Healthier Washington Medicaid Transformation

Accountable Communities of Health

Semi-annual report Template

Reporting Period: July 1, 2018 – December 31, 2018

January 25, 2019

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Attachments:

- Semi-annual report workbook
- Organizational self-assessment of internal controls and risks

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

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

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

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

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved Project Plans and corresponding Implementation Plans. HCA and the IA will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted at any subsequent time for purposes of monitoring and auditing, or general follow-up and learning discussions with the state (HCA), the Independent Assessor (IA) and/or the Independent External Evaluator (IEE).

Reporting requirements

The semi-annual report template for this reporting period includes four sections as outlined in the table below. With one exception, the reporting period for this semi-annual report covers July 1, 2018 to December 31, 2018.[1] Sections 1 and 2 instruct ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 4 per the Medicaid Transformation Toolkit. Sections 3 and 4 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

> Note: Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:
>
> - The ACH as an organization
>
> - The ACH's partnering providers
>
> - The ACH and its partnering providers
>
> Please read each prompt carefully for instructions as to how the ACH should respond.

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[1] The reporting period for Value-based Payment (VBP) milestones covers the full calendar year, January 1 through December 31, 2018.

ACH semi-annual report 2		
Section	**Reporting period**	**Sub-section description**
Section 1. Required milestone reporting (VBP Incentives)	DY 2, Q1-Q4	Milestone: Inform providers of value-based payment (VBP) readiness tools to assist their move toward value-based care
		Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH
		Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey
		Milestone: Support providers to develop strategies to move toward value-based care
Section 2. Required milestone reporting (Project Incentives)	DY 2, Q3-Q4	Milestone: Support regional transition to integrated managed care (2020 regions only)
		Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)
		Milestone: Engagement/support of Independent External Evaluator (IEE) activities
Section 3. Standard reporting requirements (Project Incentives)	DY 2, Q3-Q4	ACH organizational updates
		Tribal engagement and collaboration
		Integrated managed care status update (early- and mid-adopters only)
		Project implementation status update
		Partnering provider engagement
		Community engagement and health equity
		Budget and funds flow
Section 4. Provider roster (Project Incentives)	DY 2, Q3-Q4	Completion/maintenance of partnering provider roster
Section 5. Integrated managed care implementation (Integration Incentives)	N/A	Milestone: Implementation of integrated managed care (mid-adopters only)

Key terms

The terms below are used in the semi-annual report and should be referenced by the ACH when developing responses.

1. **Community engagement**: Outreach to and collaboration with organizations or

individuals, including Medicaid beneficiaries, that are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

2. **Health equity**: Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.[2]

3. **Integrated managed care:**

   a. **Early-adopter:** Refers to ACH regions implementing integrated managed care prior to January 1, 2019.

   b. **2020 adopter:** Refers to ACH regions implementing integrated managed care by January 1, 2020.

   c. **Mid-adopter:** Refers to ACH regions implementing integrated managed care on January 1, 2019.

4. **Key staff position**: Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, and Program Management and Strategy Development.

5. **Partnering provider**: Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

6. **Project areas:** The eight Medicaid Transformation projects that ACHs can implement.

7. **Project Portfolio**: The full set of project areas an ACH has chosen to implement.

Achievement Values

Throughout the transformation, each ACH can earn Achievement Values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).

2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).

ACHs can earn AVs by providing evidence of completion of reporting requirements and demonstrating performance on outcome metrics. The amount of incentive funding paid to an ACH will be based on the number of earned AVs out of total possible AVs for a given payment period.

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

All possible earned incentives for the second semi-annual report are associated with P4R. The required P4R deliverables and milestones for the second semi-annual reporting period are identified in the table below.

Deliverable/Milestone	One-time / Recurrent	Reporting Period	AVs
Section 1. Required milestone reporting (VBP Incentives)			
Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH	One-time	DY 2, Q1-Q4	1.0
Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey	One-time	DY 2, Q1-Q4	1.0
Milestone: Support providers to develop strategies to move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Section 2. Required milestone reporting (Project Incentives)			
Milestone: Support regional transition to integrated managed care (2020 regions only)	One-time	DY 2, Q3-Q4	1.0
Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	One-time	DY 2, Q3-Q4	1.0
Milestone: Engagement/support of Independent External Evaluator (IEE) activities	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 3. Standard reporting requirements (Project Incentives)			
Deliverable: Complete and timely submission of SAR. *Note: All non-milestone, standard reporting requirements are a part of the SAR 1.0 AV.*	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 4. Provider roster (Project Incentives)			
Deliverable: Completion/maintenance of partnering provider roster	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 5. Integrated managed care implementation (Integration Incentives)			
Milestone: Implementation of integrated managed care (mid-adopters only)	One-time	N/A	N/A

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the Independent Assessor **no later than January 31, 2019 at 3:00p.m. PST.**

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

ACHs must submit their semi-annual reports through the WA CPAS, which can be found at https://cpaswa.mslc.com/.

ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled "Semi-Annual Report 2 – January 31, 2019."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 2 – January 31, 2019.

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

File format

ACHs must respond to all items in the Microsoft Word semi-annual report template and the Microsoft Excel semi-annual report workbook based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

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

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

- *Main Report or Full PDF:* ACH Name.SAR2 Report. 1.31.19

- *Excel Workbook:* ACH Name. SAR2 Workbook. 1.31.19

- *Attachments:* ACH Name.SAR2 Attachment X. 1.31.19

***Note that all submitted materials will be posted publicly to HCA's Medicaid Transformation resources webpage.*[3]**

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

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[3] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

ACH semi-annual Report 2 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report template and workbook for reporting period 2 to ACHs	HCA	August 2018
2.	Submit semi-annual reports	ACHs	Jan 31, 2019
3.	Conduct assessment of reports	IA	Feb 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2019
7.	Issue findings to HCA for approval	IA	End of Q2

Contact information

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH contact information

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

ACH name:	Olympic Community of Health
Primary contact name **Phone number** **E-mail address**	Margaret Moore (360) 689-2345 margaret@olympicch.org
Secondary contact name **Phone number** **E-mail address**	JooRi Jun (360) 900-3539 joori@olympicch.org

Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

1. **Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

   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 informing providers of and/or disseminating readiness tools. If the ACH checked "Yes" in item A.1, respond "Not applicable."

   ACH response:

   Not applicable.

