulness and creative problem solving
- ★ Cooperation among nontraditional partners
- ★ Growing community-wide recognition of the impact that social determinants have on health

Misconceptions that people encounter:

- ★ The homeless "are not from here"
- ★ Poverty is not a big problem—or not "our" problem
    - The poor are unemployed—ignoring the working poor
    - The poor are drunk, on drugs, etc.
- ★ Stereotyping of Hispanics

        - The poor and homeless are Hispanic
        - Hispanics are poor and homeless
        - Hispanics are stealing all the resources
    - ★ Services are more accessible than they actually are

Challenges for people:

- ★ Depression and social isolation
- ★ Difficulty of traveling to services and appointments
- ★ Inability to use housing vouchers because no housing is available
- ★ Unawareness of free or affordable resources
- ★ Difficulty of understanding and navigating complicated requirements, paperwork, etc.

Challenges for organizations:

- ★ State funding models reflect urban concerns and priorities
- ★ Hard to recruit, pay, and house the workforce and avoid burnout
- ★ Bridging culture gaps can be very difficult
- ★ Reimbursement rates don't reflect true costs
- ★ Discrepancies between data sources

The information that was gathered during the focus groups was synthesized, and several themes were developed suggesting ways NCACH could help address transportation and housing in the region. The following ideas were developed and presented at the NCACH Annual Summit on April 20.

- Help organizations acquire external funding, including finding grant opportunities, supporting grant writing, and mentoring organizations
- Provide technical assistance for business practices, data and information management, workforce, communications, community outreach
- Convene, coordinate, and advocate—including spearheading and coordinating outreach, demonstrating how social determinants affect health, and catalyzing problem solving
- Coordinate and align information, including investigating the strengths and weaknesses of current efforts and developing strategies for sustained improvement

- Provide direct access to funds, potentially encompassing rapid-response awards for critical investments and/or large awards for significant initiatives that bring partners together

After presenting the content above at the Annual Summit, NCACH distributed feedback forms, asking attendees to rank the possible strategies. There were 115 responses. The two highest ranked strategies were to identify high-impact funding opportunities and to coordinate and align information.

Chemical Dependency Professional Shortage Assessment

The NCACH region has a shortage of chemical dependency professionals (CDPs), in part due to typical barriers associated with being in a rural region and in part due to training and certification requirements of the CDP certification. To assess what the NCACH can do to help with this shortage, NCACH hired a summer intern from the University of Washington Master's in Health Administration program to:

1. Interview providers and key partners about barriers that providers experience when recruiting and retaining CDPs
2. Research CDP training and certification requirements in comparison to other health care professional certifications and other states
3. Provide a report summarizing information collected from interviews and research along with recommendations of policy changes, both at the county/region level and state level that would mitigate barriers providers are experiencing in recruiting and retaining CDPs in NCACH's region.

This project started at the beginning of June and the final report is expected to be completed by August 31. Based on findings from this study, NCACH may pursue program development, policy advocacy, increased awareness, or other strategies that can contribute to project planning and implementation.

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

ACH Response:

PCMH-A/MeHAF Assessment

The NCACH has not adjusted its project plans based on the PCMH-A and MeHAF assessments completed by outpatient providers in its region. It was always NCACH's intention that these assessments would provide partners with a foundation for understanding improvement opportunities to target. NCACH's network of outpatient providers is currently working on change plans that ask them to outline their assessment scores, and to use these plans as a guide for specific practice transformation goals they want to accomplish over the course of the Transformation.

Whole Person Care Collaborative Learning Community Assessment

NCACH staff sent a survey to the WPCC Learning Community to gain a better understanding of their coaching needs and to inform how Domain 1 investment priorities might support the objectives of the project portfolio they are contributing to. Because about 80% of NCACH's providers are interested in coaching, NCACH will examine how they rated specific coaching roles (in terms of helpfulness) to augment the coaching they might already have access to. NCACH's plan is to pull together a coaching network that its partnering providers can draw on to receive tailored assistance for their practice transformation needs. Their responses specific to workforce, VBP, and health information technology and exchange (HIT/HIE) will continue to help prioritize achievable wins in these areas. Some of the strategies outlined under Milestone 2, Section 3 were directly informed by these survey responses.

Community-Based Care Coordination (Pathways Community HUB)

After the assessment activities and the selection of NCACHs HUB lead agency, NCACH selected target population criteria and developed a preliminary launch date and scaling plan (shown below). Given the anticipated launch in Moses Lake in October 2018, NCACH is focusing outreach to CCAs there. NCACH used the results of the WPCC Learning Community survey, the list of organizations providing Health Homes Care Coordination, and the selected target population to identify three agencies to be initial CCAs. Contract negotiations are still underway, but each agency has verbally communicated their intent to serve as a CCA and hire the necessary staff for this role. NCACH's next step will be to survey and inventory community resources so that care coordinators can easily access and connect clients to needed resources.

County	Grant County	Chelan-Douglas Counties	Okanogan County
Specific Location	98837 Zip Code	TBD	TBD
Target Population	3+ ED visits in the past 12 months	3+ ED visits in the past 12 months	3+ ED visits in the past 12 months
Launch Date	October 2018	April 2019	October 2019

Additionally, through its surveys and assessments, NCACH has learned that, as suspected, there is a lot of care coordination happening in its region, although much of it is siloed and there is difficulty in making the necessary clinical-community linkages and closing the loop on referrals. For example, within NCACH's WPCC Learning Community, care coordination is different across different providers, and some are not engaging in community-based care coordination (they are more focused on care coordination on medical needs, medications, and follow-up from acute settings.) NCACH is intending to explore opportunities to provide the infrastructure needed to facilitate a closed loop

referral system between clinical providers and community-based and social services organizations. In this case, providers would also be able to take advantage of the community resource inventory described above.

Opioid Current State Assessment

The results of the Opioid Current State Assessment were synthesized into a chart categorizing initiatives by county and by type (i.e., Prevention, Treatment, Overdose Prevention, and Recovery). The NCACH Regional Opioid Stakeholders Workgroup developed a process to fund partners through a Rapid Cycle Application. The application included a list of priority approaches that could help fill some of the service gaps identified. These were selected from the list of approaches provided in the Medicaid Transformation Toolkit and then narrowed down based on needs identified in the Current State Assessment. The Rapid Cycle Application, which was open to partners April 9 through May 10, provided up to $10,000 per application for short, shovel-ready projects that could be started and completed from July to December 2018. NCACH's Governing Board allocated up to $100,000 for this application cycle.

Diversion Interventions Assessment

L.E.A.D

Based on the assessment findings, NCACH decided not to proceed with L.E.A.D. NCACH is still actively involved with the law enforcement community and as the Transformation Project progresses, it will be determined if there are needs within law enforcement that can benefit from the support of the NCACH Transformation Project.

Emergency Department Diversion

The initial assessments and follow-up meetings with ED partners shaped the three main approaches that NCACH's region will implement to support the ER is for Emergencies Seven Best Practices. ED partners were also involved in developing recommended funding amounts that were then approved by TCDI partners. Those approaches and the funding strategies were incorporated into the application that will allow hospital partners to engage in the work.

Community Paramedicine

Based on meetings held with EMS partners, it was determined that NCACH would not select community paramedicine as an evidence-based approach. That said, NCACH determined that paramedics play an important role in supporting the goals of its Emergency Department Diversion and Transitional Care projects. EMS partners plan to adopt components of the community paramedicine model to help support those initiatives in the region.

As mentioned above, NCECC is currently working with 10 local EMS transport agencies to further assess how they might address identified components of community

paramedicine selected by the region, and to develop individual and regional plans for EMS partners to support the goals of NCACH's Medicaid Transformation projects.

Transitional Care

Based on initial feedback from potential partners, NCACH's TCDI Workgroup provided input as NCACH staff compared the transitional care models from the Medicaid Transformation Project Toolkit and a transitional care management model adapted and in use by the largest hospital in its region. After evaluating models and assessing partner's willingness to engage, the region selected the local transitional care management model. This is an adjustment to what NCACH originally proposed in its preliminary project plan.

Now that organizations in the region know they are progressing with a common model, the next step will be to survey organizations that apply to implement the model. This will help NCACH identify capacity development needs that NCACH can support over the course of implementation and determine what processes could be implemented in future years to further increase (scale) the scope of the project.

CHI Stakeholder Surveys

NCACH will be accepting survey responses until July 31. Currently, NCACH has received 145 surveys from its community stakeholders. NCACH will analyze this information for areas of overlap, common gaps and challenges, and priorities. The CHIs are critical partners for bridging the gap between community-based social service providers and healthcare providers. NCACH will look for alignment and synergy between community partners and the overall NCACH and Medicaid Transformation goals. NCACH will use information gleaned from this survey to support the strategic plans of the three CHIs.

Social Determinants of Health Facilitated Discussions

Based on findings from NCACH's facilitated discussions and subsequent feedback collected through its Annual Summit, NCACH staff and OHSU developed the following recommendations, which the Governing Board approved on June 4.

1. **Hire a full-time Capacity Development and Grant Specialist.** The person in this position will be responsible for engaging community organizations that are focused on transportation and housing, and for helping these organizations obtain and capitalize on external funding. The individual might also engage with organizations outside of transportation and housing as necessary.

   The responsibilities of the Capacity Development and Grant Specialist will include (a) proactively matching organizations to valuable grant opportunities, (b) supporting organizations in applying for grants, (c) helping organizations prepare for effective implementation, (d) serving as a conduit for cross-organizational coordination and partnership, (e) mentoring organizations to build their in-house fundraising capabilities, and (f) identify advocacy

opportunities for the ACH. The individual in this position will also be a resource for improving coordination and engagement across the region.

2. **Hire a contractor to evaluate current asset-mapping solutions** such as WIN211 and recommend next steps for achieving a highly useful and sustainable asset-mapping system. Next steps recommended by the contractor would be evaluated and could lead to additional strategic investments.

Chemical Dependency Professional Shortage Assessment

NCACH intends to use results and recommendations of this study to guide advocacy efforts on CDPs in its region and at the state level. Because this study is still underway and NCACH does not yet have results, it is premature to state how this study might influence ongoing project planning.

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

ACH Response:

Social Determinants of Health Screening: With limited resources and long distances to travel between services, many of NCACH's partnering providers have already been practicing some form of wraparound care and/or community-based referrals for their clients. As a result, many partners in the region understand and proactively address barriers to health. Across the region, a shared goal has been to address the social determinants of health as a means of reducing barriers to health. This is reflected in the selection of the Pathways HUB as a project and the implementation of several of NCACH's Medicaid Transformation projects. For example, NCACH is recommending that members of the WPCC Learning Community use social determinants of health screening tools and referral services to ensure that clients are receiving care that is responsive to the factors outside the clinic that affect their health most.

Affordable Housing Facility Development: Catholic Charities Housing Services is undergoing construction of a $15.45 million 67-unit affordable-housing facility. With an apartment market vacancy rate of 0.5% and 370 homeless people in 2017, this is highly needed in Chelan and Douglas Counties. Catholic Charities recently secured the funding needed, and NCACH Executive Director, Senator Parlette, was a partner in securing the needed funding. Catholic Charities has partnered closely with NCACH over the past 18 months, first by engaging in the fully integrated managed care (FIMC) planning process in 2017 and by being a WPCC Learning Community member. NCACH plans to continue to partner with Catholic Charities and leverage its knowledge and skills on integrating social services into clinical work.

Workforce Collaboration Summit: To increase regional capacity for supportive services, an initiative called the Workforce Collaboration Summit has been convened by a local organization, SkillSource. Hosted across Grant, Adams, Chelan, Douglas, and Okanogan Counties, SkillSource has been working to increase agency referrals by creating an NCW Partner Directory that allows agencies to efficiently and quickly access the information they need to facilitate warm handoffs for clients between agencies. Through a series of surveys, SkillSource has complied in-depth service profiles for over 40 organizations regionally and hosted a series of summits to connect all critical partners to increase awareness of available resources. SkillSource is also creating a digital inventory resource for service providers to access and identify client eligibility with a series of "yes" questions to ensure that referrals are appropriate. NCACH staff attended the Chelan-Douglas Workforce Collaboration Summit and has since connected SkillSource with each of the three CHIs. SkillSource will be delivering presentations on the NCW Partner Directory to all three CHIs in July and August 2018. NCACH will also coordinate with them as it investigates asset-mapping solutions and inventory community resources so that Pathways HUB care coordinators can easily access and connect clients to needed resources. Strengthening access to and communications across the network of services in its region is an important step toward improving health equity.

Drug Court: Okanogan County has had a successful drug court for many years. After many years of opposition, Chelan County recently started a drug court on June and has had its first case. Grant County is extremely interested in starting a drug court as well and will likely be starting one soon. This is exciting news given the responses of key informants participating in the Opioid Current State Assessment. When asked “What is the one thing that is needed most in response to the Opioid epidemic?” nearly every interviewee in Chelan and Grant counties immediately responded “drug court.” This is an important step for community members who are unable to attain their health potential because of struggles with substance abuse.

Syringe Exchange Programs: A syringe exchange program has been offered to residents of Okanogan County by the Okanogan County Health Department since 2007. Since the syringe exchange program was started, Okanogan County has seen a reduction in disease rates. Additionally, this program has recently started dispensing naloxone rescue kits in the city of Okanogan, the only location in Okanogan County where naloxone can be obtained free of charge for those in need. Given the huge geographic size of Okanogan County, not all residents who would benefit from a syringe exchange program are able to access this resource. The Heath Department is currently working to develop a Mobile syringe exchange program. Until May of 2018, this was the only syringe exchange program in NCACH’s four county region, the next closest one being in Ellensburg or Spokane. In May of this year, with modest support from the NCACH, the Grant County Health Department started a 1-to-1 mobile syringe exchange program. This harm reduction program is focused on reducing disease rates, providing wound care, and referral to treatment and testing—an important step toward achieving better health for individuals struggling with substance abuse issues.

Clubhouse in Okanogan County: Okanogan Behavioral Healthcare intends to expand its current day treatment program through expansion of the Clubhouse model. Their desire is to focus on recovery (and not only treatment), provide peer support, empower individuals, and offer resources toward gainful employment. To assist individuals in building job skills and experience, they plan to have computer stations for resume building and job searching, as well as a thrift store. The Clubhouse will be open at least 30 hours per week and will include peer specialists and case managers.

Crisis Stabilization and Crisis Residential Facilities: In the summer of 2018, Parkside, a 16-bed crisis stabilization facility and a 16-bed crisis residential facility will be opening in Wenatchee. In late 2018, an eight-bed crisis residential facility will be opening in Moses Lake. Medicaid beneficiaries are the primary target population. However, the facility will be a resource for uninsured individuals and individuals with Medicare and commercial insurance who are frequently using crisis services. The NCACH region currently has zero licensed mental health stabilization beds available for individuals experiencing a serious behavioral health crisis. This facility will offer local resources to divert individuals from higher levels of care, the emergency department, and criminal justice. Parkside will help prevent further escalation of crises and facilitate step-downs from institutional settings, such as Eastern State Hospital.

Law Enforcement Parkside Protocol Development: Behavioral health issues contribute to many law enforcement encounters, and some individuals are detained in jail because of the lack of better placement alternatives. With the opening of the American Behavioral Health Services facility at Parkside, which provides crisis stabilization and crisis residential behavioral health services, law enforcement members in the community have identified the opportunity to develop protocols for their officers to transfer individuals to the Parkside facility. Parkside staff and local law enforcement have met regularly to develop a protocol for officers to follow. This protocol will help them determine whether a patient is an appropriate client to transport to Parkside and who to contact to confirm that Parkside has the capacity for the patient. This protocol was originally developed with law enforcement in Chelan County, but will be available and rolled out to law enforcement agencies in all four counties.

True Blood and Crisis Diversion: In 2018, Catholic Charities was one of three organizations awarded a True Blood grant to provide criminal justice diversion services post-arrest or prior to release. The Catholic Charities Diversion Team provides active outreach services to Chelan-Douglas law enforcement agencies and area jails in contact with individuals in need of support or services. The goal is to prevent incarceration and unnecessary forensic evaluations by providing access to behavioral health care, including crisis follow-up and crisis response, post-booking diversion, and support for transition out of the jail. The funding allows for the addition of four mental health professionals/case manager positions and a project lead, as well as funding for housing and other support to encourage wellness, recovery, and community stabilization. Designated crisis responders evaluate the individual in jail and conduct an assessment of the risks associated with release. If the individual meets criteria and is willing to participate, a release plan is developed and offered to the court as an alternative to

incarceration and criminal competency evaluation. A court team consisting of jail and mental health staff, prosecutor, defense attorney, and a judge are involved in weighing risks and benefits of the plan. Diversion staff also provide support to individuals whose lack of access to human services places them at risk of reincarceration at the time of release from jail. This is a great asset for NCACH's community, especially since criminal justice involvement often correlates with poor health outcomes.

Grant Integrated Services Mobile Outreach: The Grant Integrated Services Mobile Outreach team makes contact with individuals in the community prior to incarceration and one assigned staff member from this team acts as a liaison with the local jail for incarcerated individuals. Activities include assisting individuals with signing up for eligible benefits, helping to make appointments, and providing transportation to appointments. These efforts help to address recidivism by addressing social determinants and behavioral health needs.

Regional Justice Liaison: NCACH has worked to be inclusive of the criminal justice system in its Medicaid Transformation work. Recently, Chelan County Regional Justice Center convened stakeholders to discuss a regional jail liaison program for coordination of mental health services across its three jails in the region. In a rural region like NCACH, the resources for jail services are extremely scarce and none of the jails in the region are able to dedicate substantial resources to mental health services. A centralized liaison function allows for cost savings along with streamlined coordination and efforts for individuals who have multiple incarcerations in jails in the region. This program was so well supported by partners that the behavioral health administrative services organization (ASO), Beacon Health Options, incorporated funding for the regional jail liaison Program in its *Plans for Regional Behavioral Health Initiatives and ESSB 6032 Section 213 (5)(pp) Funds for Enhancements to Community Behavioral Health Programs*.

Jail Reentry Program: NCACH staff are participating in the development of a regional jail reentry collaboration between Worksource, primary healthcare, behavioral healthcare, criminal justice, and education systems. This group is just forming; the first meeting was on June 20. There is strong enthusiasm for developing a Jail Reentry Navigator Program, working to reduce stigma, and strengthening relationships between these various systems that need to work together to help eligible community members achieve positive outcomes in their lives.

Coalitions, Collaboratives, and Common Goals: The NCACH region is rich with coalitions, partnerships, collaboratives, and a common goal to improve the health (physical, economic, spiritual, etc.) of the community. Below is a sampling of the many groups that have formed to work together to improve health and well-being of the residents of the region:

- Mobility Council
- Behavioral Health Law Enforcement Group

- Coalition for Children and Family
- Our Valley, Our Future
- Homeless Taskforce
- Behavioral Health Provider Alliance
- NCW Opioid Stakeholders Workgroup
- Mental Health Stakeholders
- North Central Emergency Care Council
- NCW Regional Hospital Council
- Interagency Networking Group
- Grant County Resource Group

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

ACH Response:

NCACH has been working to embed health equity into its Medicaid Transformation project portfolios. At the core of the NCACH guiding vision for whole-person care is the understanding that NCACH work will address health equity as it addresses social determinants of health. Our 17 partners in the WPCC Learning Community are being encouraged to use social determinants of health screening tools and to strengthen their relationships with community-based organizations and other social service providers (e.g. transportation, employment, and housing) as a tangible way to facilitate health equity. Over the next year, providers will be working on adopting new screening tools or adapting existing ones within their clinical settings. NCACH expects to learn from the data gathered through social determinants of health screenings to identify and address specific health equity barriers. Some WPCC partnering providers identified the lack of internal resources to address social determinants of health as a barrier to health equity, and many are eager to make referrals to the Pathways Community HUB to meet this need for their patients.

NCACH staff are working closely with the Pathways Community HUB Lead Agency and providers to investigate implementing a closed loop referral system to allow healthcare providers to seamlessly and efficiently refer clients to needed social services. The Pathways Community HUB will result in more community health workers across the region, which has been shown to be an effective measure to addressing health disparities in targeted populations. As the model stipulates, the intention is for community health workers to be of the community they serve. Additionally, since the model is based on home visiting, clients with few transportation options will receive services and if necessary, assistance obtaining transportation to other needed services.

In response to community feedback, NCACH is currently researching the feasibility of a regional 24-hour Nurse Hotline model, which would lower barriers for callers to receive expert medical advice without travelling or accessing the emergency department because of a lack of other options. Considerations include determining which populations are likely to use a hotline service, and the need for bilingual and bicultural nurses answering the hotline.

Based on community feedback, transportation and housing were identified as significant barriers to health in the region. Like most of Washington, the North Central region is experiencing a rise in the cost of housing and a lack of affordable housing units. Most of the region's supported housing programs are full and have waitlists. Additionally, most of the region's specialized services are located in Wenatchee or Moses Lake, requiring some community members in the vast region to travel several hours each way to receive services. Travel distances are compounded by limited public transit. As described in the previous sections, NCACH is hiring a full-time Capacity Development and Grant Specialist to support housing and transportation agencies, and working to improve current regional partner and service provider directories to increase connectivity to resources and services.

NCACH also uses a variety of communications channels and groups to address gaps in knowledge about health equity. NCACH's June 2018 monthly newsletter's main feature detailed a plan to operationalize health equity in NCACH work and establish a shared definition of health equity with partnering providers. Another health equity strategy NCACH is increasing awareness by sharing health disparity data on the NCACH website and with partnering providers.

The CHIs also provide an important opportunity to exchange information and learn about opportunities to advance equity in Transformation objectives. NCACH's three CHIs are currently collecting community feedback as a means of creating a regional strategic plan, which includes identifying assets, barriers, and opportunities for addressing health equity at the county level. Using an online survey, the CHIs are asking community members to identify where people can go to learn about services and resources in their local community (e.g., a physical location or specific organization) and to identify which systemic barriers keep people from achieving their best health locally. The CHIs are also asking questions about health equity to determine opportunities to align with current and local healthy community initiatives. NCACH's goal in this work is to help strengthen the connections of the region with the understanding that these connections will result in more community members receiving high-quality, wraparound whole-person care. This information is being collected until July 31, 2018, and will be used to inform NCACH's next steps.

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

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

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

Yes	No
X	

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

   ACH Response:

   Not applicable

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

   ACH Response:

   This past reporting period, NCACH focused on fine-tuning project plans (evidence-based approaches and target populations) and outlining partners' plans to implement the projects. Leveraging relationships with NCACH's project workgroups and funded partners, NCACH engaged in several activities during the reporting period in order to identify opportunities and gaps that will inform strategies related to Domain 1 needs. NCACH adjusted its approach (as described in Section 4 below) and opted to identify relevant project partners first, and then do targeted assessments that directly tie to its project portfolio. NCACH drew on surveys, structured conversations with individual implementation partners, and workgroup discussions to identify a variety of needs and gaps that are informing its Domain 1 strategies.

   Systems for Population Health Management: Various systems need to dovetail to optimize integration and care coordination that is fundamental to whole-person care. These systems include Electronic Health Records (EHRs) in use by healthcare providers, the EDie/PreManage platform, the Prescription Monitoring Program (PMP) query site, OneHealthPort, the Care Coordination System (CCS) platform supporting the Pathways Community HUB, and asset mapping tools such as the Washington Information Network 211. Based on survey responses from

15 of NCACH's 17 outpatient primary care and behavioral health providers, NCACH knows that EHR systems vary quite a bit across its network of healthcare providers. There are 11 current systems in use in NCACHs region including Epic and Centricity, and four organizations plan to switch EHRs in the next six to 12 months. The most common quality improvement capabilities of these systems are pre-visit planning, empanelment, clinical decision support, and shared care plans. Some less common capabilities are use of registries, evaluation of program impact through core measures and drivers, risk grouping/stratification, and social needs screening. Most respondents (60%) ranked their EHR's capabilities to capture and report clinical quality information as poor or fair and many identified limited reporting capabilities or lack of robust reporting as a barrier. Time and cost are the greatest barriers to adopting a more robust HIT system.

In addition to not being able to extract robust information for their internal use, many providers struggle with information exchange within and across organizations. Some providers are using different systems in their outpatient clinics and rural hospitals, and even internal information exchange can be a challenge. A common barrier that was echoed during NCACH's site visits with providers is the exchange of behavioral health information (especially restrictions associated with sharing of substance use information), which prevents fundamental principles of the Medicaid Transformation: bi-directional integration and whole-person care. Lack of patient care coordination because of confidentiality restrictions from 42 CFR Part 2 is an issue NCACH is tracking, although NCACH has yet to formulate a policy advocacy strategy. This is likely something NCACH would want to coordinate with other ACHs on, as the issue is not unique to this region and will require statewide coordination efforts.

Given the barriers identified through the survey, workgroup discussions, and provider site visits—and knowing that HIT/HIE is a complex issue that NCACH's limited resources will not fully address—NCACH is opting to focus on discrete achievable wins. Some strategies for systems for population health management are the following:

- Promoting the use of EDie/PreManage: having access to timely information about hospital and emergency department discharges is important for outpatient providers that manage follow-up care, and for agencies providing care coordination. NCACH staff are promoting this health information exchange tool throughout the project portfolio. For example, NCACH has shared information about PreManage through its WPCC learning activities, as outpatient providers work on their change plans and think about process improvements specific to transitional, follow-up care. NCACH plans on following-up with providers who indicated that they were not currently tracking ED utilization or hospital admissions for their clients, or who were not currently receiving notifications. NCACH's Transitional Care and Diversion Interventions Workgroup is also promoting more robust use of EDie by hospitals and emergency departments, and the Pathways Community HUB Advisory Board will continue to push for integration of EDie/PreManage into care coordination IT solutions (whether it is fully integrated into the Pathways HUB platform, or not). NCACH is in the midst of discussions with Collective Medical Technologies to devise a coordinated training and onboarding strategy for healthcare providers across various settings (outpatient, inpatient, emergency department). There is some confusion about the difference between PreManage and EDie, which NCACH is working to clarify for its project

partners.

- Increasing consistency and promoting communication across EHRs: Although having one unified EHR for NCACH's entire region does not look to be feasible, there is value in reducing the variability of EHRs in use and helping those who are considering new EHRs to move toward more commonality. Having cohorts of providers on the same system can increase peer learning and sharing related to population health management solutions. If one agency is effectively using a module, NCACH can help spread that information or connect agencies to learn from one another. There is also value in ensuring that EHRs can "talk" to one another. As a concrete example, one of the providers noted that their EHR cannot send Continuity of Care Documents (CCDs) in PDF format, so other EHRs cannot decipher their CCDs. In addition, some practices/providers are not utilizing HIT/HIE capabilities or functionalities. Now that NCACH has a better understanding of the HIT/HIE landscape in the region, and the technical issues that providers are encountering, it is better positioned to engage partnering provider's HIT/HIE staff through a workgroup to prioritize and address some of these issues.

- Promoting use of telehealth: NCACH is exploring HIT that increases access to care in this rural region. Many providers indicated some level of interest in NCACH providing technical assistance on telehealth options, including how they might be incorporated into workflows. NCACH has heard from some providers that rural health clinics can only bill for "face to face visits," which means telehealth would not qualify, making it difficult to create a sustainable model for those providers. However, NCACH has also heard that MCOs have their own telehealth services and have reimbursement mechanisms in place for certain instances of telehealth services delivered by providers. Through NCACH's WPCC, it will initiate peer sharing from those organizations already using telehealth. Some providers have their own internal telepsychiatry services; others use outside contractors. For example, one outpatient/hospital provider started using a telepsychiatry service, which is planning an expansion to "direct to consumer" service for home tele visits. NCACH had a meeting in March with representatives from Forefront Telehealth (used by several providers) to learn more about their service. The UW Medicine Psychiatry Consultation and Telepsychiatry (PCAT) program offers telehealth services to meet behavioral health needs statewide. This is an area NCACH needs to explore further before it can roll out a work plan.

- Promoting use of the PMP: The PMP is an important tool to achieve the goals of NCACH's opioid project. Most EHRs in use by NCACH's healthcare providers do not connect/integrate with the PMP (only two do). Many providers indicated that their clinicians are registered with the PMP, but it is not clear how many of them are using it effectively within their workflows. The greatest deterrents to using the PMP include difficulty accessing the system and the lack of EHR interoperability. A majority of providers indicated interest in NCACH providing assistance on better use of the PMP system, and NCACH will need to understand this interface better in order to advocate for the system to be more user-friendly.

NCACH staff continue to hear that the health information exchange promise of OneHealthPort is not yet realized for providers. NCACH knows this is a strategy that the state would like ACHs to promote, but it needs a clearer understanding and direction from the Washington State Health Care Authority (HCA). NCACH staff continue to attend the monthly HIT Operational Plan updates, as well as monthly HIT/HIE technical assistance webinars offered by the HCA.

Workforce: NCACH surveyed its 17 outpatient providers (15 of whom responded as of June 30th) who collectively serve over 95% of the NCACH Medicaid population. Many of them are associated with rural health clinics and/or critical access hospitals. Workforce challenges they highlighted include recruitment, compensation, and retention. NCACH's region has a shortage of doctors, nurses, and behavioral health providers, especially bilingual staff. NCACH asked providers to identify the top roles/positions that they would hope NCACH could help increase capacity for: (1) licensed mental health professionals, (2) MDs/DOs, (3) degreed nurses, and (4) substance abuse treatment professionals. Potential strategies suggested by partners include the following:

- Working to remove barriers to certifications and licensure, including gaining dual licensure for substance use disorder and mental health
- Advocating to simplify licensure and billing dependencies that create too many specialized silos
- Exploring ways to utilize non-credentialed staff to do some of the work of CDP/CDPTs to free up counselor time and minimize shortage of credentialed staff
- Advocating for programs that attract providers to rural areas, including helping to facilitate training programs for rural community members to be trained
- Focus on training up/growing rural capacity rather than on recruiting professionals from outside of NCACH communities
- Strengthening partnership with universities and other training programs
- Clarifying roles and scope of work for community health workers

NCACH needs to leverage and coordinate with workforce resources in the region as it considers these strategies. Community resources include a regional jail re-entry initiative that is currently under development, In-Reach apprenticeship programs, workforce collaboration summits organized by Skillsource in the region, community health worker trainings, residency programs through Confluence Health and Lake Chelan Community Hospital (two partnering providers), the state's Rural Nursing Distance Learning and Diversity Initiative, and the Okanogan County Healthcare Workforce Collaborative that is just kicking off.

Although care coordination exists in many systems (and in many shapes and forms), it is clear that a workforce strategy aligned with the Pathways Community HUB model will involve engaging and/or training new community health workers for the Care Coordination Agencies (CCAs) involved. The Foundation for Healthy Generations is planning to organize a trainings for HUB

staff and supervisors in SeaTac, and a 2-week training for Pathways Community HUB Care Coordinators that NCACH suggested hosting in Wenatchee. NCACH staff and Pathways Community HUB lead agency staff are actively recruiting staff from CCAs to attend these trainings. NCACH is also considering ways to develop capacity for master trainers within our region.

Through the assessment and interview process of providers interested in implementing a transitional care management program, NCACH found that each of the hospital partners follow a different protocol to deliver transitional management services to their patients and that the training for nurses who deliver those services ranges from none to multiple weeks. As the region rolls out a standard transitional care management program, a major component of that program is providing a standard training program for the nurses at each hospital. NCACH has identified a hospital that will act as the regional transitional care management nurse trainer for all hospitals that implement the model. This training will be onsite at the hospital call center so that nurses can see firsthand how the work is completed. In additional to the local trainers, NCACH has identified a national training program for nurse case management through American Case Management Association that the region is planning to provide support for hospital nurses to complete.

NCACH also has partnered with University of Washington Masters in Healthcare Administration program to provide an internship to investigate NCACH's regional shortage of Chemical Dependency Professionals (CDPs). Our intern is working to survey and summarize barriers that providers experience when recruiting and retaining CDPs. The intern is also researching CDP certification requirements and comparing them to other comparable professional health care certifications. NCACH looks forward to the intern's summary of findings and recommendations, including policy changes that could increase CDP recruitment and retention in the North Central region.

Value-Based Payment: One of NCACH's key strategies as it engages outpatient providers in its WPCC has been to emphasize quality improvement and collaboration. Improving collaboration will improve outcomes for patients, and improving quality metrics positions the providers to do well when VBP starts. It has been difficult to understand what role ACHs should play as they work with the state, MCOs, and providers to move towards value-based care. Many of NCACH's providers, especially EMS providers and critical access hospitals, don't understand whether and how VBP will apply to them. The real questions for healthcare partners are: what does VBP mean for them on the ground? How does it change the way they should do their work? NCACH continues to track Washington's Rural Multi-Payer Payment Model and still plans to host a VBP learning activity for providers.

Drawing from HCA's 2017 VBP survey results (15 responses or 19% of total responses were from providers in NCACH region), NCACH asked outpatient providers to rank the areas where they felt it could/should play a role. In terms of "VBP enablers," providers ranked the following as priorities for NCACH to assist: (1) helping to align incentives and/or contract requirements and (2) helping to align quality measurements and definitions. In terms of "VBP barriers," providers ranked the following as priorities for NCACH to assist: (1) lack of interoperable data systems and (2) lack of access to comprehensive data on patient populations. Clearly, VBP and HIT/HIE strategies are mutually reinforcing.

Healthcare partners would like NCACH to help problem-solve the following issues:

- How does VBP apply to a rural health clinic and how will it work? What adjustments would be provided for rural providers in terms of financial support? How can VBP provide sustainability to rural services (for example, for clinics that have small volume of Medicaid patients)?
- Clearly defining the value proposition and ensuring that the outcomes NCACH invests in are priorities for the MCOs and the community.
- For cost-effective whole-person care visits to happen, the face-to-face visit with a provider for rural health clinics need to be adjusted or the costs that are part of non-face-to-face visits need to be made allowable on cost reports.
- How to make risk-based contracting work for smaller organizations—is it even feasible?
- Better understanding of MCOs' plans (next steps, timeframes, strategies/components) for VBP and how it will affect behavioral health providers, who need to know how to plan.

A general strategy for NCACH is to continue facilitating regional conversations with providers and partners to identify shared barriers that might suggest shared opportunities. NCACH will continue conversations with MCOs and HCA and advocate on behalf of its providers where it can. On April 25 2018, NCACH organized a meeting with the three MCOs in the region to discuss respective roles and how each can support the others in regional VBP development. These kinds of discussions are important because NCACH wants to ensure that the projects and healthcare improvement work in the region have a path toward sustainability.

One takeaway from this meeting was that NCACH needs to do its part to help providers invest in systems for tracking quality measures (e.g., by investing in technical assistance and supporting providers on measurement and billing/coding capacity and systems for tracking quality measures). If provider organizations can "prove" their value, they will be more competitive and attractive. Another takeaway for NCACH is that it needs to invest in a regional data and program evaluation strategy that can capture the impact of its projects, especially where there is less evidence (e.g., engaging social service providers or the Pathways HUB and community paramedicine models, which would depend on currently inexistent funding streams to be sustained). MCOs and other stakeholders (counties, hospitals) are unlikely to financially support certain work if they are not convinced of the added value. Being able to show that investments are helping drive cost-savings will be critical. In early July, the NCACH Governing Board approved moving forward with designing and implementing a program evaluation plan for the project portfolio with assistance from the Center for Community Health and Evaluation.

Another key role for NCACH in the Medicaid Transformation, which was outlined in a VBP presentation from HCA, is that it is providing upfront funds to offset costs of transitioning to VBP. These transition costs may include catalyzing pilot programs and new lines of business; bridging

the gap for lost revenue during transition periods; supporting IT infrastructure; and promoting staff training.