3. In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
Providers with low Value-Based Payment (VBP) knowledge: 1) Primary care, behavioral health and hospital Implementation Partners with **low**	Change Plan site visits and resource sharing on Olympic Reporting and Community Activities (ORCA) platform	August 2018- December 2018	All Implementation Partners were offered a site visit to assist in completing the Change Plans. Change Plans include required targeted Outcomes and Tactics, co-designed by providers, with the purpose

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
levels of VBP knowledge			of preparing for value-based contracting

Value Based Payment (VBP) resource shared by the Practice Transformation Support Hub (PTSH) were uploaded on ORCA.
Title: Defining a Strategy for Value-Based Contracting

Link: https://waportal.org/resources/defining-strategy-value-based-contracting |
| *Small providers:* 2) Eleven local behavioral health agencies, including four community mental health centers and seven stand-alone substance use disorder treatment providers, six of whom would qualify as **small providers**, defined as ≤ 25 FTE. | On-site customized integrated billing support site visits | October 2018-December 2018 | On-site, intensive clinic support from the PTSH and Outlook Associates with use of the BHA Billing Toolkit developed by Outlook Associates. The Salish Behavioral Health Organization attended three of these site visits. The sites completed a self-assessment for Integrated Managed Care (IMC) readiness, on-site intensive interview with operational staff and a gap analysis and readiness score card for IMC, with listed recommendations to prepare for success in a new billing environment. |
| *Behavioral health providers:* 3) All **behavioral health agencies** in the Olympic region were invited to participate | Olympic Community of Health co-hosted with Cascade Pacific Action Alliance a two-part VBP and billing learning event in Shelton, WA | November 1 and 14, 2018 | Behavioral Health providers attended two days of intensive training by the PTSH and Washington Council on Behavioral Health. They |

VBP readiness tool dissemination activities			
Intended audience	**Communication method**	**Date**	**Specific tools provided**
			were required to complete the BHA Billing Toolkit survey prior to attendance and learned strategies for implementing quality improvement to prepare for VBP, and billing. Each team developed a project to practice quality improvement in a PDSA (plan-do-study-act) format.

Acronyms used in this table:
IMC – Integrated managed care, ORCA – Olympic Reporting and Community Activities, PDSA – Plan-do-study-act, PTSH – Practice Transformation Support Hub, VBP – Value-based payment

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

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

Yes	**No**
X	

5. If the ACH checked "No" in item A. 4 provide the ACH's rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked "Yes" in item A.4, respond "Not applicable."

   ACH response:

   Not applicable.

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	**Identified needs**	**Resources used**
NW WA Family Residency Medical Clinic and Kitsap Mental Health Services (KMHS), Bremerton	Integration plan for KMHS Behavioral Health Provider within NW Family Residency Medical Clinic to improve care coordination and close care gaps	Olympic Community of Health (OCH) Natural Community of Care Convenings Site visits by OCH staff Collaborative Care Model/Aims Center Resource Practice Transformation Support Hub (PTSH)/Qualis Health Practice Coach
Sophie Trettevick Indian Health Center (Neah Bay)	Assessment of current state to plan for integration of care Empanelment Project to 1) design system to confirm assignments, review and update panel assignments 2) Pilot use of panel data and registries to proactively contact, educate and track patients by disease and risk status	Coaching services from Pediatric Transforming Clinical Practices Initiative (P-TCPi) Practice Facilitator and PTSH/Qualis Health Practice Coach On-site assessment, action planning, quality improvement training and on-going technical assistance
Reflections Counseling Services Group	Linkages with Primary Care, Behavioral Health and Community-Based Organizations in Clallam county in preparation for Integrated Managed Care (IMC) Integrated Billing Support Project to asses gaps and plan for success in IMC billing environment Implement PreManage through P-TCPi sponsorship to decrease avoidable Emergency Department visits	P-TCPi Practice Facilitator and PTSH/Qualis Health Practice Coach assessments, action planning and PDSA (plan-do-study-act) projects since 2017 BHA Billing Toolkit completion, gap analysis and readiness report for IMC from Outlook Associates. Workflow mapping to close care gaps with no-show clients On-going technical assistance from Collective Medical and P-TCPi Practice Facilitator/Department of Health

Acronyms used in this table:
IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, OCH – Olympic Community of Health, PDSA – Plan-do-study-act, P-TCPi – Pediatric Transforming Clinical Practices Initiative, PTSH – Practice Transformation Support Hub

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH's efforts to support completion of the state's 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	**Incentives offered? (Yes/No)**	**New tactic? (Yes/No)**
Contractual expectation of provider: Copied the state provider survey into Olympic Community of Health's assessment and made completing the assessment a requirement for becoming an Implementation Partner	Yes	Yes
Post survey link to ACH website; email communication to broad distribution list: Email communication to broad distribution list	No	No
Individual communication with providers: Individual, targeted communication with providers that had not completed the survey	No	No

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	**Provider needs (e.g., education, infrastructure investment)**	**Supportive activities**	**Description of action plan: How provider needs will be addressed (if applicable)**	**Key milestones achieved**
Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.				
Provider with low VBP knowledge: Beacon of Hope/Safe Harbor Recovery, Port Townsend	Understanding of clinical reporting requirements under Value-based payment (VBP) Assessment of current billing practices and plan for transition to managed care Assessment of Electronic Health Record (EHR) capabilities for direct contracting with Managed Care Organizations (MCOs) Identification of Integrated Managed Care (IMC) workforce training needs and current skill gaps Building linkages for integration activities with primary care, community mental health and community-based organizations (CBOs)	Inclusion in MTP and commitment to NCC and Change Plan process OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner Coaching services to provide quality improvement (QI) culture training Current state assessment with the Practice Assessment Tool, The Maine Health Access Foundation Assessment or Patient-Centered Medical Home Assessment (PCMH-A) Pediatric Transforming Clinical Practices Initiative and Qualis Health action plan and on-going system of QI introduced to teams	Participation in OCH MTP NCC convenings and site visit by OCH staff Submission of Change Plan Participation in the Qualis Health On-site Integrated Billing Support Project and use of BHA Billing Toolkit	Engagement in OCH NCC and signed Change Plan completed Integrated billing readiness assessment completed, and gap analysis report received

ACH provider support activities				
Provider type	**Provider needs (e.g., education, infrastructure investment)**	**Supportive activities**	**Description of action plan: How provider needs will be addressed (if applicable)**	**Key milestones achieved**
Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.				
Small provider: Kitsap Medical Group, Bremerton	Linkages with primary care, behavioral health and CBOs in the region to develop integration strategies Technical assistance to prepare and sustain Collaborative Care Model staffing, documentation and billing to improve clinical care	Inclusion in MTP and commitment to NCC and Change Plan OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner Request for contacts in rural and remote area primary care clinics who have implemented telepsychiatry and Collaborative Care	QI team formed and protected time for QI activities Three completed PCMH-A and action plans Participation in OCH Kitsap NCC convenings and submission of Change Plan Multiple convenings with Kitsap Mental Health Services (KMHS) and developing pilot plan for KMHS integrated behavioral health provider	Engagement in OCH NCC and signed Change Plan completed Pilot project launched with KMHS for integrated behavioral health provider and use of collaborative care codes Alignment with NCC partners to network and advance integration within the Kitsap NCC
Behavioral health providers: Peninsula Behavioral Health, Port Angeles	Understanding of clinical reporting requirements under VBP Assessment of current billing practices and plan for transition to IMC Assessment of EHR capabilities for direct contracting with MCOs	Inclusion in MTP and commitment to NCC and Change Plan OCH staff site visits, technical assistance to maximize engagement as OCH NCC Change Plan Partner	Participation in VBP Academy QI team formed and pilot of PDSA (plan-do-study-act) and PHQ-9 (a standardized depression screening tool) tracking treatment to target Submission of Change Plan	Engagement in OCH NCC and signed Change Plan completed Procurement of new EHR to meet capacity of IMC, planning to implement in early 2019 Attendance to Southwest Accountable Community of Health behavioral health