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

   ACH Response:

   NCACH staff originally intended to convene both a VBP Workgroup and an HIT/HIE Workgroup in quarter 1 of 2018. NCACH opted to postpone engaging these workgroups until there was a better understanding of the state's plans, strategies, and expectations of ACHs. NCACH also realized that it made more sense to ask busy professionals to volunteer their time when more concrete information about opportunities and gaps and a better sense of key questions requiring their input was available. The current state assessments helped illuminate specific issues that input can now be requested from partners about. As NCACH works on regional Domain 1 strategies, these workgroups may be formed, or ad-hoc and discrete outreach to key representatives may prove add more value.

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

   ACH Response:

   HCA staff gave a very helpful and concrete presentation at an ACH/HCA convening at the end of January 2018, with Emily Transue providing examples of how MCOs and ACHs might play complementary roles on VBP. These types of resources, with concrete examples and actionable guidance, are always appreciated, especially with respect to Domain 1 areas. If NCACH is expected to focus on collective approaches to develop and reinforce statewide strategies and capacity, it needs a better understanding of those statewide strategies. Without a clear roadmap from the state, ACHs are left to devise their own solutions.

   Additional technical assistance, actionable resources, and support from the state would be helpful in the following areas:

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole person care and value-based payment. CPAA	streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.

Stronger collaboration between HCA and MCOs	ACH's would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPi Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the Value-based Payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.
In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes	Support from the state on VBP, specifically understanding how we can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other technical assistance from the state.	ACHs wants to ensure that information held in these data repositories (*All-Payers Claims Database and Clinical Data Repository*) is accurate, accessible, timely, and useful to our transformation work and to our partners.
Systems for Population Health Management support for: •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries	Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists)	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid
Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing, and licensed social workers	Training and TA for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, Trauma Informed Practices, Cultural Sensitivity	Establishing a career path for rural nursing and workforce needs, from high school, through 4-year programs
Support for Dental Health Aide Therapists and other dental professions that expand scope of practice will improve dental access	Increased capacity for practice transformation support directly to participating providers-i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions	Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.
	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models and how it will impact them, and what steps they should take to be prepared.	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care

	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.

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

For this milestone, the ACH should either:

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

  Or,

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

1. Medicaid Transformation Approaches and Strategies

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

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

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

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

c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area,

and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

2. Target Populations

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

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

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

3. Expansion or Scaling of Transformation Strategies and Approaches

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

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
Project 2A: Bi-directional Integration of Physical and Behavioral Health	
1. Transformation Strategies and Approaches	NCACH is following the Bree Collaborative evidence-based approach while incorporating principles of the Collaborative Care Model that are more applicable to behavioral health providers. The eight common elements from the Bree Collaborative recommendations have been mapped to the change plan template. The template is structured based on the Institute for Healthcare Improvement (IHI) model for improvement. It includes aims, measures, and change concepts (drivers and tactics) that provide a roadmap for integration activities and associated process improvements. Many of these change concepts are also aligned with principles assessed through the MeHAF. All 17 outpatient providers (primary care and behavioral health) in the WPCC are required to submit a change plan in order to be eligible for funding. Because its providers are at various levels of integration, NCACH is leaving it up to them to select and prioritize change ideas that they want to implement over the next three-plus years. Providers will receive coaching and be able to opt-in to learning activities designed to provide training and technical support specific to the selected evidence-based approaches.
2. Target Populations	Medicaid beneficiaries (children and adults) with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder. Note that NCACH is encouraging providers to approach the change plan and evidence-based approach as broader process improvements that have the potential to improve care for their entire patient population, regardless of payer.
3. Expansion or Scaling of Transformation Strategies and Approaches	NCACH has structured the change plan template to allow providers to sequence their approaches by indicating start dates and target dates for each change idea they select. Because many organizations have limited bandwidth, achieving sustainable change will require them to take an incremental approach to change. NCACH doesn't expect the scope of the target population to change, but it does expect that providers will build on change ideas and activities over time. In other words, the scope of their practice transformation efforts will evolve as they go through Plan, Do, Study, Act (PDSA) cycles. The natural progression for practice transformation is to plan a change idea or process improvement, test and measure it at a small scale, and then spread what works. Scaling of strategies and approaches will vary by provider, but NCACH expects more and more of the evidence-based principles on bi-directional integration to be implemented over time. The idea is

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	that the peer-sharing and collective-learning structure NCACH has set up through the Collaborative will help achieve this more quickly.
Project 2B: Care Coordination	
1. Transformation Strategies and Approaches	NCACH has selected the Pathways Community HUB Model (HUB), the only evidence-based approach recommended. HUB model is an evidence-based approach to identify and address risk factors of an individual through community-based care coordination. As individuals are identified, they are assigned a care coordinator and receive a comprehensive risk assessment. Each risk factor identified in the assessment is translated into a Pathway. Over time, each risk factor, or Pathway, is systematically addressed until all risk factors have been addressed. The HUB removes duplication of services through a singular IT platform and tracks health outcomes of clients. The anticipated launch date of the HUB is October 2018. The Governing Board has selected Community Choice to serve as the lead agency for the HUB. Community Choice will be responsible for all planning and implementation of the HUB with financial support provided by NCACH. Three organizations have been selected in Moses Lake to serve as CCAs for the initial launch. Note that the change plan template being used by all 17 outpatient providers (primary care and behavioral health) in the WPCC encourages them to adopt change ideas that can also contribute to the goals and objectives of this project.
2. Target Populations	Individuals who are enrolled in Medicaid (or Medicaid eligible) who have had three or more ED visits in the past 12 months and reside in zip code 98837. Notes on Target Population Selection: • ED visits anywhere qualify; not restricted to ED visits in Moses Lake. • The past 12 months is a rolling calendar year. At any given point in time, it is the last 12 months from the current day.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	• 98837 is a zip code in the center of Moses Lake.
3. Expansion or Scaling of Transformation Strategies and Approaches	It is expected that the HUB will launch in October 2018 in Moses Lake. The target population is intentionally very limited by geography (to one zip code) to prevent having a higher number of referrals than capacity to provide care coordination services in the early days of implementation. The intention is to expand the geographical criteria as rapidly as is feasible. It is anticipated that it will expand to begin serving clients in Chelan/Douglas counties in April 2019 and to Okanogan County in October 2019. Expanding into Okanogan County last was determined by Okanogan County transitioning to FIMC on January 1, 2019, whereas Chelan, Douglas, and Grant counties already transitioned to FIMC on January 1, 2018. The current plan is to continue using the eligibility criteria of three or more ED visits within the past 12 months, but the HUB Advisory Board, HUB staff, and NCACH will closely monitor implementation to ensure that this is an appropriate target population. If necessary, NCACH will adjust the target population prior to expanding into Chelan, Douglas, and Okanogan Counties. NCACH does anticipate that the eligibility criteria to define the target population will expand. At this time, NCACH is uncertain whether the target population will expand concurrently with geographical expansion or after HUB services have expanded geographically and HUB operations are established in each of the counties in the region.
Project 2C: Transitional Care	
1. Transformation Strategies and Approaches	NCACH has selected the Transitional Care Management (TCM) model (adapted from Confluence Health). In this model, prior to patient discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. The bedside RN and inpatient case manager discuss instructions with the patient. The patient is sent home with written material that has all of this included on it, in addition to a patient-specific summary of the visit. That document is called an AVS (after visit summary). The AVS is also used by the transitional care management nurses (TCM-RN) who make the post-discharge hospital follow-up phone call.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	The TCM-RN makes a 24-48 hour (two business days) post-discharge phone call that affirms that the patient has a follow-up appointment with their primary care provider, a medication review, and all of their post-hospital services arranged (durable medical equipment, oxygen, home health and hospice, adult family homes, and assisted living facilities), and/or caregiver help. Any problems identified will be worked on and then directed to the appropriate provider. Patients are instructed to call their provider with certain red flags or 911 for immediate medical attention for some symptoms. The TCM-RN identifies patients from a daily discharge report, with exceptions for patients discharged to hospice, assisted/skilled nursing facility, patients receiving hemodialysis, or those that are in another case-managed programs. Patients who have a follow-up appointment the day after discharge are not called. A prompt follow-up visit with a primary care provider provides follow-up care, ongoing symptom and medication management, and continuous access for the 30-day post-discharge period. Note that the change plan template being used by all 17 outpatient providers (primary care and behavioral health) in the WPCC encourages them to adopt change ideas that can also contribute to the goals and objectives of this project.
2. Target Populations	Medicaid beneficiaries discharged from acute care to home or to supportive housing. The TCM model does prioritize patients to be called by the nurse, but the goal of the program is to ensure that all patients discharged from the hospital receive a follow-up phone call regardless of payer.
3. Expansion or Scaling of Transformation Strategies and Approaches	NCACH currently plans to start with hospital organizations that have > 200 Medicaid discharges from their hospital and hospitals that currently maintain some level of transitional care services at their facility. This initial phase will be utilized to test the model with a smaller group and allow for regional trainers to space out the number of facilities trained at one time. The goal is to have all organizations (up to 10 hospitals) trained by the end of 2019. The initial years (2018–2019) of the Transformation Project will include standardizing transitional care across the region and shared learning between the providers. As each hospital entity establishes a standard program, NCACH will continue to evaluate how connections with community-based organizations and outpatient providers are being completed when hospitals are

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	transitioning patients out of inpatient settings. NCACH will determine the best way to ensure that those connections are made and work with outside providers to help enhance their processes to work with patients transitioning onto their caseloads. During 2019, hospital and community providers will evaluate whether additional process improvement work needs to occur in the hospital to expand and improve this approach or whether it would be more appropriate to scale the approach to focus on process improvement efforts within the community partner organizations.
Project 2D: Diversion Interventions	
1. Transformation Strategies and Approaches	NCACH selected ED diversion strategies that complement and enhance the ER is for Emergencies Seven Best Practice model. This will be achieved through work done by ED and EMS providers who will participate by achieving the following approaches/strategies outlined below: <u>ED strategies to reduce inappropriate ED utilization:</u> Through input from ED representatives across the region, NCACH has identified three priority approaches. These approaches, listed below, were selected for their alignment with the ER is for Emergencies Seven Best Practices. 1. Reduce inappropriate ED visits by collaborative use of visits to primary care physicians and improving access to care; 2. Patient education of how to access appropriate care; and, 3. Work with EDs to integrate the use of EDie into their department workflows Each hospital will complete an application process that outlines how it will achieve the above goals, which will require hospitals to share best practices across the region. However, each hospital will also choose appropriate strategies for their specific organization/community to achieve the above approaches. <u>EMS strategies to reduce ED utilization:</u>

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	Although NCACH did not select community paramedicine as an official evidence-based approach, EMS partners have selected to adopt components of the community paramedicine model to support ED diversion by reducing the number of inappropriate ED visits that arrive via ambulance. Those components include: 1. Develop protocols for non-acute patients who interact with EMS 2. Develop procedures for in-home assessment 3. Review and make recommendations on how EMS can participate in care coordination and follow-up services 4. Standardize the EMS data collection system to better collect and evaluate EMS data to use in future process improvement efforts Note that the change plan template being used by all 17 outpatient providers (primary care and behavioral health) in the WPCC encourages them to adopt change ideas that can also contribute to the goals and objectives of this project.
2. Target Populations	*ED Strategies Target Population:* The initial target population in year one will focus on individuals with five or more ED visits the past 12 months using a rolling calendar year. Beyond year one, NCACH expects to expand the target population to Medicaid beneficiaries presenting at the ED for non-acute condition with three or more visits in the past 12 months. *EMS Strategies Target Population:* Medicaid beneficiaries who access the EMS system for non-emergent conditions.
3. Expansion or Scaling of Transformation Strategies and Approaches	NCACH will work with ED partners to develop regional protocols, train EMS partners and staff on protocols and workflows, and ensure that there is a process to measure and evaluate the success of ED and EMS strategies. Specific to ED diversion, as each hospital entity establishes a standard program, NCACH will continue to evaluate clinical-community linkages. NCACH will determine the best way to ensure that connections between

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	EDs and community-based organizations are made and work to enhance the processes of community-based organizations that have patients transitioning onto their caseloads. During 2019, NCACH and partners will evaluate whether additional process improvement work needs to occur in the ED setting to expand and improve the approach or whether it is more appropriate to scale the approach by focusing on process improvement efforts within the community-based organizations. The EMS provider plan will last 24 months (through 2020) and include up to 10 EMS transport agencies. EMS agencies will phase-in multiple process improvement strategies during that time period. As strategies are implemented, NCACH will evaluate data to determine what changes need to be made to the original EMS process. As better protocols with agencies outside of acute care providers are established, EMS partners will also evaluate how those connections to community-based organizations can further be developed to ensure that clinical providers who receive patients from EMS agencies have the infrastructure in place to address patients' needs. Each year, EMS agencies will evaluate process improvement efforts and decide where to expand and scale efforts. Although the target population will not change, EMS providers plan to phase-in additional strategies into the workflow during the Transformation Project, expanding the number of ways they support improved patient care for the population they encounter.
Project 3A: Addressing the Opioid Use Public Health Crisis	
1. Transformation Strategies and Approaches	Unlike other projects, a number of potential strategies were listed in the Medicaid Transformation Toolkit for the opioid project. The NCACH Regional Opioid Stakeholders Workgroup evaluated all strategies listed in the Toolkit, along with additional strategies described in the Washington State Interagency Opioid Working Plan. Potential strategies were divided into two categories: (1) approaches that involved purely outpatient primary care and behavioral health and (2) all other approaches. Approaches that were considered to be purely within the domain of outpatient primary care and behavioral health were vetted by subject matter experts, and the approaches that were considered high impact were incorporated into the WPCC change plan template being used by all 17 outpatient providers (primary care and behavioral health). The WPCC encourages providers to adopt change ideas that contribute to reducing opioid-related morbidity and mortality. The approaches that were not outside the purview or in collaboration with outpatient primary care and behavioral health were vetted by the NCACH Regional Opioid Stakeholders Workgroup based on need and

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	potential impact. Approaches considered high in need and impact were incorporated into a Rapid Cycle Opioid Application. Additional approaches were eligible for funding but required rationale for the approach. Through this approach, NCACH funded 11 partners for a total of $97,390. Examples of funded projects are below: • North Central Washington Opioid Communication Plan • Installation of a drug disposal kiosk • Implementation of Narcan take home and opioid overdose education in the ED for a patient after an opioid overdose • Launch of a syringe exchange program • Training for newly established drug court team members • Creating Resilience Against Opioids initiative
2. Target Populations	In general, the target population for this project is individuals on Medicaid who use or abuse opioids (with approaches focused on prevention, treatment, overdose prevention, recovery) and those at risk for using or abusing opioids (prevention). Each funded partner will typically have a more specific target population. For instance, the implementation of a Narcan take home program will specifically target people who have presented to the ED with an opioid overdose, but they fall into the more general target population.
3. Expansion or Scaling of Transformation Strategies and Approaches	NCACH will continue releasing a Rapid Cycle Application every six months with $50,000 of funding available for each cycle. In addition, NCACH uses the Rapid Cycle projects as pilot projects. Those that are successful and show promise will be implemented on a larger scale, potentially across the entire region if appropriate. A large component of the opioid project is the work the clinical providers are doing to address the opioid epidemic. This work will be guided through the change plan process. The change plan template includes aims, measures, and change concepts that provide a roadmap for improved opioid prescribing practices and increased access to opioid use disorder treatment. The change plan includes 60 opioid-related tactics.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	Providers will pick a subset of these tactics to address during the first year of the change plan implementation and it is expected that each year providers will build on their prior opioid work and include additional tactics.
Project 3B: Reproductive and Maternal/Child Health	
Not Applicable	
Project 3C: Access to Oral Health Services	
Not Applicable	
Project 3D: Chronic Disease Prevention and Control	
1. **Transformation Strategies and Approaches**	NCACH selected the Chronic Care Model, the only evidence-based approach recommended. The elements from the Chronic Care Model have been mapped to the change plan template, including specific evidence-based change concepts for each element. The template is structured based on the IHI model for improvement. It includes aims, measures, and change concepts (drivers and tactics) that provide a roadmap for chronic disease prevention and control activities and associated process improvements. Many of these change concepts are aligned with PCMH principles. All 17 outpatient providers (primary care and behavioral health) in the WPCC are required to submit a change plan in order to be eligible for funding. Because providers focus on different chronic conditions (and because screening for primary healthcare needs will be new to some behavioral health providers), NCACH is leaving it up to providers to select and prioritize change ideas that they want to implement in the next three-plus years. NCACH is also leaving it up to providers to focus on one or more of the four chronic conditions it is prioritizing as a region (listed below in Target Populations), based on their patient needs and agency goals. Providers will receive coaching and be able to opt-in to learning activities designed to provide training and technical support specific to the Chronic Care Model.
2. **Target Populations**	Medicaid beneficiaries (adults and children) with a focus on populations experiencing the greatest burden of chronic disease(s), especially diabetes, respiratory issues, cardiovascular issues/heart disease, and depression.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations	
	These chronic conditions were selected based on analysis of data that showed a higher prevalence in the region, and/or contributors to hospital and ED utilization.
3. **Expansion or Scaling of Transformation Strategies and Approaches**	NCACH has structured the change plan template to allow providers to sequence their approaches by indicating start dates and target dates for each change idea they select. Many organizations have limited bandwidth; achieving sustainable change will require them to take an incremental approach to change. NCACH doesn't expect the scope of the target population to change, but it does expect that providers will build on change ideas and activities over time. In other words, the scope of their practice transformation efforts will evolve as they go through PDSA cycles. The natural progression for practice transformation is to plan a change idea or process improvement, test and measure it at a small scale, and then spread what works. Scaling of strategies and approaches will vary by provider, but NCACH expects more and more of the principles from the Chronic Care Model to be implemented over time. NCACH also expects more and more of the four chronic conditions to be addressed collectively, over time. The idea is that the peer-sharing and collective-earning structure established through the WPCC will help providers achieve this more quickly.

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

ACH Response:

NCACH's set of regional transformation objectives cross all of NCACH's work and have guided the selection of our region's Medicaid Transformation Toolkit Projects and the evidence-based approaches chosen within those projects. Regional objectives have been defined in the past as NCACH's theory of action and alignment. The below table outlines NCACH's regional transformation objectives and project outcomes that contribute to our region achieving those objectives.

Regional Transformation Objectives	**NCACH Project Outcomes**
Stronger connections and relationships between organizations (clinical and non-clinical) that will promote coordinated whole person care and care	Improve connections and relationships both between organizations and in terms of health information exchange
	Peer sharing, training, and coaching resources will support process improvements that lead to increased quality of care
	Outpatient providers will have moved up from their baseline level of collaboration/integration (using the Standard Framework for Levels of Integrated Healthcare, which was mentioned in the toolkit and built into the change plan template)
	Provide resources to all partners, including acute care, outpatient, and social service providers, so those partners understand what preventative services are available for them to refer patients/clients to and who they can contact to get that information if they are not currently aware of available resources
	Improve transitional care services by adopting a regional transitional care model that ensures patients that are released from inpatient care are connected with their outpatient providers and service providers who can assist in coordinating their care post discharge

	Better educate patients who routinely utilize the Emergency Department regarding more appropriate places to seek care in their community, and connect those patients with the providers who deliver that care
Partnering providers develop systems to be financially viable under new payment models being developed under the Medicaid Transformation Project	Develop processes so that services that are not currently reimbursed under traditional Medicaid contracting will be delivered and have a sustainable financial model (e.g. EMS providers will be able to deliver and receive compensation for services outside of acute transports to the Emergency Department)
	Assist partnering providers in better understanding what the HCA's Rural Multipayer and Value Based Purchasing models mean to their organization
	Ensure that collaborative care codes associated with reimbursement to providers will align with the bi-directional integration efforts occurring in the region
	Improve capacity and systems for measurement. This infrastructure is critical in any future environment that rewards value (providers need to be able to articulate and show value).
	Create actionable health information exchange within and across organizations in North Central Washington. This health information exchange could be through integrated electronic health records (EHRs) or through clinical workflows that ensure information is better communicated to outside providers through other avenues.
Increase awareness of the opioid crisis in North Central Washington and reduce opioid-related morbidity and mortality.	Increase MAT availability by increasing the number of clinical providers who provide Medication Assisted Treatment in the region
	Increase number and awareness of medication take back boxes
	Increase availability of Narcan

	Increase the number of providers effectively using the Prescription Monitoring Program (PMP)
	Improve opioid prescribing practices
	Increase awareness of opioid use disorder and treatment options available in the region
	Partners will better understand the resources available to them for long term recovery in the communities along with an increase in utilization of these resources
Develop a self-sustaining Pathways Community HUB to coordinate care coordination services across the region	Reduce the number of duplicated care coordination services across the region by partnering with clinical and non-clinical care coordination agencies
	Coordinate a network of care coordinators to share resources across the region
	Reduce Emergency Department visits by ensuring that those who chronically access the ED for care get connected with a care coordinator
	Managed Care Organizations (and other payers) financially reward Care Coordination Agencies for completion of Pathways
Ensure patients receive culturally appropriate services that address the whole person at multiple entry and exit points in the health care and social service system	Use population health data to identify, target, and reduce health disparities
	Partnering providers will include addressing social determinants of health as part of their process improvement efforts within their change plans and applications

D. Milestone 4: Identification of Partnering Providers

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

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

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

Section 2: Standard Reporting Requirements

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

ACH-Level Reporting Requirements

A. ACH Organizational Updates

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

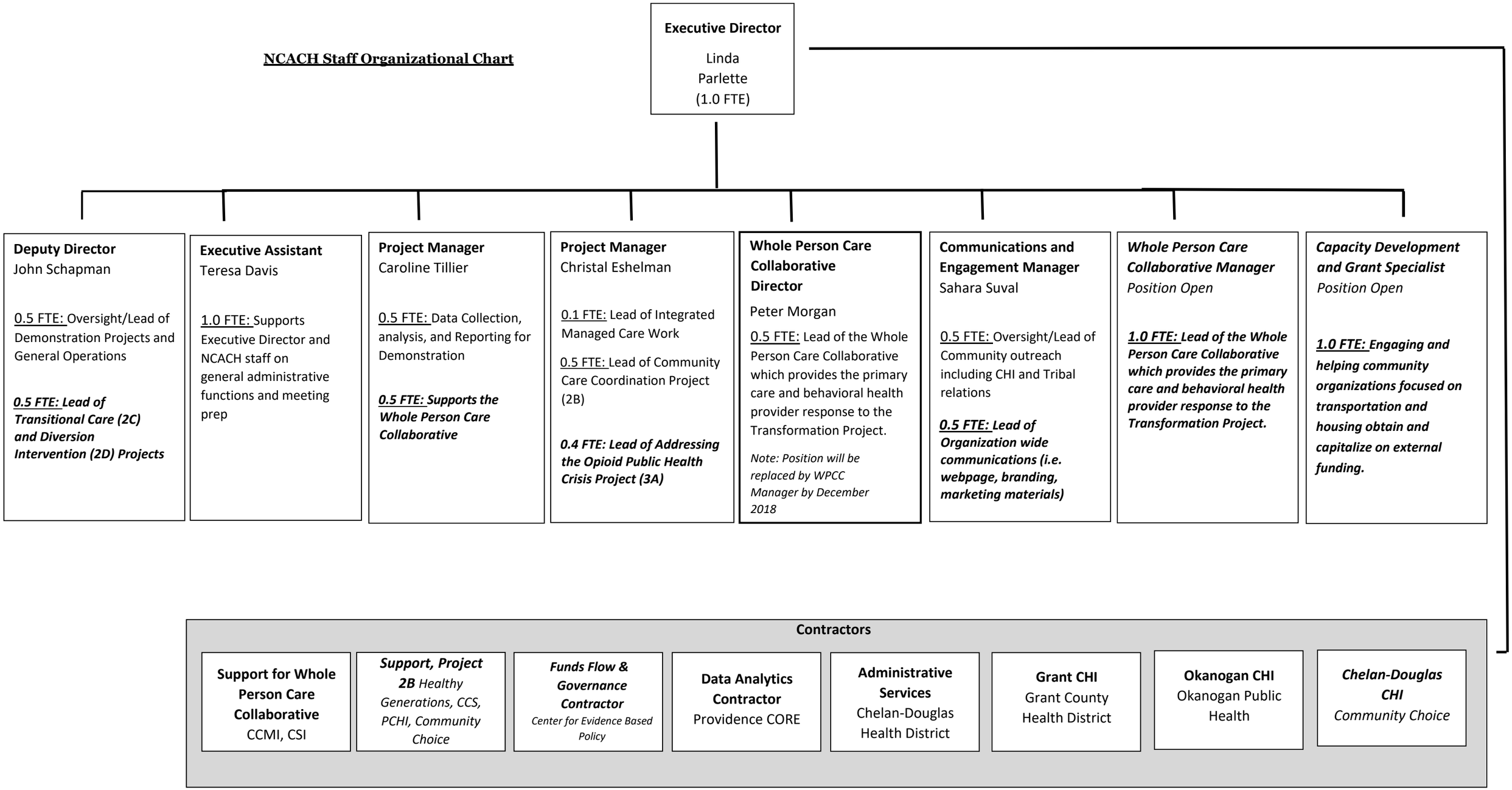
	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that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

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

3. **Key Staff Position Changes**: Provide a current organizational chart for the ACH. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period. Place an "X" in the appropriate box below.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

NCACH Staff Organizational Chart



B. Tribal Engagement and Collaboration

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

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome/Next Steps**
NCACH becomes member of ACH Tribal Liaison Calls (hosted by HCA)	April 2018	ACHs, HCA, Tribes, American Indian Health Commission (AIHC)	ACHs, HCA, Tribes, AIHC	To establish partnerships and opportunities for ACHs and Tribes to align Transformation objectives and funding opportunities	HCA hosts ACH-wide staff meeting in Tukwila, May 2018; HCA begins scheduling visits between Tribes and ACHs for June 2018
Email–Tribal Governing Board member forwards information about HCA scheduling visits between tribes to local Indian Health Services providers (IHS)	April 3, 2018	NCACH's Tribal Partners		To determine a date for HCA and NCACH to visit IHS for a meeting	No response
Email–NCACH Executive Director to local IHS	May 18, 2018			Re: HCA Visits	A date in June is selected
HCA cancels visit between	June 8, 2018				*A visit has been rescheduled for July 2018*

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	**Date**	**Invitees**	**Attendees**	**Objective**	**Brief Description of Outcome/Next Steps**
HCA, NCACH, and IHS					
NCACH awards $8,000 to Family Health Centers as a part of its Rapid Cycle Opioid Project Funding	June 11, 2018	Lead Organization: Family Health Centers	Contributors: Nine School Districts in Okanogan County, Okanogan County Community Coalition	Through the Rapid Cycle Opioid Application, utilize an $8,000 award to become a Trauma Informed and Resilient Community leading to healthier lifestyles.	As part of this project, Family Health Centers will partner with nine school districts in Okanogan County including Pascal Sherman Schools, which is a Tribal school on the Colville Reservation.

NCACH has been working to engage and include tribal partners in its MTP efforts. In late 2017, NCACH invited the Indian Health Services Provider (IHSP) with the Confederated Tribes of the Colville Reservation to join the WPCC. Despite repeated attempts to contact the IHSP administrator, NCACH was unable to connect and continued moving forward in project design without tribal partner input. Although NCACH does not currently have formalized agreements with the local IHSP as partnering providers in project work, it remains committed to including tribal partners as implementation partners when appropriate and assist with efforts to improve population health for tribal members.

Project Reporting Requirements

C. Project Status Update

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

    - Examples of activities may include, but are not limited to the following:
      The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.
    - *Partnering providers have completed training on project interventions.*
    - *Partnering providers have adopted and/or are using project tools/protocols.*
    - *The ACH has invested in and/or provided technical assistance for partnering providers.*
    - *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
    - *New services are being offered/provided to Medicaid beneficiaries*

    ***Note**: Project status updates are organized by NCACH Workgroup/Project. Each project update will be listed in order until all updates are providers. Some workgroup cross multiple projects and will be noted as such*

    ACH Response:

    NCACH is attaching its Governance chart that outlines the relationship between its Board, workgroups, and coalitions for health improvement. The attachment is titled North Central Accountable Community of Health.SAR1 Attachment A 7.31.18

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
Governing Board Approved Funding Principles, a funds flow decision matrix between workgroups, CHIs, and the Board, and estimated project budget allocations through 2022. This has been achieved through providing a series of Governing Board retreats (quarterly), a full day focused on the project approaches and funding strategies that have been developed as part of the workgroup and community engagement activities.	2A, 2B, 2C,2D, 3A, 3D	Y	Funding principles and budget allocations were shared with NCACH workgroups. Workgroup members will continue to build plans based on budget projections and bring annual budgets to the Governing Board. Initial annual budgets should be presented to the Governing Board in quarter 4 of 2018.
Governing Board approved guidelines to fund emerging initiatives that occur during the Transformation Project to help identity a process for community requests to filter through the appropriate venue associated with the NCACH decision-making process/structure.	2A, 2B, 2C,2D, 3A, 3D	Y	The Governing Board document that outlines the ability for emerging initiatives to be implemented in the region was shared at the CHI and workgroup levels, so everyone has a good understanding how NCACH will address new projects. If new projects are brought to NCACH's attention, the process outlined in the document will be followed.
NCACH signed MOUs with the 17 WPCC Learning Community partners to complete change plans and participate in a learning activity. Partners include	2A, 2B, 2C,2D, 3A, 3D	Y	Partners initiated the work of developing their organizations' change plans and participated in a change plan learning and action network.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
outpatient behavioral health and primary care providers.			
NCACH organized a full-day kickoff for the WPCC Learning Community on March 24, 2018. Facilitated by leaders in health systems innovation, the Centre for Collaboration, Motivation and Inspiration (CCMI) and CSI Solutions, over 100 representatives from 17 healthcare organizations convened to identify shared goals and help design learning activities that will meet their needs as they work on practice transformation.	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH intends to have in-person convenings of the WPCC Learning Community annually. All post kickoff materials were shared with attendees and initiated the first learning activity designed to assist providers with their change plans.
NCACH held monthly meetings of the WPCC. The WPCC formed through State Innovation Model (SIM) funding in 2016, after starting as a care transformation workgroup. This broader advisory group of stakeholders is asked to endorse recommendations by its workgroup and promotes alignment of provider transformation efforts in the North Central region with a shared vision of whole-person care.	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH will continue to hold these monthly meetings because they are an important mechanism for feedback and buy-in.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
NCACH formed a WPCC Workgroup in February 2018. This smaller subset of the WPCC guides NCACH staff with process development including eligibility parameters and funding levels for funded partners, measurement and reporting, and input to ensure the success of clinical provider engagement in NCACH's Medicaid Transformation projects. The goal of forming this workgroup was to reduce the cycle time on process change, improve the quality of documents brought to the broader WPCC on a monthly basis, and thereby accelerate the change process. Major workgroup activities this reporting period included: providing input into the change plan template, guiding target population selection for projects 2A and 3D, providing input into learning activities scheduled for the rest of 2018, exploring and guiding stage 2 funding framework, and providing input into change plan evaluation criteria.	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH will continue to hold these monthly meetings. It is expected that the workgroup will help adjust the change plan evaluation criteria in July or August. In August, NCACH plans on asking the workgroup to provide guidance on a core set of social determinants of health screening questions that it would encourage outpatient providers to ask, regardless of the tool.
NCACH staff completed 17 in-person site visits with WPCC Learning Community providers in the month of June, over eight days. These check-ins gave NCACH an opportunity to assess the providers' progress on developing change plans and to provide	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH has already synthesized some of the lessons learned and shared them at a July meeting of the WPCC. Feedback from the site visits have shaped and will shape the approach to the change plan and learning activities. This was really

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
any assistance needed for them to complete the task by July 31. NCACH staff also used the opportunity to delve into responses to a questionnaire sent to all the members and to get feedback on the proposed learning activities. As an ACH, investing time in these meetings was important to check and adjust the process by listening and responding to partner feedback, both the good and the bad.			important for relationship building and will likely be repeated annually.
NCACH offered its first learning activity to WPCC Learning Community members. The Change Plan Learning and Action Network (LAN) was designed to support primary care and behavioral health organizations eligible for the WPCC Learning Community to develop a change plan that captures their vision for transformation. The LAN consisted of six webinars over three months. Facilitated by subject matter expert faculty and staff, NCACH introduced funded providers to the evidence-based approaches and change ideas associated with the six selected projects, as well as topics on access and social determinants of health. Participants were asked to commit to actions in between webcasts, and an optional "office hours" at the conclusion	2A, 2B, 2C,2D, 3A, 3D	Y	This was the first learning activity offered to the WPCC Learning Community. Two 2-day skills workshops, one on Quality Improvement in July and another on Motivational Interviewing in August are being offered as well. Additional LANs are being planned for the fall, including: population health 1 (systems and data); bi-directional integration (one targeting behavioral health providers, and another targeting primary care providers). NCACH is currently working with consultants on scheduling and lining up faculty for these LANs.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
gave them a chance to ask questions about their draft change plans.			
NCACH worked with consultants from CSI Solutions on the development and launch of its WPCC Learning Community portal using the Healthcare Communities platform. This is a password-protected platform that NCACH is using to centralize communication and resources specific to the regional Medicaid Transformation projects. In April, NCACH staff asked all 17 organizations to submit authorization forms identifying users they wanted invited to the portal, and those who should have access to the change plan template.	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH has been using the portal to share documents and notes with the Learning Community, post Change Plan LAN webinar recordings, post announcements, manage listservs, and share registration links/forms for upcoming learning activities. Currently, 106 members have accepted the invitation to the portal, including practice transformation coaches working with providers in the region.
NCACH worked with consultants from CSI Solutions on the development and launch of the change plan template. This web-based template was a massive undertaking that would not have been possible without the clinical practice transformation and IT development skills of the consultants. The change plan template is designed to be an actionable tool for outpatient providers to outline	2A, 2B, 2C,2D, 3A, 3D	Y	Generally, NCACH has received positive feedback about the change plan template. Aside from some minor improvements to the interface, NCACH has been told it is user-friendly and provides a great structure for providers to articulate their practice transformation goals and action steps. Entries in the change plan template will become the basis for future reporting, in that providers will be asked to provide quarterly progress updates.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
and update their practice transformation roadmap during Medicaid Transformation.			
NCACH Governing Board approved charters for the WPCC Learning Community and WPCC Workgroup at the January 2018 meeting. This was part of revising and fine-tuning the longstanding WPCC group structure. In March, they approved specific eligibility parameters for WPCC Learning Community membership (which includes eligibility for funding through the WPCC).	2A, 2B, 2C,2D, 3A, 3D	Y	NCACH developed Stage 1 MOUs for all 17 outpatient providers who qualified. These same providers will be eligible for Stage 2 funding starting in September 2018.
NCACH is facilitating monthly Okanogan County FIMC provider meetings. Providers and MCOs are invited to a meeting the second Tuesday of the month to allow for planning and keeping stakeholders updated for the FIMC transition in Okanogan County. Topics already covered include an overview of FIMC, a presentation from Beacon Health Options, the ASO in NCACH's region, a collective presentation by the three MCOs in its region, and development of a client communications plan.	2A	Y	NCACH intends to continue monthly meetings through December 2018. Future planned topics include the Early Warning System, understanding American Indian/Alaska Native Medicaid benefits, further refining NCACH's client communications plan, and presentations from the Behavioral Health Ombuds in its region.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
NCACH is utilizing already existing CHI meetings in Okanogan County for broader stakeholder engagement and communications on preparations for the FIMC transition. The CHI meets every other month. NCACH presented at their April and June meetings.	2A	Y	NCACH intends to provide updates at each CHI meeting throughout this year. The next CHI meeting is in August, and the MCOs have been invited to provider information on their plans for integration in Okanogan County.
NCACH contracted with Xpio Health to provide IT technical assistance to Okanogan Behavioral Healthcare (OBHC) in their preparation for the transition to FIMC. NCACH facilitated a kickoff meeting between OBHC and Xpio Health.	2A	Y	OBHC is planning to send the IT self-assessment they completed to Xpio. OBHC and Xpio will develop a work plan and regularly meet to check progress.
NCACH offered a managed care training by Adam Falcone to all its the providers in its region.	2A	Y	Adam Falcone offered follow-up assistance in the form of contract review for the providers. This request was presented to the Governing Board and approved the behavioral health providers.
NCACH contracted with Adam Falcone to provide managed care contracting technical assistance to its 6 behavioral health providers. Each of NCACH's behavioral health providers has 3 or 4 managed care contracts that they are eligible to receive one-on-one technical assistance on addressing unfavorable	2A	Y	A point of contact was identified for each behavioral health provider and introduced to Adam Falcone via email. The providers and Adam will facilitate the contract review.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
language in their contract and advice on negotiations.			
In February 2018 NCACH convened a mix of community partners (non-funded) to come together and develop projects and funding strategies related to the opioid project. This workgroup has been meeting monthly to develop an RFP process to be used to select the HUB lead agency and initial target population.	2B	Y	This workgroup ended on June 27. The purpose of the workgroup, to select a lead agency and an initial target population, has been fulfilled. In its place, a smaller HUB Advisory Board was formed for oversight of HUB planning and implementation.
On June 13-14, NCACH held a 2-day strategic design workshop. A technical subgroup of workgroup members (who became HUB Advisory Board members) participated in this 2-day meeting. Key outcomes of this meeting included defining NCACH's target population and initial geography for the HUB to serve, setting a launch date, developing an elevator speech, and identifying potential care coordination agencies.	2B	Y	The HUB Advisory Board is continuing to meet every two weeks. NCACH is considering care coordination training requirements and plans, contracting with CCAs, and developing a budget.
On February 5, NCACH contracted with Foundations for Healthy Generations, Care Coordination Systems, and Pathways Community HUB Institute to provide technical assistance in	2B	Y	NCACH continues to meet with the consultants weekly and discuss progress and questions as they