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
Note: Providers in all three categories are invited to engage in the Olympic Community of Health (OCH) Medicaid Transformation Project (MTP) Natural Community of Care (NCC) and Change Plan process. Action steps and milestones required for these three categories are shared in order to meet the Tactics and Outcomes of Change Plans.				
	Identification of IMC Workforce training needs and current skill gaps		Participation in the Qualis Health On-site Integrated Billing Support Project and use of BHA Billing Toolkit	agency site visit for lessons learned during IMC transition and best practices for IMC success

Acronyms used in this table:
CBO – Community-based organization, EHR – Electronic medical record, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed care organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, PCMH-A – Patient-Centered Medical Home, PDSA – Plan-do-study-act, QI – Quality improvement, VBP – Value-based payment

Acronyms used in Section 1:
CBO – Community-based organization, EHR – Electronic medical record, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed care organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PCMH-A – Patient-Centered Medical Home, PDSA – Plan-do-study-act, P-TCPi – Pediatric Transforming Clinical Practices Initiative, PTSH – Practice Transformation Support Hub, QI – Quality improvement, TA – Technical Assistance, VBP – Value-based payment

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. 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 "No" in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked "Yes," to item E.1 respond "Not applicable."

   ACH response:
   During this reporting period, the Olympic Community of Health (OCH) did not formally engage or convene partners to discuss a process and timeline for regional transition to integrated managed care (IMC). The reason for this is that until November 2018, the Salish Behavioral Health Organization (SBHO) executive board was actively pursuing a legislative alternative to IMC. Additionally, the previous SBHO administrator informed the OCH Board of Directors that the SBHO would assume sole responsibility for planning, convening, engaging and preparing partners for either pathway: (1) the proposed alternative model to IMC and, if that failed to move forward, (2) IMC. At a subsequent SBHO executive board meeting the OCH was encouraged and agreed to participate in this process where invited.

   OCH staff and Board of Directors took many opportunities during this reporting period to offer support, assistance and resources to the SBHO in order to collaborate in the engagement and convening of providers, Managed Care Organizations (MCOs) and other regional partners. The OCH Board had challenging and important conversations during board meetings regarding how to leverage support for providers in the three-county region and how to support health care reform efforts.

   During this reporting period OCH coordinated a technical assistance training opportunity for Behavioral Health Agencies (BHA) providers in the form of on-site intensives and 2-day value-based payment (VBP) readiness trainings, in conjunction with the Cascade Pacific Action Alliance Accountable Community of Health (ACH). OCH worked with the SBHO to recruit and secure participation of BHA providers in our region.

   In December of 2018, OCH and SBHO began discussions to explore a joint effort to convene and engage providers in preparation of the IMC transition. These meetings began in December and will continue into the next semi-annual report (SAR) reporting period, 2019.

Finally, it is important to note that the OCH executive director sits on the SBHO executive board and OCH staff attend multiple monthly meetings to strengthen collaboration between the SBHO, providers, and the OCH.

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. 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 "No" in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked "Yes," to item E.1 respond "Not applicable."

ACH response:
During this reporting period, OCH did not formally work with county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to develop a plan for regional transition to IMC. The rationale for this, as described in A.1 above, is because the SBHO maintained it would assume responsibility for this role should the proposed alternative to IMC not be pursued. To better understand the SBHO's intent and plan, members of the OCH executive leadership and the OCH executive director called for a meeting with the SBHO administrator and the Kitsap County Human Services director (who oversees the SBHO) in June 2018. At this meeting, the SBHO shared its work plan and timeline for regional transition to IMC that would begin in 2019 if the alternative model was not pursued.

Beginning in December of 2018, OCH and SBHO began exploratory discussions on a joint effort to prepare the IMC transition, including an interlocal leadership structure. These meetings began in December of 2018 and will continue into the next SAR reporting period, 2019.

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?
   a. If yes, describe the region's plan to establish an EWS Workgroup, including:
      i. Which organization will lead the workgroup
      ii. Estimated date for establishing the workgroup

  iii. An estimate of the number and type workgroup participants

 b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response:

The region has not established an early warning system during the current reporting period. Beginning in December of 2018, OCH and SBHO began discussions to explore a joint effort to prepare for IMC transition, including an early warning system. These meetings began in December and will continue into the next SAR reporting period, 2019. OCH plans to continue discussion with the SBHO regarding the establishment of an early warning system in the next reporting period.

4. Describe the region's efforts to establish a communications workgroup, including:

  i. Which organization will lead the workgroup

  ii. Estimated date for establishing the workgroup

  iii. An estimate of the number and type of workgroup participants

ACH response:

The SBHO assumed responsibility for formal communications to contracted BHA providers specific to IMC during this reporting period. The SBHO began convening and coordinating meetings of their subcontracted behavioral health providers, the OCH, the Washington State Health Care Authority (HCA) and the MCOs. These meetings were held in June and July of 2018. These meetings communicated an overview of House Bill 6312 (Fully Integrated Managed Care) and the SBHO-proposed pathways to get to IMC. They also included an orientation to the five MCOs.

The SBHO convened monthly provider meetings with contracted providers. At these meetings, the SBHO provided updates to BHA providers about progress towards securing an alternative model to IMC. OCH attended these meetings and, when called on, answered questions based on available facts. This was an opportunity for OCH, which wanted to both support and inform the BHA providers. The OCH Board directed staff to remain neutral about the viability of a legislative alternative to IMC while providing information and support to the SBHO and providers as appropriate.

During this reporting period, the OCH is not aware if the SBHO convened a formal communications workgroup for IMC. However, in December of 2018, the OCH and SBHO began exploratory discussions on a joint effort to prepare for IMC transition, including the exploring the establishment of a communications workgroup.

5. Describe the region's efforts to establish a provider readiness/technical assistance (TA) workgroup, including:

  i. Which organization will lead the workgroup

ii. Estimated date for establishing the workgroup

iii. An estimate of the number and type of workgroup participants

ACH response:

The SBHO assumed responsibility for technical assistance to contracted BHA providers during this reporting period. The SBHO contracted with Adam Falcone to provide technical assistance to subcontracted behavioral health providers in the area of MCO contracting and arranged for MCOs to attend a number of the monthly BHA providers meetings.

During this reporting period, the OCH is not aware if the SBHO convened a formal technical assistance workgroup to establish provider readiness/technical assistance for IMC. However, in December of 2018, OCH and SBHO began exploratory discussions on a joint effort to prepare for the IMC transition, including identifying the necessary provider readiness/technical assistance needed.