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
planning and launching a Pathways Community HUB.			arise. The intention is for the support to continue through the launch of the HUB.
On March 28, NCACH issued an RFP for a Pathways Community HUB lead agency. The posting was open for 1 month and due on April 27. On April 9, NCACH hosted an informational webinar on the RFP that three agencies attended in person or via webinar (only one submitted an application). An evaluation process was developed and the proposal was scored by three subject matter experts and three local members of the Pathways Community HUB Workgroup.	2B	Y	On June 4, a recommendation was put forth to the Governing Board to select Community Choice as the lead agency. The recommendation was approved.
NCACH and Community Choice signed an MOU for the planning phase of the Pathways Community HUB. The intention is for the funding available through this MOU to be available for planning up to HUB launch.	2B	Y	After the HUB is launched, NCACH and Community Choice will execute a new contract for the implementation phase.
NCACH staff met with MCO partners to discuss potential HUB target populations and funding strategies.	2B	Y	NCACH continues to meet with MCO partners as the planning and implementation progress. NCACH and the HUB lead agency will have follow-up meetings with each of the MCOs in August and September.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
In October 2017 NCACH convened a mix of community partners (funded & non-funded) to meet and develop projects and funding strategies related to TCDI. This workgroup has been meeting monthly to define what approaches will be selected for Projects 2C and 2D, vote on funded strategies, and share additional tactics that could support NCACH projects.	2C, 2D	Y	NCACH continues with monthly meetings of the TCDI Workgroup. As funded partners move into the stage of implementation of the Medicaid Transformation projects, the workgroup will evaluate the success of those projects, additional process improvement work that needs to occur with the acute care provider community, and what other initiatives within the community NCACH needs to support to enhance the measures and goals of NCACH.
TCM partners reviewed the selected evidence-based approaches and defined criteria for achieving the model in the transitional care project. Each approach was researched and presented to workgroup members. Members discussed the issues associated with models outlined in the toolkit and voted to include a regional model in the review of evidence-based approaches.	2C	Y	TCM partners reviewed the models available to them, and selected the approach they would like to achieve. Because of the rural nature of the region, partners believed the models were not a good fit and instead chose a standardized regional approach that has been tested and proven effective in North Central region. NCACH is currently creating an application for partners to engage in the project and will release the application in August 2018.
TCM partners completed a site visit to the Confluence Health call center to learn about the TCM model adapted by Confluence Health.	2C	Y	TCM partners reviewed the site visit summary and evidence-based approaches and voted to accept the TCM model adapted by Confluence Health as

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
Members asked questions about the model and received onsite training by TCM nurses on how the model is implemented in practice daily.			the approach the region would adopt under project 2C.
The HCA accepted the project modification form that outlined NCACH moving forward with a regional TCM model that was originally adapted by Confluence Health.	2C	Y	After acceptance of the project modification form, NCACH initiated the planning process to engage partners in implementing the selected approach under project 2C Transitional Care. This has included scheduled phone calls with transitional care staff at the hospitals to introduce them to the regional model and gain an understanding of partner willingness to adopt the model.
The TCDI Workgroup officially adopted evidence-based approaches for projects 2C and 2D—TCM (locally adapted program) and ED Diversion.	2C,2D	Y	The workgroup adopted those models and NCACH staff initiated the process of working with implementation partners to outline plans for achieving selected approaches.
NCACH developed a regional toolkit for partners to utilize in the implementation of the TCM model adopted by the region. This toolkit was developed in partnership with Confluence Health and included Confluence Health offering to be the regional trainer for the model after partners move into implementation.	2C	Y	The toolkit was provided to interested partners. Partners will undergo an application process in September 2018 and identify when and how plans will be implemented. After partners move into the implementation phase, NCACH will work with them to outline training needs, training schedules,

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
			and how to start implementation of the model in their organization.
NCACH held monthly ED partner meetings to define strategies to support the ER is for Emergencies Seven Best Practices. Through a series of four meetings and two online surveys, ED partners identified three main strategies they would like to implement in support of the ER is for Emergencies Seven Best Practices.	2D	Y	ED partners are currently providing input on the application process and funding based on the strategies they have selected to accomplish. NCACH is currently finalizing the application process for partners to engage in the project and will release the application in August 2018.
The TCDI Workgroup approved merging the Transitional Care and Diversion Application for hospital entities. Tentative funding ranges associated with projects were reviewed and unofficially approved, with exact details to be worked out by through specific implementation partner meetings (i.e., ED and TCM partner meetings).	2C &2D	Y	Implementation partners will have an opportunity to review the application and provide additional comments and feedback, which will be brought back to the workgroup for final approval and recommendation to the NCACH Governing Board in August 2018.
NCACH staff held regular meetings with members of the NCECC to discuss the adoption of a community paramedicine model region wide. These meetings consisted of NCACH meeting with the NCECC Board, membership, and individual	2D	Y	NCACH worked with NCECC staff to develop a proposal that could be submitted to the TCDI Workgroup and NCACH Governing Board outlining the components of community paramedicine that its regional providers would

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
partners. Through the course of these meetings, it was determined that adopting a full community paramedicine model was not in the best interest of the region given the many constraints listed at the state level. EMS partners, although skeptical of the process, did agree to adopt components of community paramedicine in conjunction with NCACH and NCECC.			adopt and the associated tactics to achieve those components.
The TCDI Workgroup in partnership with the NCECC developed a proposal with tactics EMS providers will use to address ED Diversion through the Transformation Project.	2D	Y	NCACH staff and TCDI Workgroup recommended for approval to Governing Board the proposal for Phase 1 (planning and development process).
NCACH Governing Board approved goals and tactics EMS providers will complete. NCACH developed an MOU and signed it with NCECC to work with the regional EMS partners for further development of EMS plan to engage EMS partners and reduce inappropriate ED utilization.	2D	Y	NCECC is currently surveying EMS agencies on the specific community paramedicine model components those organizations would like to achieve, the timelines to achieve those components, and how those will be incorporated into a 2-year plan for EMS to accomplish the outlined tactics.
NCECC secured commitment of 10 EMS agencies to participate in the initial phase to build out the community paramedicine regional plan.	2D	Y	NCECC will move through the planning process (Phase 1) with 100% participation from the EMS partners. This will develop into a plan that can be

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
			implemented across the region through 2021. That will include developing a regional plan for NCECC and individual EMS partner plans and goals to be achieved through 2021.
In October 2017 NCACH convened a mix of community partners (funded & non-funded) to meet and develop projects and funding strategies related to the opioid project. This workgroup has been meeting monthly to define and select approaches, vote on funded strategies, and share additional tactics that could support NCACH projects.	3A	Y	NCACH continues with monthly meetings of the Opioid Workgroup. As funded partners move into the stage of implementation of the Medicaid Transformation projects, the workgroup will evaluate the success of those projects, additional process improvement work that needs to occur with NCACH's opioid project funded partners, and what other initiatives within the community its ACH needs to support to enhance the measures and goals.
In January, the Opioid Workgroup selected approaches that would be eligible and identified priority approaches in the Rapid Cycle Opioid Application. They also recommended approaches for the WPCC change plan process.	3A	Y	The selected priority approaches were incorporated into a Rapid Cycle Opioid Application. Approaches that were recommended to the WPCC were reviewed by subject matter experts and incorporated into the change plan template used by all 17 of NCACH's outpatient primary care and behavioral health providers.

Project Status Update			
Key Activity	**Associated Project Areas**	**Is activity progressing as expected? (Y/N)**	**Next Steps**
In March, the Opioid Workgroup endorsed the Opioid Rapid Cycle Application, the Application Scoring Criteria, the Funding Process, and the Funding Principles.	3A	Y	These were presented and approved by the NCACH Governing Board in April.
On April 10, the Opioid Rapid Cycle Application was issued. The application was due on May 11. The applications were reviewed by workgroup members, NCACH staff, and OHSU consultants from May 12 to May 24. Based on scores of the applications, the Opioid Workgroup voted on a recommendation of funding on May 25.	3A	Y	The recommendation of funding by the workgroup was brought to the Governing Board and approved on June 4. A total of 11 agencies received funding.
MOUs were developed and signed by each Opioid Rapid Cycle Application awardee. Funding for most awardees was distributed on June 29. Two organizations had not returned the MOU yet and were funded on July 13.	3A	Y	The MOU references a reporting template the organization will need to complete. The MOU states that NCACH will provide this reporting template by October 31.

D. Partnering Provider Engagement

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

   ACH Response:

   The NCACH region only has a small number of participating providers that have multiple sites in different ACHs, and no large health systems cross over into any other ACH boundaries. The way NCACH has structured the engagement process for providers (including those that cross over multiple ACHs) is to encourage partners to focus on their local priorities as they advance the goals of the Medicaid Transformation. The processes NCACH is developing in the region may be distinct (for example the change plan process), but partnering providers are able to leverage this process at any of their sites in other ACH regions. That said, NCACH has made it clear that it does not expect sites outside of NCACH to engage in these specific processes unless they add value to their organization and does not interfere with the work of other ACHs. To ensure that each ACH is aware of partner engagement strategies, NCACH is sharing updates at biweekly ACH leads calls and during weekly and monthly executive director meetings. NCACH also shared the change plan template and the portal it is using with outpatient providers (Healthcare Communities) with the other ACHs. A few other ACHs have adopted or are considering adopting this portal, which would allow providers who cross ACHs to utilize one system to input the information they provide through the Transformation project (although the input forms may be different across ACHs).

   Specific to Community-Based Care Coordination (Project 2B), a key partner that crosses multiple ACHs is NCACH's Pathways Community HUB lead agency, Community Choice. Community Choice is the Health Homes lead agency across the regions of Better Health Together and NCACH. This has proven beneficial because their director has maintained a strong working relationship with both ACHs, and therefore is able to align how each region is looking at the differences, similarities, and alignments between the Pathways Community HUB and the current Health Homes programs.

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

   Although NCACH has already been a mid-adopter in three of four counties (Chelan, Douglas, and Grant), NCACH has been a very collaborative partner for all ACHs statewide that are currently in the process of moving toward FIMC in 2019. NCACH held

individual calls with ACHs to explain the process that it completed and held monthly FIMC calls with regional partners such as Better Health Together. A majority of mid-adopter ACHs have adopted the process used by NCACH in 2018 and NCACH is hosting a full-day meeting in Wenatchee for provider groups to hear and learn from the experience NCACH providers had with the process in 2017 and transition in 2018.

To ensure that data needs and collection methods are consistent across the regions and with partnering providers, ACHs have been holding biweekly data leads calls to discuss how data will be collected for project planning and target population selection, what data will be needed for continuous monitoring and improvement, and how that data could be collected by partnering providers and/or state agencies. Data collection from partnering providers will likely provide additional administrative work for those organizations, and the ability to streamline the process across ACHs ensures that providers can duplicate processes for data collection and reporting across multiple regions.

Finally, NCACH continues to collaborate across ACHs to find alignment in Domain 1 initiatives. NCACH participated in the Statewide Shared Domain 1 Investment meetings that included other ACHs, Association of Public Hospital Districts, and the University of Washington. These meetings have focused on identifying key initiatives that each region is willing to collaborate on to better achieve the goals of the Transformation Project statewide, including the following:

a. Addressing scope-of-practice, financing, and regulatory barriers to provide whole person care in mental health care and physical health care settings

b. Common training opportunities, including trauma-informed care, health equity, and historical trauma

c. Identifying a shared definition of team-based care and using the definition to influence state level actions that support team-based care such as Medicaid-MCO contracts and RFPs/grants to communities

d. Supporting the development of a state-level CHW association and statewide training programs for CHWs by CHWs

e. Support expanded site of service and scope of practice requirements for telehealth

2. Briefly describe the ACH's expectations for partnering provider engagement in support of transformation activities.

ACH Response:

NCACH expects partnering providers that participate in the projects to complete the following general requirements across all projects:

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

2. Submit data to NCACH that can be utilized in monitoring and tracking progress of selected initiatives.

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

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

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

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

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

ACH Response:

The primary movers of Transformation work will be the outpatient primary care and behavioral healthcare providers. These providers are implicated in the NCACH's ability to meet Transformation performance metrics and are critical to the success of the region's transition to FIMC. Those providers have been actively involved in the WPCC Learning Community through biweekly LAN webinars focused on developing a change plan that their organization will initiate to guide and track their process improvement efforts in the next 3.5 years. Although NCACH has had good success in participation, this process has identified the following barriers for providers:

1. The variable size and level of integration across these providers makes it more difficult to align processes and measures region-wide. NCACH has heard from larger providers that they are further down the road on bi-directional integration than most organizations, and that learning activities will need to be tailored to

their current state in order to add value.

2. Some providers struggled to form their change plan teams and to determine how those teams would actively participate in the Change Plan LAN webinars. It is clear that organizations do not have the capacity to pull entire teams offline to attend regular webinars. This was an important observation as NCACH fine-tunes engagement expectations for additional learning activities it will offer.

To help address the above issues, NCACH WPCC staff spent the month of June completing site visits with each organization. Staff spent time on the site visits reviewing the change plans, answering questions about the process, and providing general guidance on how organizations should complete change plans. Based on the input from those site visits, NCACH staff learned they may need to tailor their approach for the larger, more advanced organizations and redefine participation expectations for teams engaging in learning activities of the collaborative. NCACH staff continues to provide technical assistance to organizations as they complete their change plans due July 31.

As NCACH begins to roll out its community-based care coordination model (Pathways Community HUB Model), some providers continue to struggle to understand how Pathways community-based care coordination will cross over with the current infrastructure in place for care coordination. NCACH has continued to provide education across the region to Governing Board members and interested parties. Partnering providers who have engaged in the model are now in the process of determining how this fits into their current care coordination structure, how they would assign staff to complete this work, and what they need to do to train individuals for the organization to become a Pathways Community HUB Care Coordination Agency. Since this model is different from the current care coordination models provided in Washington State, NCACH is working to make available the resources and funding to ensure that partnering providers have staff trained and ready to implement the model when it launches in fall 2018.

As NCACH engages its acute care providers in practice transformation, the primary focus has been on creating partnerships and referral processes to connect patients with outpatient providers that provide care to keep patients out of emergency departments and hospitals. A major barrier in the more rural areas of NCACH's region is the difficulty critical access hospital providers encounter when directing patients toward more appropriate (less acute) levels of care, given the lack of resources available to them compared to larger communities (e.g., after-hours urgent care clinics).

To help mitigate this issue, NCACH is working with partners to redefine how they identify and create initiatives related to appropriate use of care, and not only look at services that could be accessed during normal business hours and traditional medical partners, but also services outside of urgent care and primary care that could meet patients' needs (e.g., EMS, community-based organizations that provide care coordination, and palliative care initiatives). Nonclinical partners who could provide a level of follow-up care and assist patients in meeting their basic needs might not meet

the state's standard definition of "follow-up after discharge." However, their assistance could prevent those patients from being readmitted into the hospital.

Finally, as NCACH's North Central Emergency Care Council partners continue to work with ambulance (EMS) partners in the region, there are multiple barriers that continue to arise that are preventing them from moving toward a community paramedicine model:

1. Lack of reimbursement for services outside of Emergency Department transports
2. Complexity and potential time involved to transport patients to providers such as mental health facilities vs. transporting directly to emergency departments
3. The shift to VBP, which does not reward ambulance providers for providing the appropriate level of care

NCACH has worked with partners across the region to address the complexity involved in patient transports to alternative sites. NCACH continues to encourage state partners to help advocate for financial incentives that allow ambulance partners to do what's right: provide the appropriate level of care to patients in the region while reducing inappropriate transports to emergency departments. NCACH has held conversations with MCOs and state partners, but a majority of EMS barriers are not short-term fixes and will need to be addressed over the course of the Transformation.

A few providers across NCACH's projects have had greater issues engaging in NCACH work. For example, a few of NCACH's smaller WPCC providers do not always have the capacity to join learning and action networks, or are not as experienced in change management. NCACH WPCC staff have scheduled individuals meetings with these organizations to review their specific change plans for adequacy and provide recommendations on process improvement efforts the organization can complete as part of the Transformation Project. In some instances, NCACH staff are meeting individually with key staff members to help them learn more about the Transformation project and the details behind the WPCC change plan, and provide tailored guidance on next steps.

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

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

ACH Response:

Chelan, Douglas, and Grant counties transitioned to FIMC on January 1, 2018. NCACH participated in the Early Warning System, including daily provider calls in January and monthly Early Warning System calls from January to June. In response to a provider request, NCACH worked with the MCOs and ASO to offer an MCO symposium in May. This was modeled after the MCO symposium held in October in preparation for FIMC, but allowed providers to ask questions post-integration that they were not aware of pre-integration.

In preparation for the transition in Chelan, Douglas, and Grant counties, NCACH convened an FIMC Advisory Committee that met about once per month. For Okanogan County, NCACH is utilizing the already existing Coalition for Health Improvement (CHI) meetings in Okanogan County for broader stakeholder engagement and communications about preparations for the FIMC transition. The CHI meets every other month; NCACH presented at the April and June meetings. NCACH intends to provide updates at each CHI meeting throughout this year. The next CHI meeting is in August, and the MCOs have been invited to provide information on their plans for integration in Okanogan County.

In addition to presenting at the Okanogan CHI meetings, NCACH is facilitating monthly Okanogan County FIMC provider meetings. Providers and MCOs are invited to a meeting the second Tuesday of each month to allow for planning and keeping stakeholders updated on the FIMC transition in Okanogan County. Topics already covered in these meetings include an overview of FIMC; a presentation from Beacon Health Options, the ASO in NCACH's region; a collective presentation by the three MCOs in the region; and development of a client communications plan. NCACH intends to continue monthly meetings through December 2018. Future planned topics include the Early Warning System, understanding American Indian/Alaska Native Medicaid benefits, further refining NCACH's client communications plan, and a presentation from the Behavioral Health Ombuds in its region.

Specific to behavioral health providers, Okanogan County has only one Spokane Behavioral Health Organization (BHO) contracted provider, Okanogan Behavioral Healthcare (OBHC). OBHC has completed the self-assessment tool provided in the *Billing and Information Technology Toolkit for Behavioral Health Providers* by Qualis Health, Washington Department of Health, and Healthier Washington. NCACH has contracted with Xpio Health to provide IT technical assistance to OBHC. OBHC and Xpio will draw on the billing and IT self-assessment to develop a work plan to ensure that OBHC is prepared for financial integration on Jan 1, 2019.

In regards to contracting, OBHC (along with other WPCC members) attended a full-day training from Adam Falcone of Feldesman Tucker Leifer Fidell LLP on managed care contracting. NCACH engaged Mr. Falcone to provide additional support to behavioral health providers (including OBHC) involving individualized contract reviews of their managed care contracts.

E. Community Engagement

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

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

   (See next page): Community Engagement activities are listed as monthly if they are standing meetings or in chronological order.

Community Engagement Activities for the Reporting Period						
Activity Description	**Date**	**Objective**	**Target Audience**	**Associated Project Areas**	**Brief Description of Outcome**	**Attendance Incentives Offered? (Y/N)**
North Central Integrated Managed Care Rapid Response calls	Daily in January, biweekly in February	To respond to systemic issues or questions that may arise due to FIMC, which need immediate attention or resolution.	HCA, Behavioral Health Providers, MCOs, and other FIMC stakeholders		The rapid response calls allowed a dedicated time each day where providers could get answers to questions, set up necessary follow-up meetings, and work to address issues.	N
NCACH Governing Board Meetings	Monthly	To update, inform, and execute NCACH monthly business, including reviewing motions and recommendations from NCACH Project Workgroups, staff, and the CHI.	NCACH Board members and broad community	2A, 2B, 2C, 2D, 3A, 3D	NCACH Governing Board oversees all activities and funding allocations of the organization. These meetings are open to the public and an important opportunity for all NCACH groups and decision-making bodies to come together.	N
CHI Leadership Council Monthly Calls	Monthly	NCACH convenes a leadership group representing each of the three CHIs, called the CHI Leadership Council. The group convenes monthly to share feedback with and learn about NCACH's key decisions and	Chelan, Douglas, Grant, and Okanogan Counties	2A,2B,2C,2D,3A,3D	The CHI Leadership Council has been instrumental in providing feedback to and from NCACH and each of the Coalitions. The Leadership Council is responsible for engaging the Coalitions and keeping them updated with NCACH key decisions and	N

		initiatives, as well as to reduce regional silos within health improvement work and community initiatives.			opportunities. The CHI Community Stakeholder Survey (2018) was developed as a result of these calls.	
CHI Leadership Council Planning Meetings	Monthly	Each of the CHI Leadership Councils (Chelan-Douglas, Grant, and Okanogan) meet individually on a monthly basis to determine each CHI's monthly meeting agenda.	Chelan, Douglas, Grant, and Okanogan Counties	2A,2B,2C,2D,3A,3D	Each CHI Leadership Council determines monthly agendas for each of the CHIs, as well as to ensure that county-level priorities are not lost in regionalization.	N
Interagency Networking Meeting (Chelan-Douglas)	Monthly	Convenes health and human service providers to share monthly updates.	Chelan and Douglas Counties	2A,2B,2C,2D,3A,3D	Provides opportunity to learn more about partners and potential partner initiatives to complement NCACH work. Active recruitment for CHIs and CHI-focused work.	N
Mental Health Stakeholders Meeting	Monthly	Convenes behavioral health service providers in Chelan County to share updates, provide feedback, and discuss issues that may be occurring (e.g. FIMC implementation or partner referrals).	Behavioral health service providers, MCOs, law enforcement	2A, 2B, 2C, 2D, 3A, 3D	Provides opportunity for community partners to share ideas, gather feedback, express challenges, and brainstorm solutions. NCACH has been attending these meetings since 2017; it is an important space to learn feedback from providers and share regular updates.	N
NCW Behavioral Health Advisory Board Meeting	Monthly	To solicit and draw on input of consumers with mental health and / or substance abuse disorders to improve behavioral health services delivery in the North Central Washington region.	Behavioral Health providers, Consumers	2A	Provides opportunity for community partners and consumers to provide feedback and engage in quality improvement of Behavioral Health services.	N

Parkside Meetings	Monthly	Updates, networking, and process-development meetings for Parkside, a crisis stabilization center to be opened in late 2018.	NCACH, service providers, law enforcement, MCOs, healthcare providers	2B, 2C, 2D 3A	NCACH sits in on monthly meetings to learn and provide insight, including connections with local law enforcement to determine transportation process for those eligible for Parkside's services.	N
Regional Hospital Council Meetings	Bi-Monthly	An opportunity for the region's hospital executives to come together and share ideas. NCACH attends to provide updates and hear feedback from implementation partners.	Hospital Executives	2A,2B,2C,2D,3A,3D	Outreach, networking, and quality improvement feedback.	N
Washington State of Reform Health Policy Conference	1.4.18	Each ACH was invited to attend and share information about their ACH and selected MTP projects.	Health professionals	2A, 2B, 2C, 2D, 3A, 3D	Opportunity for outreach, education and networking.	N
Meeting with Living With Autoimmunity (LWA)	1.10.18	NCACH Executive Director met with Director of LWA to encourage them to attend Chelan-Douglas CHI meeting.	LWA	2A, 2B, 2C, 2D, 3A, 3D	LWA Director introduced to partners at the Chelan-Douglas CHI meeting.	N
Meeting with Health Homes & Transitional Care Staff Lead	1.10.18	Review how hospitals participating in the TCM project can be sure to include community based organizations who provide care coordination outside of clinical organizations.	Health Homes Staff	2C	Reviewed TCM model and recommended approaches for hospitals to ensure they outreach into the community.	N

Chelan Douglas CHI Meeting	1.10.18	Focused on populating a Current State Assessment identifying ongoing needs, programs, and gaps for both Transitional Care and opioid/substance use disorder services across Chelan and Douglas Counties.	Chelan and Douglas County	2A,2B,2C,2D,3A,3D	Group reconvened after several month hiatus. Reviewed CHI function and role with NCACH. Worked to populate a Current State Assessment for Regional Opioid Stakeholder Workgroup to use for project design.	N
Grand Coulee Mobility Summit	1.11.18	Community members convened to give feedback on the upcoming Health and Human Services Transportation plan facilitated by People for People.	Grant, Adams, Lincoln, and Kittitas Counties	2c, 2D	Group reviewed challenges to transportation across the region and prioritized focus areas to address.	N
Meeting with Beacon Health Options	1.22.18	Discuss plans for the Behavioral Health Advisory Board and how NCACH can collaborate with the Advisory Board.	Beacon Health Options	2A	Reviewed options that the Behavioral Health Advisory Board could pursue.	
Meeting with Opioid Workgroup Chair	1.22.18	Reviewed current plans of Opioid Workgroup and how to proceed with a new workgroup chair.	Opioid Workgroup Chair	3A	Established regular meetings one week after Opioid Workgroup meetings and one week before Opioid Workgroup meetings.	N
Regional Hospital Council Meetings	1.23.18	Review current issues occurring across the region for the regional hospital entities.	Hospital Executives	2A, 2B, 2C,2D,3A, and 3D	Reviewed rural nursing shortage and talked about training programs. More information in the future to come on topic. Provided an update to Hospital leaders on progress of NCACH.	N

Conversation with Grant County Police Department	1.23.18	Discussed current needs of law enforcement related to Transformation Project efforts and discussed law enforcement interest in L.E.A.D. program.	Law Enforcement Staff	2D	Learned about law enforcement interactions with opioid and other drug related offences. Determined that L.E.A.D. program is not appropriate for NCACH's region at this point.	N
Meeting with community partners Chelan Douglas Health District and Catholic Charities	1.26.18	Chelan Douglas Health District and Catholic Charities staff met with NCACH to discuss solutions for crisis stabilization services.	Service provider organizations	2A, 2B, 2C,2D,3A, and 3D	NCACH was able to help identify funding opportunities.	N
Meeting with Moses Lake Assured Home Health and Hospice	1.30.18	Meet with Assured Home Health and Hospice to determine how transitional care programs implemented would affect their workflow.	Assured Home Health and Hospice Staff	2C	Reviewed Transitional Care Project efforts and talked about appropriate patterns of referral to organizations. Information was utilized in discussions with TCDI Workgroup and the selection of a TCM model.	N
Aging and Adult Care of Central Washington (AACCW) – NCACH Meeting	2.2.18	Met with AACCW to gain a better understanding on how transitional care services could interact with their community care coordination services.	AACCW Staff	2C	Review transitional care project efforts and how transitions from hospitals interact with care coordination agencies.	
Meeting with Catholic Charities	2.2.18	NCACH Executive Director met with Catholic Charities to discuss funding opportunities for	Catholic Charities	-	NCACH connected Catholic Charities with local newspaper to get the word out with need of extra funding needed	N

		Catholic Charities housing projects.			for a housing program to serve Chelan and Douglas Counties. As a result of this meeting, Catholic Charities was able to receive funding authorized by the Chelan County Commissioners.	
Wenatchee Police Department Meeting	2.2.18	Discussed current needs of law enforcement related to Transformation Project efforts and discussed law enforcement interest in L.E.A.D. program.	Law Enforcement Staff	2D	Learned about law enforcement interactions with opioid and other drug related offences. Determined that L.E.A.D. program is not appropriate for its region at this point.	N
Meeting with Upstream	2.7.18	Executive Director from statewide nonprofit, Upstream, met with NCACH Executive Director to discuss opportunities to connect with providers who work with patients to reduce unplanned pregnancies.	Upstream	-	NCACH was able to facilitate a connection between local provider groups and Upstream for further collaboration.	N
Behavioral Health and Law Enforcement Meeting (led by Curt Lutz)	2.8.18	Receive a current update of the issues law enforcement faces when interacting with behavioral health patients.	Law Enforcement and Behavioral Healthcare Partners	2C,2D	Started discussion on how patients will be diverted to Parkside for behavioral health services and the plan when patients are released back into the community to ensure they are able to get back to their county of residence.	N
Opioid Change Plan Section Meeting	2.8.28	Meeting with local opioid champion and consultants to discuss tactics that should be incorporated into the WPCC change plan template.	Local opioid champion, consultant	3A	Selected which tactics to include in the Opioid Section of the Whole Person Care Collaborative (WPCC) change plan template.	N

Grant County CHI Meeting	2.13.18	Review role of CHI within ACH and vote for Grant County CHI Board seat for NCACH Board.	Grant County	2A,2B,2C,2D,3A,3D	Reconvene group after several month hiatus. Grant County CHI selected candidate for Grant County CHI Board seat on NCACH Board. Reviewed the six selected Transformation Projects and status of FIMC in Grant County.	N
Chelan-Douglas CHI Meeting	2.14.18	Identify goals and focus areas of the Chelan-Douglas CHI, in particular as they relate to NCACH's MTP and project goals.	Chelan and Douglas Counties	2A,2B,2C,2D,3A,3D	Group identified success stories, partnerships, and community assets that benefit the Chelan-Douglas CHI. NCACH staff were able to preview new communications tools and resources for the group to use, including monthly meeting summary and individual CHI webpages.	N
MCO Strategic Check-in	2.14.18	Promote alignment and coordination between NCACH's Transformation efforts and MCO efforts as its region embraces whole-person care while moving to FIMC and VBP.	MCOs,	2A,2B,2C,2D,3A,3D	Better understanding of data sharing possibilities. Follow-up involved getting clarification from MCOs about the data (what and at what level) they would be able/willing to share. Also clarified high-value measures NCACH should make sure to incentivize in its change plan template.	N
NCACH Executive Director meets with Governor's Office of Washington State to	2.14.18 - 2.15.18	NCACH Executive Director went to Olympia to clarify what and when ACHs owed B&O taxes.	All ACHs, State of Washington, HCA	-	Based on Senator Parlette's testimony, legislation resulted and was signed into law that clarified when ACHs must pay B&O Tax.	N

discuss B&O Tax that ACHs must pay						
Meeting with Sue Birch, HCA Director	2.15.18	NCACH Executive Director met the (then new) Director of HCA.	HCA	-	Director Birch accepted Senator Parlette's invitation to tour the NCACH region and appear as one of the keynote speakers at the NCACH Annual Summit (4.20.18).	N
Our Valley, Our Future Meeting	2.21.18	Meeting with Executive Director to learn more about housing and transportation initiatives in NCACH's community.	Individual Meeting	2A,2B,2C,2D,3A,3D	NCACH staff and OVOF were able to gain a better understanding of each other's initiatives and the potential interaction between the two.	N
Meeting with Chelan County Sheriff	2.21.18	NCACH met with Chelan County Sheriff to learn about regional collaboration opportunities.	Chelan County Sheriff	2C, 2D, 3A	Resulted in a series of meetings regarding opioid response and transportation to and from Parkside, a new crisis stabilization center opening in late 2018.	N
Jail services meeting	2.22.18	Development of a regional jail liaison program in Grant, Chelan, and Okanogan County.	Jail Directors, Behavioral Health Staff, and MCOs	2D	Progressed in next steps of the planning process.	N
Okanogan County CHI Meeting	2.26.18	Review goals and focus areas of the Okanogan County CHI. Determine members of Okanogan County CHI Leadership Council.	Okanogan County	2A,2B,2C,2D,3A,3D	Reconvened group after several month hiatus. Selected committee to form the Okanogan County CHI Leadership Council. Developed goals and focus areas for the CHI in 2018. Reviewed NCACH selected Medicaid Transformation projects.	N

Behavioral Health Provider Alliance Meeting	2.26.18	Discuss with behavioral health providers any concerns or needs they have specific to FIMC.	Behavioral Health Providers	2A	Requested MCOs to provide a post-FIMC MCO symposium.	N
City of Wenatchee Homeless Task Force Meeting	2.27.18	City of Wenatchee convened service providers and community stakeholders to discuss the assessment for a low-barrier shelter for Chelan and Douglas Counties.	Chelan and Douglas Counties	2B, 2C, 2D, 3A	Group reviewed barriers to shelter, currently existing programs, and identified more opportunities for community collaboration.	N
Meeting with Chelan County Sherriff's Office	2.21.18	Discussed current needs of law enforcement related to Transformation Project efforts and discussed law enforcement interest in L.E.A.D. program.	Law Enforcement Staff	2D	Learned law enforcement interactions with opioid and other drug related offences. Confirmed that L.E.A.D. program is not appropriate for NCACH's region at this point.	N
Meeting with Chelan County Jail	02.20.18	Discussed current needs of the jail related to Transformation Project efforts.	Jail Staff	2C, 3A	Learned about the Chelan County Jail. Potentially interested in pursuing jail transitions as a target population for the Pathways Community HUB.	N
NCW Mobility Council	2.28.18	Understand the initiatives the Mobility Council is taking on and how NCACH can collaborate.	Chelan, Douglas, Grant, Okanogan County Transportation and Health care	2A, 2B, 2C, 2D, 3A, 3D	Learned about current efforts including a region wide survey that the Mobility Council is preparing.	N