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response:

Two individuals, a practice coach and practice facilitator, have been working in the OCH region since 2017 through Qualis Health and the Department of Health as well as through Practice Transformation Support Hub and Pediatric Transforming Clinical Practices (P-TCPi), respectively. OCH integrated the practice coach and practice facilitator into the OCH Medicaid Transformation Project (MTP) team. This team meets regularly to work together to decide goals, activities, engagement and partnership strategies, as well as messaging and relationship-building in the region. The coach and facilitator have worked with over 40 providers across primary care, behavioral health and substance use disorder (SUD) clinics/agencies and tribal partners in order to teach basic quality improvement models, the goals of integrated care and assist these providers in developing a culture of quality improvement in preparation for a different billing model with MCOs and/or incentive funding received as Change Plan partners. It has been a priority to deploy the Qualis Health practice coach and P-TCPi practice facilitator to new partners in the region who would like to participate, may not have completed a Change Plan with OCH for MTP, and intend to work toward transformation within their Natural Community of Care. Remote and rural clinics that began participating during this reporting period include the Sophie Trettevick Indian Health Center (Neah Bay), Kitsap Recovery Center (Port Orchard), Beacon of Hope/Safe Harbor Recovery SUD (Port Townsend), True Star Behavioral Health (Port Angeles), Peninsula Behavioral Health (Port Angeles) and Catholic Community Family Services (Bremerton).

The technical needs requested have included comprehensive training around the transition to IMC, electronic health record assessment for success in a direct billing environment, clinical and operational documentation requirements, transition planning from SBHO model to IMC billing, PreManage communication systems and care

coordination strategies, MCO contracting strategies and best practices in regions of our state that have already transitioned to direct billing.

OCH is identifying additional steps to build bridges between direct care providers of Medicaid consumers and partners in our three-county region. We have addressed these technical needs and leveraged resources to share best practices. These activities include:

- Convening of Natural Communities of Care
- Convening of SUD providers for Electronic Health Record (EHR) training and interoperability
- Webinars and follow up visits, emails and phone calls to address questions, concerns and/or provide resources
- Ongoing attendance at reginal provider, coalition, and mental health/substance use disorder committee meetings
- On-site visits to orient and field questions regarding the Change Plan model
- Continued building of assessments and action planning with engaged providers across the three-county region.

Qualis Health, through the Healthier Washington Practice Transformation Support Hub, was asked to provide technical assistance to a select group of behavioral health agencies (BHA) in the Olympic region in order to determine readiness to transition to IMC. The consultants evaluated each participating site's information systems, processes, and reporting capability and provided an assessment and gap analysis of current billing operations and systems. Eleven sites in the OCH region participated, including four BHAs and seven SUD providers.

As a result of the integrated billing site-visits, a Q&A document was developed between OCH BHA teams and Columbia River Mental Health Services staff. Information is collected regarding IMC billing and issues to consider when transitioning to Care Logic, an EHR for BHAs.

The Practice Transformation Support Hub, in partnership with the Washington Council for Behavioral Health, provided a two-part learning event for BHAs in order to prepare for VBP and IMC. The days were structured for team participation and group work. The OCH and SBHO assisted in outreach to agencies to broaden participation.

The OCH BHA partners visited the Southwest Washington region on December 4, 2019. This visit was organized by the Practice Transformation Coach and the Southwest Washington ACH at the request of a BHA in the OCH region. Five SUD and BHA agencies in the Southwest region took the time to meet with OCH BHA teams with 28 participants total. The team spent the afternoon with Vanessa Gaston, the lead administrator during the Regional Support Network transition to IMC in 2016.

7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response:
Below is a list of non-financial technical assistance OCH has identified to help address provider readiness needs:

- An assigned lead or team at the HCA with experience in working with early or mid-adopter IMC in other regions, that regularly attends local meetings, offers resources developed in other regions, and provides general staff support to workgroups or committees
- Access to consultants contracted with HCA to assist in the transition to IMC

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response:
The OCH has not formally engaged MCOs, regional behavioral health organizations, tribal health clinics, or other affected stakeholders in planning for the transition to IMC. The rationale for this, as described in A.1 above, is because the SBHO maintained it would assume responsibility for this role should the alternative model not be pursued.

In November 2018 the SBHO executive board determined that the alternative model to IMC was no longer viable and affirmed moving forward toward an IMC launch date of 1/1/2020.

On December 4, 2018 OCH encouraged BHAs to travel to Vancouver for an IMC learning session hosted by Southwest Washington ACH. The SBHO, OCH and BHAs from the Olympic region spent the day learning from their IMC experience.

On December 7, 2018, OCH hosted a meeting between the SBHO executive board chair/ county commissioner, SBHO administrator, OCH staff and representatives from all five MCOs to begin exploratory discussions on a joint effort to convene and engage providers in preparation of the IMC transition. The meeting was chaired by the SBHO executive board chair/county commissioner.

Also, on December 7, 2018, the SBHO hosted its Advisory Board meeting which includes consumers and stakeholders to discuss planning for IMC.

On December 10, 2018, the SBHO executive board chair/ county commissioner and SBHO administrator spoke directly to the OCH Board of Directors about a potential collaboration between the SBHO and OCH to prepare providers for IMC.

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond "Not applicable."

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity's qualifications. Include a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

   ACH response:

   Not applicable.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?

   a. If yes, describe when it was certified, or when it plans to certify.

   b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

   ACH response:

   Not applicable.

3. Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

   ACH response:

   Not applicable.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:

   - ACH participation in key informant interviews.

   - Identification of partnering provider candidates for key informant interviews.

   - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

   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 C.1, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked "Yes," to item C.1 respond "Not applicable."

ACH response:

Not applicable.

Acronyms used in Section 2:
BHA – Behavioral health agency, EHR – Electronic health record, HCA – Washington State Health Care Authority, IMC – Integrated managed care, MCO – Managed care organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, P-TCPi – Pediatric Transforming Clinical Practice Initiative, SAR – Semi-annual report, SBHO – Salish Behavioral Health Organization, SUD – Substance use disorder, VBP – Value-based payment,

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the 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 Medicaid Transformation's Special Terms and Conditions and ACH certification requirements, the ACH attests to complying 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	

	Yes	No
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," to all items respond "Not applicable."

ACH response:

Not applicable.

3. ***Attestation****:* The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

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

Place an "X" in the appropriate box.

Yes	No
X	

a. If the ACH checked "No" in item A.3, describe the ACH's process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked "Yes," to item A.3 respond "Not applicable."

ACH response:

Not applicable.

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an "X" in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period		X

If the ACH checked "Yes" in item A.4 above:

Insert or include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period.

B. Tribal engagement and collaboration

1. **Attestation:**

   The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy.](https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf)[4]

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

   Place an "X" in the appropriate box.

Yes	No
X	

2. If the ACH checked "No" in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked "Yes," to item B.1 respond "Not applicable."

   ACH response:

   Not applicable.

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond "Not applicable."

    ACH response:

   Not applicable. Please note that the Olympic Community of Health (OCH) Tribal Collaboration and Communication Policy as approved by the OCH Board is significantly stronger than the Model ACH Tribal Collaboration and Communication Policy. It is OCH.SAR2 Attachment 1. 1.31.19.

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

   ACH response:

   Not applicable.

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

   ACH response:

   Not applicable.

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[4] https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

   ACH response:

   Not applicable.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues ***after*** the transition to integrated managed care?

   ACH response:

   Not applicable.

5. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

   Not applicable.