			Stakeholders			
Community Resource Fair	3.1.18	A community resource fair offering information on legal services, health and wellness, health screenings, mobile foodbank, and more.	Wenatchee community members	2A,2B,2C,2D,3A,3D	Able to share information with service providers about NCACH and the CHIs, as well as to learn more about local community services and areas of need. Resulted in local Planned Parenthood staff attending NCACH Annual Summit and other NCACH Workgroup meetings.	N
Narcan "Save" Follow-up Meeting	3.1.18	Explore developing a program to follow-up with and engage in treatment for people who have been revived after an opioid overdose by administration of Narcan.	Opioid Stakeholders and Treatment Providers	3A	Determined feasibility of program and barriers. Assigned follow-up tasks and scheduled a next meeting.	N
Meeting with Chelan Valley Hope	3.2.18	Meet and greet with local rural basic needs and health service hub in Chelan, WA.	Chelan Valley Hope	2A,2B,2C,2D,3A,3D	Learned about challenges facing Chelan, WA specifically, as well as programs and opportunities for overlap. Chelan Valley Hope now regularly attends Chelan-Douglas CHI Meetings.	N
Meeting with Okanogan Economic Alliance (OEA)	3.2.18	Informational meeting between OEA and NCACH.	Okanogan Economic Alliance	-	Outreach and networking; OEA Director then attended NCACH Annual Summit and Okanogan County CHI.	N
DOH Conversation about	3.6.18	To learn more about the current progress DOH is making to promote community	DOH,	2D	Learned about the current regulations and barriers at the state level for implementing community	N

Community Paramedicine		paramedicine and evaluate the scope of practice of providers in the state.			paramedicine. Shared these discussions with NCECC as they work to implement their plan for the EMS community.	
Chelan Douglas CHI Meeting	3.14.18	Chelan-Douglas Leadership Council established; reviewed community success stories and connections identified from February meeting.	Chelan-Douglas County	2A,2B,2C,2D,3A,3D	Identified Chelan-Douglas Leadership Council. Reviewed group goals and objectives. Determined April's meeting agenda to include a "NCACH 101" refresher presentation.	N
Pathways Community HUB RFP Subgroup Meeting	3.14.18	To develop an RFP for an organization to serve as the HUB lead agency.	Subgroup of Pathways Community HUB Workgroup	2B	Reviewed RFP plans and developed necessary components to RFP.	N
Grand Coulee Mobility Summit part 2	3.15.18	Community members convened to give feedback on the upcoming Health and Human Services Transportation plan facilitated by People for People.	Grant, Adams, Lincoln, and Kittitas Counties	2c, 2D	Group reviewed challenges to transportation across the region and identified local solutions to address barriers to transportation.	N
Regional Hospital Council Meeting	3.20.18	Review current issues occurring across the region for the hospital entities.	Hospital Executives	2A, 2B, 2C,2D,3A, and 3D	Provided update to hospital executives on NCACH work to ensure individuals continue to stay informed of progress on Transformation Project.	N

Pathways community HUB RFP Subgroup Meeting	3.21.18	To develop an RFP for an organization to serve as the HUB lead agency.	Subgroup of Pathways Community HUB Workgroup	2B	Reviewed and approved draft of NCACH HUB Lead Agency RFP.	N
Jail Services Meeting	3.22.18	Development of a regional jail liaison program in Grant, Chelan, and Okanogan County.	Jail Directors, Behavioral Health Staff, and MCOs	2D	Progressed in next steps of the planning process.	N
Meeting with The Center for Alcohol and Drug Treatment	3.22.18	NCACH Executive Director met with CEO of CFADT to discuss capital improvement funding.	CFADT	2A,2B,2C,2D,3A,3D	NCACH was able to help identify funding opportunities for CFADT to modernize their building.	N
Washington State Hospital Association Call	3.27.18	Update ACHs and WSHA on the initiatives of both groups.	ACH Directors, WSHA staff	2A,2B,2C,2D,3A,3D	Updated on current WSHA Initiatives and how they link to ACH work. Plan to continue in the future to ensure ACHs and WSHA stay in alignment with initiatives both organizations roll out to partners.	N
Dental Opioid Prescribing Guidelines Meeting	3.29.18	Discuss new Dental Opioid Prescribing Guidelines.	FQHC Dental Directors	3A	Discussed with dental directors of 2 of 3 FQHCs in NCACH's region the Bree Collaborative Dental Opioid Prescribing Guidelines. Discussed disseminating guidelines to private practice dentists in the region.	N

Social determinants of health Facilitated Discussions	4.3.18 - 4.4.18	NCACH hosted a series of facilitated discussions with transportation and housing service providers to learn more about transportation and housing as barriers to health in the North Central region.	Housing and Transportation Sector Partners	2A,2B,2C,2D,3A,3D	Feedback collected from these meetings resulted in a survey at the NCACH 2018 Annual Summit (4.20.18) as well as an NCACH staff retreat focused on operationalizing recommendations on health equity work.	N
Meeting with Central Washington Hospital and NCW BHO	4.4.18	NCACH, CWH, and BHO met to learn more about CWH's MU1 during the FIMC transition.	BHO	2A, 2C, 2D	Community connection.	N
Chelan-Douglas CHI Meeting	4.11.18	Review Accountable Communities of Health and the Medicaid Transformation.	Chelan and Douglas Counties	2A,2B,2C,2D,3A,3D	NCACH staff provided an "NCACH 101" presentation.	N
Meeting with Catholic Charities Housing Program	4.12.18	Learn about the housing program Catholic Charities of Yakima Diocese is currently work on and what their needs are in NCACH's region.	Catholic Charities Housing Staff/Volunteers	2A,2B,2C,2D,3A,3D	Referred Catholic Charities Housing programs to local connections in the community they can reach out to and get additional information.	N
Jail Services Meeting	4.12.18	Development of a regional jail liaison program in Grant, Chelan, and Okanogan County.	Jail Directors, Behavioral Health Staff, MCOs	2D	Progressed in next steps of the planning process.	N
Community Health Worker Conference	4.12.18	Statewide Community Health Worker Conference in Lynnwood, WA.	Community Health Workers from	2B	To better understand the role of the Community Health Worker and opportunities within NCACH's	N

			across the state		Transformation work. Learned about Mental Health Peers.	
Grant County CHI Meeting	4.13.18	Share NCACH updates. Establish Grant County CHI Leadership Council. Review NCACH Projects and project Workgroup activities.	Grant County	2A,2B,2C,2D,3A,3D	Grant County CHI Leadership Council established. Reviewed NCACH projects and project work, including the open application for Rapid Cycle Opioid Project funding.	N
Wenatchee Chamber of Commerce Leadership Cohort Presentation	4.13.18	To share an overview of NCACH and the Medicaid Transformation as a part of the Wenatchee Chamber of Commerce's Leadership Cohort.	Wenatchee business leaders	2A,2B,2C,2D,3A,3D	Was able to connect directly with the business community in Wenatchee, and establish direct connections between businesses in the room and partners in need (Wenatchee Valley Humane Society's "Pets for Life" program with City of Wenatchee's Homeless Task Force).	N
Chelan Douglas Health District Board of Health	4.16.18	NCACH Executive Director delivered update and informational presentation to CDHD Board of Health.	CDHD Board of Health	2A,2B,2C,2D,3A,3D	Outreach and networking.	N
Informal meeting: NCACH, HCA's Director Birch, and Confluence Health	4.18.18	Senator Parlette hosted an informal meeting between Director Birch and partnering provider, Confluence Health, to discuss Value-Based Purchasing.	HCA, partnering providers	2A,2B,2C,2D,3A,3D	Senator Parlette connected Confluence Health, the region's largest health care system, with HCA Director, Sue Birch, to discuss Value-Based Purchasing and contracting.	N
NCACH Executive Director takes HCA Director,	4.19.18	Director Birch accepted Senator Parlette's invitation to go on a 309-mile day-driving trip around NCACH region, visiting 10	NCACH, HCA	-	Director Birch was able to visit NCACH for the first time and see how NCACH's rural healthcare systems	N

Sue Birch, on tour of NCACH region		partnering provider clinics across four counties.			differ from more concentrated and urban areas.	
NCACH hosts videoconference with Director Birch for providers	4.19.18	Director Birch speaks to providers across NCACH region via videoconference.	Partnering Providers, HCA	-	Director Birch was able to connect with local providers working in NCACH.	N
NCACH 2018 Annual Summit	4.20.18	Convene stakeholders, partners, and providers to learn about NCACH, the Medicaid Transformation, and to hear from others who have led similar programs and initiatives in healthcare delivery transformation.	Chelan, Douglas, Grant, and Okanogan Counties	2A,2B,2C,2D,3A,3D	Convened over 200 community stakeholders to learn more about the NCACH, how to address the social determinants of health, local opioid initiatives occurring in the region, and to gather feedback on recent focus groups convened on transportation and housing across NCACH.	N
Wenatchee Valley Law Enforcement/ NCACH meeting	4.19.18	Meet with local law enforcement to outline what could be done to support tracking progress of different initiatives/protocols developed between healthcare and law enforcement.	Local Law Enforcement partners	2D	Developed a plan to define protocols across law enforcement and healthcare and discussed the data collection component NCACH can assist with.	N
Chelan Hospital Guild B Luncheon	4.23.18	NCACH Executive Director delivered informational presentation to Chelan Hospital Guild B Luncheon.	Lake Chelan Community Hospital	2A,2B,2C,2D,3A,3D	Outreach and networking.	N
Narcan "Save" Follow-up Meeting	4.23.18	To explore developing a program where individuals who are successfully revived after an opioid overdose through the administration of Narcan would	Opioid Stakeholders and Treatment Providers	3A	Discussed options for making opioid overdoses a notifiable condition on the Health Officer's orders in Chelan and Douglas Counties and how referral to treatment would work.	N

		be connected to treatment and peer support services.				
FIMC Presentation at Okanogan County Commissioners Meeting	4.24.18	NCACH Executive Director presented on FIMC process to Okanogan County Commissioners.	Okanogan County	-	NCACH has established a relationship with the Okanogan County Commissioners, which will help keep lines of communication open as FIMC is implemented in Okanogan County in 2019.	N
Okanogan County CHI Meeting	4.24.18	Recap NCACH 2018 Annual Summit. Begin discussing FIMC implementation for Okanogan County. Develop action plan to apply for the Rapid Cycle Opioid Funding released from the Regional Opioid Stakeholders Workgroup.	Okanogan County	2A,2B,2C,2D,3A,3D	Members established that they wanted to use the Okanogan County CHI as a place for FIMC updates, particularly for consumer engagement related to FIMC. Group identified a series of viable projects to apply for Rapid Cycle Opioid Project Funding.	N
NCACH/MCO Meetings	4.25.18	Discuss what VBP means in regards to NCACH projects.	MCO Partners	2A,2B,2C,2D,3A,3D	Determined that a number of VBP discussions may need to occur in individualized meetings between the ACH and MCOs.	N
City of Wenatchee Homeless Task Force Meeting	5.1.18	City of Wenatchee convened service providers and community stakeholders to discuss the assessment for a low-barrier shelter for Chelan and Douglas Counties.	Chelan and Douglas Counties	2B, 2C, 2D, 3A	Group reviewed current state assessment developed for low barrier shelter services and provided feedback.	N
NCACH Executive Director gives	5.2.18	NCACH Executive Director was invited to give the	WSU School of Pharmacy	-	Outreach and networking.	N

commencement speech at WSU School of Pharmacy graduation		commencement speech at the WSU School of Pharmacy.	and greater community			
MCO Symposium Planning Meeting	5.2.18	MCOs and NCACH plan for the North Central MCO Symposium Post-FIMC.	MCO Partners	2A	Planned for MCO symposium on May 9th.	N
Una Platica		NCACH staff attended a partner presentation on trauma-informed care and resilient communities, which included a jail re-entry simulation.	Okanogan County	2C, 3A	Outreach and networking.	N
Chelan-Douglas CHI Meeting	5.9.18	Review community success stories to develop new ideas for CHI-led initiatives. Review HCA performance metrics and determine how CHI can complement NCACH work through prevention strategies and community partnerships.	Chelan and Douglas Counties	2A,2B,2C,2D,3A,3D	Group reviewed HCA performance metrics and began developing initiative matrices, which outlined prevention strategies and action steps that the community could take to complement NCACH project work. Group voted to continue developing matrices at June meeting.	N
FIMC MCO Symposium	5.9.18	Allow providers to meet with all 3 MCOs together to ask questions.	MCO Partners, Behavioral Health Providers	2A	Behavioral Health Providers were able to get clarification on many remaining questions.	N
Seeking a Collective Vision for a Common	5.14.18	Develop a common vision for an asset inventory.	State partners, ACHs	2B	Identified necessary functions and features of a successful asset inventory.	N

Community Inventory						
Regional Hospital Council Meeting	5.15.18	Review current issues occurring across the region for the hospital entities.	Hospital Executives	2A, 2B, 2C,2D,3A, and 3D	Provided update to hospital Executives on NCACH work to ensure individuals continue to stay informed of progress on Transformation Project.	N
Governors Poverty Reduction Workgroup Meeting	5.17.18	Gain a better understanding of the work occurring at a statewide level of poverty reduction and the recommendations that will be generated from that working group.	Governor's Poverty Workgroup Members	2A,2B,2C,2D,3A,3D	Gained a better understanding of workgroup tasks and objectives over next year. Made connections with the workgroup members in NCACH region for additional follow up on local work.	N
Meeting with CEO of Quincy Valley Medical Center	5.17.18	NCACH was able to able to make a face-to-face connection with potential partnering provider, Quincy Valley Medical Center.	Quincy Hospital	2A,2B,2C,2D,3A,3D	Outreach and networking; Quincy Valley Medical Center later considered as a partnering provider on TCDI Workgroup approaches.	N
NCW Opioid Stakeholders Meeting	5.17.18	Share current opioid initiatives and collaborate on new or emerging initiatives.	Chelan, Douglas, Grant Counties	3A	NCACH reported on Rapid Cycle Opioid Application and Narcan "save" follow-up program.	N
North Central Funding Collaborative Workgroup	5.17.18	Gain feedback on ESSB 6032 funding opportunity and North Central Plans.	MCOs, ASO, Behavioral Health Providers, Law Enforcement	2A	Group identified priorities to be (1) recruitment and retention of behavioral health clinical staff, (2) regional jail liaison program, and (3) expansion of Clubhouse model in Okanogan County.	N

Entiat Valley Services Health Fair	5.18.18	A health services fair for people (especially Medicaid beneficiaries) who live in greater Entiat, WA.	Community members	2A,2B,2C,2D,3A,3D	Was able to make community connections and recruit for the Chelan-Douglas CHI.	N
ACHs selected to submit "Lessons Learned from Engaging with Communities " document to Group Health Foundation	5.18.18	ACHs are invited to submit application for small award on "Lessons Learned from Engaging with Communities" to Group Health Foundation. NCACH, HealthierHere, and Better Health Together selected.	Group Health Foundation, ACHs	2A,2B,2C,2D,3A,3D	NCACH to submit a document outlining community engagement strategies and lessons learned to Group Health Foundation.	N
Caravan Health	5.23.18	Learn more about the ACO model that is specific to Medicare, but which has many common elements with the Medicaid Transformation.	NCACH		Improved understanding of how this model works and how it might align with the Medicaid Transformation. This is important given that some of NCACH's providers are also engaged in this Medicare transformation work, and NCACH needs to do its part to understand how to promote alignment and dispel confusion.	N
North Central Funding Collaborative Workgroup	5.23.18	Gain feedback on North Central ESSB 6032 draft plan.	MCOs, ASO	2A	Group reviewed draft plan for submission.	N
Chelan-Douglas Workforce Collaboration Summit	5.30.18	A Summit for social service providers (especially employment services) to learn more about one another and strengthen community referral network.	Employment and social service providers in Chelan and	2B, 2C, 2D	Through the summit, NCACH was able to invite Skillsource (hosting agency) to attend each of the CHI meetings to share work and resulting resource: The NCW Partnership Directory. Once completed, the Directory will be a referral resource	N

			Douglas Counties		that will be invaluable to many of NCACH's partnering providers.	
EMS Meeting with Law Enforcement and Parkside	5.31.18	Review protocols for transport to a mental health facility instead of the Emergency Department.	EMS and Healthcare providers	2D	Reviewed current protocol options for transport to regional mental healthcare facility and outlined next steps to finalize process.	N
ACH Directors present at The Forum, a group of CEOs from Washington State's major health systems	6.1.18	NCACH Executive Director was invited along with HealthierHere and Pierce County ACH to attend and present at The Forum.	Healthcare systems, ACHs	-	Community connection and education.	N
Workforce Collaboration Call	6.5.18	Discuss workforce development collaboration opportunities with WACMHC.	WACMHC, NCACH	-	NCACH learned of WACMHC's InReach program for Medical Assistant apprenticeships.	
Meeting with WA Health Care Association and Area Agencies on Aging	6.7.18	NCACH Executive Director met with WA Health Association and Area Agencies on Aging to discuss upcoming legislation to provide long-term care insurance for all.	Agency partners	-	Community connection.	N
North Central WA Re-entry Program Call	6.8.18	Explore developing a program similar to South Seattle College's Life-Skills-2-Work Program.	Criminal Justice, Education, WorkSource, Healthcare	2C	Determined there was enough interest from stakeholders to organize an in-person meeting in June to explore possibilities.	N

Washington State Ambulance Association Meeting	6.11.18	Update Washington State Ambulance partners on the work of NCACH, gain a better understanding of the issues private partners are dealing with across Washington State.	Association Members	2D	Reviewed Transformation project with members. NCACH was able to establish a connection with statewide ambulance advocacy groups, and local partners.	
Okanogan County FIMC Provider Meeting	6.12.18	A regular monthly meeting of providers and MCOs/ASO to prepare for Okanogan County's transition to Fully-Integrated Medicaid Contracting on January 1, 2019.	Okanogan County, MCO Partners	2A	There was an overview of what FIMC is, the process NCACH will use to prepare for FIMC, and in depth presentation by Beacon Health Options.	N
Grant County CHI Meeting	6.12.18	CHI members to elect new Grant County CHI Board Seat (after shift in NCACH Governing Board openings). CHI members to select initiative to focus on in Grant County.	Grant County	2A,2B,2C,2D,3A,3D	The group identified focus areas and community need, landing on families and communities who are affected by substance use/misuse by family members. The Grant County CHI will begin to identify opportunities to impact families, especially youth, upstream of substance use/misuse.	N
Presentation at Grant County Board of Health	6.13.18	NCACH Executive Director shared updates and presentation on NCACH to Grant County Board of Health.	Grant County Board of Health	2A,2B,2C,2D,3A,3D	Outreach and networking.	N
Chelan-Douglas CHI Meeting	6.13.18	Continue developing initiative matrices focused on HCA Performance Metrics and preventative strategies. Provide feedback to the City of Wenatchee's Homeless Task	Chelan and Douglas Counties	2A,2B,2C,2D,3A,3D	CHI members learned about the upcoming low-barrier shelter services coming to Chelan and Douglas Counties. CHI continued developing ideas for action strategies to take to	N