D. Project implementation status update

Implementation Plans are "living documents" that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH's Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH's activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.[5]

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.

- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.

1. Provide the ACH's current implementation plan that documents the following information:

   a. Work steps and their status (in progress, completed, or not started).

   b. Identification of work steps that apply to required milestones for the reporting

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[5] Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

The current updated implementation plan is included in PDF format. There are 3 attachments, one for each stage (1, 2, and 3). They are the following attachments respectively:

OCH.SAR2 Attachment 2. 1.31.19

OCH.SAR2 Attachment 3. 1.31.19

OCH.SAR2 Attachment 4. 1.31.19

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

ACH response:

Achievements:

1. Contracted Implementation Partners
A total of 33 partners submitted a Change Plan and signed a contract with Olympic Community of Health (OCH), agreeing to participate in the Medicaid Transformation Project (MTP). In total, these partners submitted 38 Change Plans: 12 Primary Care, 14 Behavioral Health, 4 Hospital, and 8 Community Based Organizations and Social Services.

	Partner	NCC	Primary Care	Behavioral Health	Hospital	CBOSS
1	Bogachiel and Clallam Bay Primary Care Clinics	Clallam	x			
2	Olympic Personal Growth	Clallam		x		
3	Reflections Counseling Services Group	Clallam		x		
4	Peninsula Behavioral Health	Clallam		x		
5	West End Outreach Services	Clallam		x		
6	Jamestown Family Health Clinic	Clallam	x	x		
7	North Olympic Healthcare Network	Clallam	x	x		
8	Sophie Trettevick Indian Health Center	Clallam	x	x		
9	Forks Community Hospital	Clallam			x	
10	Olympic Medical Center, Hospital	Clallam			x	
11	Olympic Medical Center (OMP)	Clallam	x			
12	First Step Family Support Center	Clallam				x
13	Olympic Peninsula Health Communities Coalition	Clallam				x
14	OlyCAP	Clallam/Jefferson				x
15	Olympic Area Agency on Aging	Clallam/Jefferson				x
16	Beacon of Hope, Safe Harbor Recovery	Jefferson		x		
17	Discovery Behavioral Health	Jefferson		x		
18	Jefferson Healthcare	Jefferson			x	
19	Jefferson Healthcare Primary Care	Jefferson	x			
20	Northwest WA Family Medical Residency	Kitsap	x			
21	Harrison Health Partners Primary Care Clinics	Kitsap	x			
22	Kitsap Children's Clinic	Kitsap	x			
23	Kitsap Medical Group	Kitsap	x			
24	Peninsula Community Health Services	Kitsap	x	x		
25	Port Gamble S'Klallam Wellness Center	Kitsap	x	x		
26	Kitsap Mental Health Services	Kitsap		x		
27	Kitsap Recovery Center	Kitsap		x		
28	West Sound Treatment Center	Kitsap		x		
29	Harrison Medical Center	Kitsap			x	
30	Answers Counseling	Kitsap				x
31	Kitsap Division of Aging and Long-Term Care	Kitsap				x
32	Kitsap Public Health District	Kitsap				x
33	YMCA (Pierce & Kitsap Counties)	Kitsap				x

Combined, these 33 partners signed up for a total of 2,556 Tactics (values summed in the column labeled "Count" in the table below) across the four Domains (green shaded rows) and forty-four Outcomes (white shaded rows) that comprise the OCH Change Plan. This scope reflects a wide-range of transformation activities.

Domain and Outcome	Count
⊟ Care Coordination	**775**
At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate ⊞ services to treat mental health, substance use disorders and/or co-occurring disorders	13
Care coordination protocols that include screening, appropriate referal, and closing the loop on ⊞ referrals are developed to connect specific subpopulations to clinical or community services	196
Individuals utilizing the criminal justice system are linked to a patient-centered medical home ⊞ and appropriate services to treat mental health, substance use disorders and/or co-occurring	3
⊞ Organization develops or enhances services to help keep patients/clients out of ED	15
⊞ Patients/clients are assisted to understand appropriate settings for receiving health care	62
⊞ Population-based platform is systematically utilized to follow subpopulations for more efficient	236
⊞ Providers are notified of patient/client ED visits	46
⊞ Services are provided to individuals to keep them out of jail	10
⊞ Social determinants of health (SDOH) are assessed and integrated into standard practice	116
⊞ Streamlined process is in place for information to be shared in a timely manner for shared	78
⊟ Care Integration	**489**
⊞ Access to behavioral health services is convenient and timely	58
⊞ Access to physical health services is convenient and timely	33
⊞ Oral health education and screening are integrated into care	28
⊞ Oral health education, screening and/or preventive procedures are integrated into care	40
⊞ Organization chooses and implements an evidence-based program for care integration	16
⊞ Patients are screened for behavioral health conditions and patient tracking is initiated (BC 6,	114
⊞ Patients are screened for physical health conditions and patient tracking is initiated	63
⊞ Staff work together regularly across behavioral and physical health to coordinate care	57
⊞ Staff work together regularly across physical and behavioral health to coordinate care	54
⊞ Organization chooses and implements an evidence-based program for care integration (BH)	26

⊟ Care Transformation	**924**
⊞ All patients are offered the full spectrum of contraceptive options and are able to make	22
⊞ Best practices for opioid prescribing are promoted and used	137
⊞ Capacity is built to prevent OUD	12
⊞ Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management	47
⊞ Coordinated, targeted outreach and engagement to increase well-child visits and immunizations	43
⊞ Culture shift across organization to prioritize chronic disease prevention and management is	46
⊞ Full spectrum of evidence-based care for OUD is available	181
⊞ Health information technology is used efficiently to facilitate effective care	110
⊞ Hospitals and primary care clinics partner with mental health and substance use disorder providers to deliver acute care and recovery services to patients with OUD	35
⊞ Manage OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome	29
⊞ Naloxone is accessible	79
⊞ Patient reproductive health planning and management is promoted and offered across the life	35
⊞ Patients are empowered and prepared to manage their own health care	36
⊞ Patients are engaged around prevention of OUD	37
⊞ Providers are trained to recognize potential for opioid use disorder (OUD) and utilize a standardized protocol for screening and referring these patients	26
⊞ Public is offered education and awareness around opioid epidemic	16
⊞ Team members are trained in preconception health and have access to evidence-based	11
⊞ Treatment is expanded to those with OUD in the criminal justice system	22
⊟ Care Infrastructure	**368**
⊞ Access to care is increased	67
⊞ All staff understand the impact of trauma and health inequities on health	44
⊞ Health information is exchanged securely, appropriately, timely, and efficiently	49
⊞ Organization can exercise effective leadership, management, transparency and accountability of MTP activities throughout the duration of its Change Plan	49
⊞ Quality improvement methods are used to improve care and care delivery	25
⊞ Transformation is sustained beyond the Medicaid Transformation Project	66
Count	**2556**

2. Six Building Blocks
OCH successfully launched the Six Building Blocks evidence-based model in our region. The Six Building Blocks is a program for improving opioid management in primary care, directly tied to several required Outcomes under the Care Transformation Domain in the OCH Change Plan and specifically related to MTP Toolkit Project 3A. The first site to launch the program was one of the region's tribal Implementation Partners, Jamestown Family Health Clinic. The second site was Northwest Washington Family Medical Residency.

3. Intermediary Measures
OCH formed and convened its Performance, Measurement and Evaluation Committee. The first task of this committee was to complete development of a slate of reporting metrics for Implementation Partners. A total of 66 metrics were developed for five partner types: Hospital, Primary Care, Mental Health, Substance Use Disorder and Community-Based Organization/Social Service Organization. These metrics are

designed to track implementation of the Change Plan and are one of four reporting requirements associated with the Change Plan. Reporting on these metrics will occur bi-annually in Olympic Reporting and Community Activities (ORCA), the OCH online reporting and community activities platform. The metrics were designed to help OCH and Implementation Partners track individual progress as well as track regional performance associated with MTP pay-for-performance metrics close to real-time. They will help OCH make data-driven decisions to support Implementation Partners with investments and technical assistance.

Risks:

1. IMC Transition
Behavioral Health (BH) providers are challenged to work on achieving *clinical* and *financial* integration (IMC) simultaneously. There is a risk that one or both initiatives might lack focus, funding and infrastructure. BH providers may need more support with financial integration before working toward clinical integration. OCH is considering a mitigation strategy for BH Implementation Partners to delay certain deliverables and reporting requirements related to Outcomes in their Change Plans tied to clinical integration for 2019, so they may focus on IMC during 2019. A tailored timeline for certain deliverables for BH Implementation Partners will be finalized by DY3Q1. OCH is also working closely with the Salish Behavioral Health Organization (SBHO) and county commissioners to explore OCH's role in supporting providers and avenues of support for IMC.

2. Financial Stability of Implementation Partners
Several Implementation Partners might be at risk for not being able to carry out their MTP work due to organizational financial instability and lack of funds to cover costs associated with MTP work. Understanding the precarious financial situation, particularly of the smaller BH providers in the region, was an important first step in mitigating this risk. OCH is in the process of amending its contracts with Implementation Partners to include an attestation of financial solvency, which Implementation Partners will be asked to sign in DY3 Q1.

3. Tension of Roles
OCH has multiple roles as the Accountable Community of Health (ACH) contracted to implement MTP in the region (see graphic below). It has roles in supporting and coaching Implementation Partners and monitoring partner performance. In addition, it has a role in holding partners accountable through a contract. OCH is finding a need to balance these roles carefully in order to fulfill each successfully without causing conflict between them or damaging relationships with Implementation Partners. To mitigate this tension, OCH has decided to separate site visits designed for monitoring and coaching visits designed for quality improvement; OCH will deploy different staff members for each. OCH will also be crafting policies on performance and compliance that outline expectations and deliverables with consequences for not meeting these in DY3 Q1.

Figure 1:

ACH-Partner Relationship Roles and Tensions, DRAFT 12-12-18
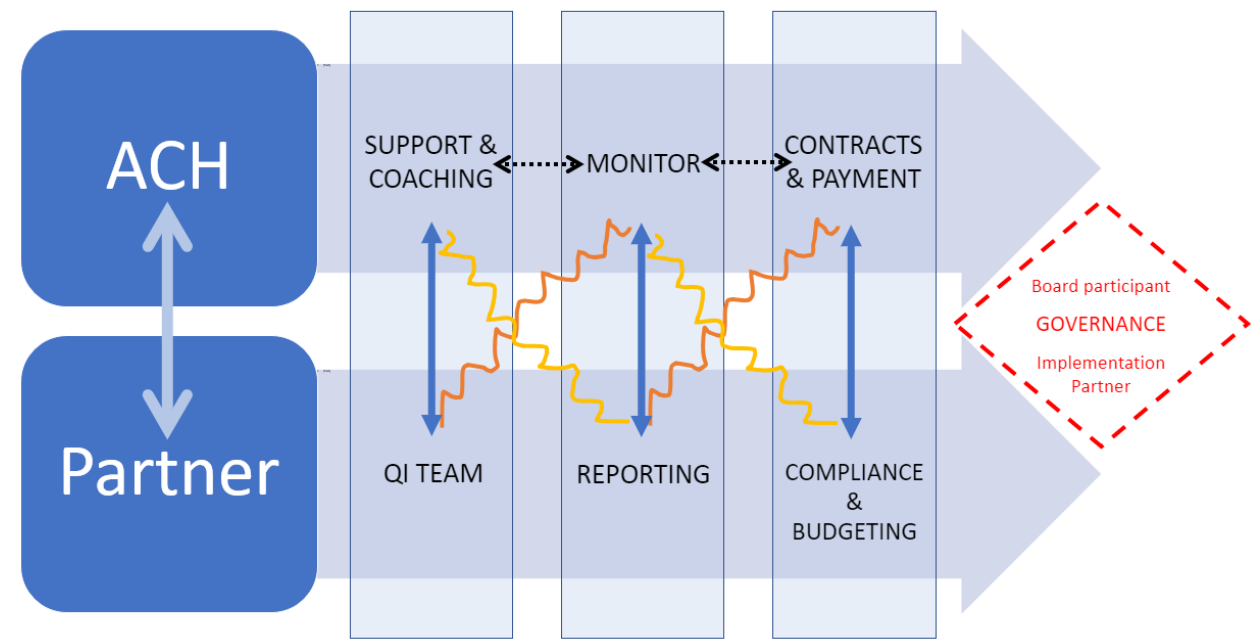
3. **Did the** ACH make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

   Place an "X" in the appropriate box.

Yes	No
	X

4. If the ACH checked "Yes" in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked "No," to item D.3 respond "Not applicable."

   ACH response:

   Not applicable.

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid

duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	**Objective**	**Brief description of outcome**

OCH is actively participating with other Accountable Communities of Health (ACHs) to identify joint contracting opportunities	Enhance efficiencies in the Medicaid Transformation Project (MTP) expenditures and increase opportunities for partners across ACHs	1. Cross-ACH training grid
		2. Agreement across multiple ACHs to jointly contract for health equity training:
		   a. John A. Powell, Director of the Haas Institute for a Fair and Inclusive Society to conduct health equity trainings
		   b. Kitsap Strong to train Practice Partners on program-level change related to the impact of Adverse Childhood Experiences (ACEs) and resilience

OCH is aligning reporting metrics for Implementation Partners with current reporting requirements to Managed Care Organizations (MCOs)	1. Reduce duplicative reporting for Implementation Partners 2. Align MTP performance with MCO contracts	A subset of the intermediary measures required for reporting by Implementation Partners will overlap with MCOs, reducing reporting burden
Qualis Health Value-based payment and Integrated Managed Care (IMC) Billing	Prepare partners for IMC	Partnering providers from both ACHs attended and participated in joint trainings to increase alignment across ACHs

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	**Objective**	**Brief description of outcome**
Support training with Cascade Pacific Action Alliance		

Acronyms used in this table:
ACH – Accountable Community of Health, IMC – Integrated managed care, MCO – Managed care organization, MTP – Medicaid Transformation Project

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond "Not applicable."