		Force's plan for a low-barrier shelter mandated by Department of Commerce in every county by July 1, 2018.			complement NCACH project objectives.	
Pathways Hub 2-day Strategic Design Workshop	6.13 & 6.14	HUB Workgroup Core Team to dive deeper into HUB planning, target population, and capacity assessments.	Pathways Community Health Advisory Board	2B	HUB workgroup selected target population, expansion plan, elevator speech, reviewed and selected IT platform, set target launch date.	N
Presentation at Premera Blue Cross	6.18.18	NCACH Executive Director joined other ACH Directors to present information about ACHs, especially rural ACHs, to Premera Blue Cross executives.	Premera Blue Cross, ACHs	2A,2B,2C,2D,3A,3D	Outreach and networking.	N
City of Wenatchee Homeless Task Force Meeting	6.19.18	City of Wenatchee convened service providers and community stakeholders to discuss the assessment for a low-barrier shelter for Chelan and Douglas Counties.	Chelan and Douglas Counties	2B, 2C, 2D, 3A	NCACH presented at the Homeless Task Force Meeting, and was able to make connections with several service providers interested in learning more about NCACH and Initiative 3.	N
Presentation at Wenatchee Kiwanis	6.19.18	NCACH Executive Director shared presentation with local Kiwanis on NCACH and Medicaid Transformation efforts.	Kiwanis	2A,2B,2C,2D,3A,3D	Outreach, networking, and education.	N
North Central WA Re-entry Program Meeting	6.21.18	Explore developing a jail re-entry program in North Central WA. Reviewed shared interests, available resources, and opportunities.	Criminal Justice, WorkSource, Education, Healthcare	2C	Decided to pursue further developing a Jail Re-entry Navigator Program, ways to reduce stigma through things such as hope cafes, and strengthening linkages between WorkSource,	N

					healthcare, and jails/juvenile detention centers.	
Okanogan County CHI Meeting	6.26.18	Listen to a presentation from WA 2-1-1. Learn more about Okanogan County-based Rapid Cycle Opioid Projects from award recipients.	Okanogan County	2A,2B,2C,2D,3A,3D	Group heard from Rapid Cycle Opioid Project award recipients based in Okanogan County and identified ways that the CHI could support the success of the projects. Group also heard a presentation from WA 2-1-1 and were able to connect directly with both the call center service representatives and the statewide WA 2-1-1 service provider.	N
CDP Study Interview with Worksource	6.26.18	NCACH intern interviewed WorkSource staff to help understand CDP shortages in its region.	WorkSource Staff	3A	Throughout the summer, the intern will interview 10-15 key informants to gain a better understanding of CDP shortages in NCACH's region and potential policy advocacy opportunities for the NCACH.	N
Informal meeting between NCACH, HCA Director Birch, and Representative Eileen Cody	6.26.18	NCACH Executive Director joined State Legislator and Director Birch to discuss ACHs.	Local legislators, HCA	-	Outreach and networking.	N
NCACH Executive Director 42nd Annual WSHA	6.27.18	NCACH Executive Director sat on panel to share how local hospitals are involved with NCACH projects.	Washington State Hospital Association	2A,2B,2C,2D,3A,3D	Outreach and networking.	N

Conference as panelist						
Interview for Group Health Foundation by Urban Institute	6.28.18	Through data collected by Urban Institute, Group Health Foundation is contacting ACHs to learn more about health equity.	Group Health Foundation	2A,2B,2C,2D,3A,3D	NCACH Executive Director and staff were interviewed on questions relating to health equity and community engagement .	N

It is worth noting that because of the rural nature of the region and Executive Director Senator Parlette's unique skillset (first as a practicing pharmacist and then as a state legislator for 20 years), many organizations and individuals still contact Senator Parlette for advice and consultation, especially as it pertains to the state legislature. Senator Parlette is a trusted leader in the region, especially among healthcare organizations and systems. She has a long history of advocating for rural populations and healthcare systems and is respected statewide for her work as a healthcare champion. Senator Parlette frequently convenes meetings and facilitates important connections that advance the region's health goals and priorities. Additionally, because of Senator Parlette's tenure at the State's Capitol, she has been able to secure legislation to benefit Medicaid Transformation projects and to initiate some important connections and outreach opportunities for ACHs statewide.

Another community initiative worth noting is the opening of a crisis stabilization center, called Parkside, in the NCACH region. Senator Parlette helped secure funding and legislation for Parkside while she was serving as a legislator and has remained very involved in facilitating community connections to help support Parkside as it prepares to open this year. Notably, Senator Parlette and NCACH staff have been attending meetings between local law enforcement and Parkside staff to help establish protocols for law enforcement and EMS providers who may transport individuals who are eligible for Parkside's services. Once opened, Parkside will complement many of the initiatives NCACH has developed through its Medicaid Transformation projects and will provide a critical service for the region.

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

ACH Response:

NCACH is fortunate to have many partnering providers who are culturally responsive to the needs of their communities, often employing multilingual staff members and translators, and releasing information in both English and Spanish. Many of NCACH's partnering providers and MCOs provide mobile outreach and services to the region's large migrant agricultural workforce. Recognizing that NCACH's role within the scope of Medicaid Transformation is intermediary between partnering provider organizations, it has relied heavily on partnering providers to reach out to the populations they serve regarding important Medicaid Transformation-related measures and initiatives.

When Chelan, Douglas, and Grant counties became mid-adopters of FIMC in January 2018, NCACH and its partnering providers advocated for the creation of pamphlets with information in both Spanish and English to be sent in a mailing campaign to local Medicaid beneficiaries. NCACH is currently assisting providers in Okanogan County as they transition to FIMC in January 2019, including providing a project timeline and resources in both Spanish and English for consumer engagement.

NCACH has added a Google Translate feature to its website, making it available for translation in any language offered in the Google Translate software. The community stakeholder survey currently being implemented by NCACH's CHI (referenced earlier) is

available in both English and Spanish, and NCACH remains responsive to the needs of partnering providers as their needs develop. Moving forward, NCACH plans to reach out to partnering providers as the Medicaid Transformation progress to see if there is a specific role that the ACH can play in continued engagement with populations with limited proficiency in English.

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

ACH Response:

As NCACH began developing project plans, it became clear that the primary focus of NCACH's efforts would fall in the realm of clinical transformation efforts, with much of its energy during the reporting period aimed at creating project workgroups and developing implementation plans. NCACH has wide representation from clinical partners, with 17 partnering provider organizations in the WPCC Learning Community, and many community-based organizations and government agencies participating in other project workgroups and CHI.

NCACH has heard from the CHI that Transformation efforts, specifically the selected projects, do not place enough emphasis on children. The superintendent of the North Central Educational Service District (serving 29 school districts across NCACH's four-county region) is on the NCACH Governing Board, another Educational Service District staff member on the Opioid Project Workgroup and another on the Leadership Council for the Chelan-Douglas Coalition for Health Improvement, but the formal role for schools and educational partners in NCACH's Medicaid Transformation is very limited. NCACH realizes this, however, and is actively working to recruit more education partners in their CHIs, which have attendees from early learning programs, public schools, and local community colleges.

Law enforcement has also been identified as a group that is underrepresented in NCACH's Transformation efforts. Although law enforcement has been represented on the TCDI Workgroup and the Opioid Project Workgroup, both workgroups have selected approaches that are more clinically focused, and do not have as much opportunity for law enforcement to be funded partners. Moving forward, NCACH and its partnering providers are continuing to develop opportunities for law enforcement to interact with the Transformation projects, especially in regards to TCDI projects.

As it relates to Addressing the Opioid Use Public Health Crisis, NCACH has had little inclusion from, or for, the recovery community. Many of the approaches identified in NCACH's Regional Opioid Stakeholders Workgroup target individuals who are entering recovery and to prevent others from using or misusing opioids, but little emphasis has been placed on those who are actively in recovery. NCACH's CHIs hope to engage more of the recovery community in their work to address opioid use within the community. The Grant County CHI, for example, has identified the recovery community as an important ally in their hopes to reach families (especially children) affected by a family member's opioid use and to navigate upstream prevention measures. The Okanogan County CHI has members of the recovery community regularly attend their meetings and

are exploring ways to provide more inclusion for the recovery community in their local efforts to address the opioid use public health crisis in Okanogan County.

The Confederated Tribes of the Colville Reservation is underrepresented in NCACH's Transformation efforts. NCACH is fortunate to have a strong advocate and tribal partner on its Governing Board, but has experienced difficulty engaging the tribes to participate in Medicaid Transformation efforts. NCACH recognizes this, however, and is committed to continuing to explore opportunities for meaningful partnership with tribal partners.

NCACH's most promising opportunity for continued or increased engagement with community groups that are underrepresented in its Transformation efforts is through the CHIs. In July 2018, the CHIs are conducting stakeholder surveys gleaning community feedback on challenges to health, health equity, and opportunities for each CHI to identify local priorities to address at the county level. Through these surveys, the CHIs and the ACH as a whole anticipate learning more about how to best engage underrepresented communities in the Transformation, and how to include them as partners in health in Transformation efforts region-wide.

F. Health Equity Activities

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

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

   ACH Response:

   NCACH has been working to embed health equity into its Medicaid Transformation projects. At the core of whole-person care is the understanding that part of this work will be to address health equity by addressing the social determinants of health.

   In May 2018, NCACH staff met with OHSU's Center for Evidence-based Policy (Center) to determine how to best operationalize health equity within its work. Center staff reviewed the recommendations from the 2018 Annual Summit (April 2018) regarding housing and transportation, along with current state assessments from each of the project workgroups. Based on the recommendations from Annual Summit participants and the project implementation plans, NCACH has decided to operationalize health equity in the following ways:

   - Creating a 1.0 FTE position dedicated to building organizational capacity and fundraising support to housing and transportation agencies across the region
   - Making health disparity data available and accessible as a resource for NCACH's partnering providers and organizations whose work aligns with Medicaid Transformation work
   - Contracting with an asset-mapping specialist to update and enhance current

regional partner and service provider directories to increase connectivity to resources and services

NCACH's belief is that by making these resources available to community partners, it can continue co-creating solutions to address health equity together.

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

ACH Response:

NCACH is dedicating resources to address some of the social determinants of health that create inequities for Medicaid (and other community) members in the region. NCACH relies on its partnering providers and the CHI to infuse community needs into its work. For example, NCACH's WPCC providers are being tasked with addressing social determinants of health in their care services, including using screening tools and community referrals to ensure that people are receiving whole-person care.

Based on feedback from the 2016 Community Health Needs Assessment process, housing and transportation were repeatedly identified as barriers to health. As mentioned in prior sections, facilitated discussions in April 2018 surfaced common misconceptions, organizational barriers, and recommendations for how NCACH could prioritize investments to support social determinants of health. NCACH has created a new position dedicated to building capacity and providing fundraising support to community organizations focused on housing and transportation. As a means of regional capacity development and equity work, NCACH is also planning on sharing data on its website and with partnering providers that highlights health disparities in the region. Some of this may involve drawing from publicly available data sources and filtering/packaging information specific to NCACH's region. NCACH may also draw on relationships with data contractors to help analyze and show health disparities using data products from the HCA. Monitoring health disparity data will help prioritize equity issues in NCACH's work, while allowing community partners to use this information in their work and funding proposals.

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

ACH Response:

The rural nature of the region means that providers and patients often have to travel great distances, or expend significant staff resources, to provide care across NCACH's region. NCACH and other ACHs have had to champion for rural healthcare systems throughout the Transformation process, as value-based and risk-based contracting are best applied to higher-volume providers. In an attempt to help NCACH's partnering providers in the WPCC (addressing Bi-Directional Integration and Chronic Disease Prevention and Control), NCACH has designed a funding model that offers financial

support to offset the cost of staff participation in the collaborative's process improvement efforts. Payments are adjusted based on the number of Medicaid patient encounters, but they do not track encounter volume commensurately. This has helped some of the region's smaller healthcare organizations to participate in process improvement along with the region's larger healthcare systems. Similarly, NCACH partnering providers contributing to TCDI work will receive a base amount for participating in a collaborative effort to reduce inappropriate emergency department use, regardless of volume or size. By reducing the barriers for participating, NCACH is ensuring that smaller partners are able to participate as well as larger groups, which means more equitable access to care for all.

The change plan template for NCACH's WPCC includes specific strategies that are designed to help its providers take action to promote health equity. Although health equity is not a distinct topic or section, multiple tactics are embedded in the template. For example, (1) ensuring that patient education materials are culturally and literacy appropriate, (2) training staff on the cultures represented in provider practices, and (3) supporting linguistic and cultural competency while screening for social determinants of health. NCACH has an entire section of the change plan template dedicated to social determinants of health outlining suggested actions and goals providers can take. It also explored specific social determinants of health screening tools (e.g. PRAPARE, EveryONE Project, Health Leads). Based on input from partnering providers, NCACH decided not to recommend a specific tool, but rather a core set of questions that it would want all of its outpatient providers to screen for, regardless of the tool. NCACH is still working on compiling this core list of questions and hopes to dovetail social determinants of health screening with referrals to the Pathways HUB. As NCACH works on this, it plans to monitor the use of screening tools among providers and work with them to compile a regional picture of social determinants of health needs based on this data.

In addition to NCACH's six selected Transformation projects, it is investigating and moving forward with initiatives that will support its project portfolio, including a Community Paramedicine model with 10 participating EMS providers across the region, a 24-hour nurse line, and a staff position dedicated to providing technical assistance and building capacity to address housing and transportation as regional barriers to health. These efforts are intended to increase access to care and remove barriers for NCACH residents to receive support services, which will close opportunity gaps that lead to health differences.

G. Budget and Funds Flow

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

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

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

Yes	No
X	

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

      ACH Response:

      The audit did not have any audit findings and all minor questions were resolved.

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

      ACH Response:

      Not Applicable

2. Design Funds

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

3. DY 1 Earned Incentives

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

4. Integration Incentives

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

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

ACH Response:

Integration incentive funding will be distributed to partners based on NCACH's overall funding principles. Every dollar received through the Transformation project goes into a global budget, which is then allocated based on recommended allocation strategies approved by the Governing Board. NCACH does not distinguish funding based on how those dollars were received. Through their sector representation on the NCACH Governing Board, involvement in the WPCC and representation in NCACH project workgroups, behavioral health providers are able to directly affect how funding is allocated. Specific to the WPCC, behavioral health provider organizations will submit independent process improvement change plans, which will help them better adapt to FIMC, prepare for VBP, and complete the integration work needed to provide better care for their patients. In addition to these measures, NCACH is reviewing the option to utilize funding to enhance interoperability between EHRs of behavioral health and physical health providers. If implemented, this will allow for better communication between providers and ensure true integration between organizations.

To ensure that all county commissioners stay informed about the Transformation progress/status, the NCACH Executive Director attends board of health meetings (the boards of health are composed of county commissioners and local elected officials) in the three local health jurisdictions (Chelan-Douglas, Grant, and Okanogan) semiannually. As Okanogan County adopts FIMC (January 2019), NCACH has met with county commissioners to ensure open communication and that the transition occurs smoothly for behavioral health providers. This model for engagement of behavioral healthcare providers and county government has received support from all local agencies in NCACH's community.

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

ACH Response:

NCACH does not categorize funds based on the source of DSRIP funding (e.g. design funds, integration funds, and VBP incentive funds). Therefore, stewardship and transparency of every fund type of the Transformation will be upheld by the same principles and policies of all NCACH funds. Funding transparency is achieved by only allowing motions for funding allocations to occur at public Governing Board meetings. NCACH's Governing Board has the final approval of all Transformation funds that are distributed by NCACH. Meeting minutes are published on the NCACH webpage and distributed to community partners.

Although NCACH does not distinguish between the source of funds when distributing funding to partners, NCACH has supported partnering providers that have and/or are moving toward integration. To determine the funding needs of

partnering providers, NCACH continues to stay in communication with Chelan, Douglas, and Grant behavioral health providers through monthly Early Warning System meetings, which were established to identify current issues with FIMC. NCACH has established regular FIMC meetings in Okanogan County (2019 mid-adopter), which include routine conversations with providers. NCACH staff use needs identified by providers through these channels to develop recommendations to the Governing Board. Below are examples of specific integration funding that has been supported by the Governing Board:

1. NCACH contracted with Feldesman Tucker Leifer Fidell LLP to provide contracting technical assistance and review for behavioral health providers with limited experience contracting with MCOs.

2. NCACH provided IT and billing technical support through Xpio to behavioral health providers that needed assistance in making adjustments to their medical record systems to better be able to bill MCOs for services provided.

3. Staffing support to coordinate the partners and workflows through the FIMC process over the next year continues to be provided in Okanogan County to ensure that providers have the resources to successfully move toward integration.

As additional integration-specific needs arise for providers, NCACH will evaluate and address those needs to the NCACH Governing Board for support (funding or other), as appropriate.

Finally, to verify that all funded partners that NCACH partners with through the Transformation serve Medicaid patients, NCACH will distribute funding in smaller payments to partners (quarterly/monthly) based on reporting requirements. Therefore, if a provider no longer provides services to Medicaid patients, NCACH is able to evaluate the situation and determine whether funding will continue to that organization in the future.

5. Total Medicaid Transformation Incentives

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