ACH response:
OCH staff and leadership continue to prioritize community engagement and partnership beyond that with partners who are formally participating in MTP. We accomplish this by:

- Regularly and consistently attending standing tribal, committee, workgroup, coalition, association, and partner meetings across the region including those with Medicaid beneficiaries in their membership. For example, the Director of Community and Tribal Partnership attends the monthly SBHO Providers meeting, which includes those substance use disorder providers not formally participating in the MTP. Their work is critical to the success of the region and successful transformation of the healthcare delivery system. A more complete list of engagement activities is in the monthly OCH Board packets which are posted on our website.

- It has been a priority to deploy a Qualis Health coach and a Pediatric-Transforming Clinical Practices Initiative facilitator to partners in the region who would like to participate, may not be formally participating in MTP, and intend to work toward transformation within their Natural Community of Care/community. Remote and rural partners that began participating during this reporting period include the Sophie Trettevick Indian Health Center (Neah Bay), Kitsap Recovery Center, Beacon of Hope/Safe Harbor Recovery (substance use disorder provider), True Star Behavioral Health, Peninsula Behavioral Health and Catholic Community Family Services.

- OCH hired a Communications and Development Coordinator in July of 2018. We prioritized strong communication and collaboration skills to coordinate activities related to Olympic Community of Health's mission and MTP and maintain clear, consistent, culturally appropriate messaging about the mission, vision and work that the OCH is doing. Strategies include a new website that is much easier to access and navigate; up to date and relevant social media; collaboration with other ACH communication leads to align messaging; revamping the OCH newsletter for clarity

and consistency; tracking information relevant to serving Medicaid beneficiaries and providers.

- OCH staff and leadership attended the American Indian Health Commission Tribal and State Leaders Health Summit. This biannual summit provides an opportunity to engage American Indian/Alaska Natives, tribal leaders, tribal providers across the state. OCH is committed to supporting and learning from tribal leaders and partners to address equity in the region.

- OCH hosted the 2nd Annual Olympic Regional Opioid Summit on October 17, 2018. There were approximately 300 attendees from the region, neighboring regions, and the state. Attendees included primary care providers, mental health providers, substance use disorder providers, dental providers, American Indian/Alaska Native and tribal partners, tribal leaders, public health and local government officials, law enforcement, fire/emergency medical services, emergency department providers, educators, students, school district staff, and community members. Individuals struggling with opioid use disorder are some of the most marginalized members of the community and this reflects our commitment to serving them and their families. In addition, OCH implemented a pre-summit survey that included questions about equity: "How often would you say your organization has discussed equity in the past year" and "Is equity a strategic priority in your organization?". When appropriate, OCH's surveys will include questions focused on equity.

- The Director of Community and Tribal Partnership at OCH tracks work/partners/organizations in the community that can support the work and success of the MTP to stay networked and connected to OCH and to each other. The Director of Programs and Program Coordinator are very responsive to requests throughout the region to learn more about OCH and MTP. They all regularly attend meetings by invitation to provide information and learn about current efforts by organizations not formally participating with MTP.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

    ACH response:

- OCH met with Managed Care Organizations (MCOs) and the SBHO, the payer for behavioral health organizations, to determine the types of metrics that are currently collected by MCOs from regional providers. The purpose of this meeting was to align OCH MTP metrics with existing metrics in MCO contracts. Additionally, during the meeting the MCOs agreed to share aggregate-level data with the OCH on certain measures to assist in tracking progress towards shared benchmarks. A follow-up meeting is scheduled in Q1 of 2019.

- OCH convened the Performance Measurement and Evaluation Committee with an MCO-sector representative on the committee to recommend reporting measures for

providers. Wherever possible, these measures aligned with measures providers are currently reporting to MCOs.

- OCH arranged for MCO support and participation for two learning sessions for behavioral health providers to provide technical assistance in Value-based payment (VBP) readiness, billing and IT readiness support for IMC. MCOs presented valuable information to behavioral health providers on IMC and VBP during these learning sessions.

- OCH collaborated with Qualis Health and the SBHO to offer on-site intensive site visits to assess readiness for IT, billing and VBP, and provide technical assistance to reach provider-specific goals.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

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

Yes	No
X	

2. If the ACH checked "No" in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked "Yes," to item F.1 respond "Not applicable."

   ACH response:

   Not applicable.

3. Provide three examples of the ACH's community engagement[6] and health equity[7] activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

   ACH response:

- OCH staff and leadership attended the American Indian Health Commission Tribal and State Leaders Health Summit. OCH is committed to supporting and learning from tribal leaders and partners to address equity in the region.

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[6] Community engagement is defined as 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.
[7] Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

- OCH hosted the 2nd Annual Olympic Regional Opioid Summit on October 17, 2018. There were approximately 300 attendees from the region, neighboring regions, and the state. Attendees included primary care providers, mental health providers, substance use disorder providers, dental providers, American Indian/Alaska Native and tribal partners, tribal leaders, public health and local government officials, law enforcement, fire/emergency medical services, emergency department providers, educators, students, school district staff, and community members. Individuals struggling with opioid use disorder are some of the most marginalized members of the community and this reflects our commitment to serving them and their families. In addition, OCH implemented a pre-summit survey that included questions about equity: "How often would you say your organization has discussed equity in the past year" and "Is equity a strategic priority in your organization?". When appropriate, future OCH surveys will include questions focused on equity.
- OCH staff and leadership continue to prioritize community engagement and partnership beyond that with partners who are formally participating in MTP. We accomplish this by:
  - Regularly and consistently attending existing tribal, committee, workgroup, coalition, association, and partner meetings across the region including those with Medicaid beneficiaries in their membership. This allows OCH to keep community members and partners updated, and to stay informed about the efforts underway.
  - OCH hired a Communications and Development Coordinator in July of 2018. We prioritized strong communication and collaboration skills to coordinate activities related to Olympic Community of Health's mission and our Medicaid Transformation Project, and maintain clear, consistent, culturally appropriate messaging about the mission, vision and work that the OCH is doing.

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 December 31, 2018.

1. **Design Funds**

   Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. **Earned Project Incentives**

   Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health

providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

OCH issues MTP investments based on progress reported by Implementation Partners in their Change Plans. Specific to health systems capacity building, OCH incentivizes broad transformation goals of value-based contracting and population health management capability. To track progress towards these goals, Change Plans track and incentivize progress towards short term outcomes such as:

1. Common or interoperable electronic health records or electronic behavioral health records.

2. Adoptions of population health management tools.

3. Implementation of value-based payment arrangements with MCOs.

Implementation Partners benefit from these investments because it allows them to deploy MTP payments in the most efficient manner possible for their organization.

In addition to the above investments, OCH continues to sit at the table with the other eight ACHs, the University of Washington and the Association of Washington Public Hospital Districts to align and plan Health Systems and Capacity Building investments from Domain 1 activities to achieve shared short-term goals and broader transformation goals.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

Not applicable. OCH has not elected to establish a community health fund or wellness fund. This topic may be revisited in 2020 if OCH's performance in MTP exceeds budgeted expectations.

Acronyms used in Section 3:
ACH – Accountable Community of Health, BH – Behavioral health, IMC – Integrated Managed Care, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, SBHO – Salish Behavioral Health Organization, VBP – Value-based payment

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation

efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).[8]

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
    a. All active partnering providers participating in project activities.
    b. Project participation by active partnering provider. Place an "X" in the appropriate project column(s).
    c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

   Complete item 4.A in the semi-annual report workbook.

   Please see item 4.A in the attached SAR Workbook, it is OCH.SAR2 Workbook. 1.31.19.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

   ACH response:

   All Olympic Community of Health (OCH) Implementation Partners are participating on an organizational level versus a site level. There are no organizations participating that are excluding certain sites from the transformation activities outlined in their Change Plan. This means that reporting will occur on an organizational level.

   As outlined in the Implementation Plan, the OCH Quality Improvement Plan (QIP) model (Figure 2) involves a continuous plan-do-study-act cycle informed by multiple quarterly and biannual inputs from partnering providers and other sources. OCH's

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[8] Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

approach to partnering provider management is embedded within this model. The approach will be the same for both traditional and non-traditional Medicaid providers.

In Figure 2, the two concentric circles depict two quality/rapid improvement cycle layers based on a plan-do-study-act methodology. The two concentric circles show the division of responsibilities between OCH (outer light blue circle) and the partnering providers (darker blue inner circular arrows). The partnering providers will be responsible for managing their internal quality improvement (QI) cycle (darker blue inner cycle). OCH will support partnering providers by offering technical assistance through Qualis Health and Pediatric Transforming Clinical Practices Initiative (P-TCPi) coach/facilitators. OCH will not oversee this internal process. OCH will ensure that partnering providers are engaging in their internal process and utilizing the key skills learned at the personalized Jedi Mind Control training with Master Yoda; this is a requirement in the Change Plan.

Some of our Implementation Partners have internal QI teams, defined as an established process for QI and protected time for staff to participate in this process. Other partners have accessed the free services available in our region through the Department of Health's Practice Transformation Support Hub Qualis Health Practice Coach Connector and P-TCPi Practice Facilitator. These coaches provide on-site assistance for clinics and agencies to facilitate assessments that measure readiness for integrated care, Collaborative Care Model, Chronic Care Model and Value Based Purchasing, identify healthcare and community-based support/social support partners with whom to build collaborative relationships and develop QI projects to close care gaps and improve care coordination. OCH has chosen to directly contract with Qualis Health to continue to provide Practice Coach Connector resources to Implementation Partners in 2019.
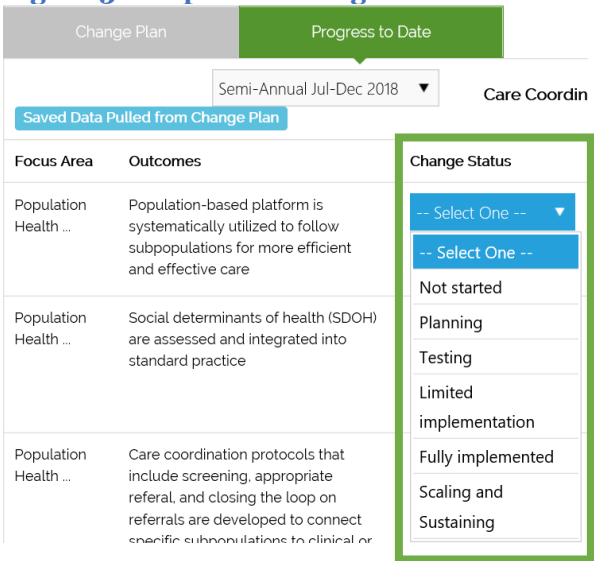
Figure 2:
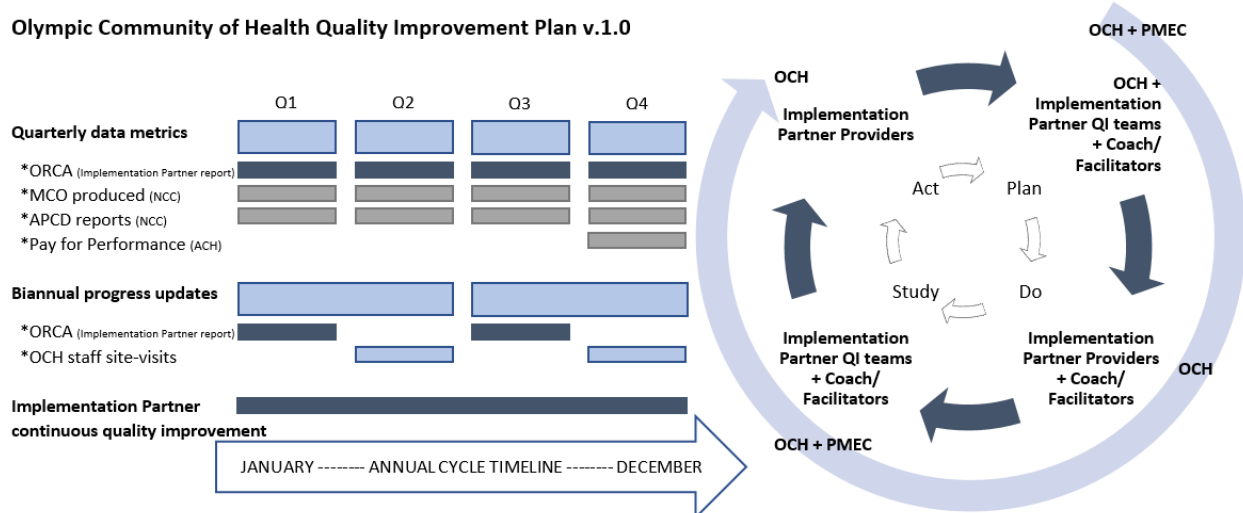
Acronyms used in Figure 2:
APCD – All Payer Claims Database, MCO – Managed Care Organization, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, QI – Quality Improvement

OCH will use what is included in the table below to do a quality/rapid improvement cycle to assess partnering providers' transformation. The table includes expectations, key indicators to measure implementation progress by providers and the processes and tools OCH will use to do rapid cycle quality improvement.

Expectations	Key Indicators	Processes and Tools
Implement Change Plan Outcomes and Tactics for both traditional and non-traditional Medicaid providers	Bi-annual **status updates on progress to date** on Outcomes measured in 6-stages: not started, planning, testing, limited implementation, fully implemented, scaling and sustaining (Figure 3, outlined in green). **Figure 3. Snapshot of Progress to Date Change Status** 	Progress to date status updates on Outcomes selected in each providers' Change Plan will be entered directly by the provider biannually in the OCH online platform, Olympic Reporting and Community Activities (ORCA).

	Bi-annual **narrative updates** in 6 open-ended questions asked by Olympic Community of Health (OCH). Questions 1–3 are answered for each Outcome, questions 4–6 are answered for the whole Change Plan (Figure 4).
	  1) Please describe the top priority Tactics you worked on during the previous 6 months. What are you most proud of?
	  2) What are your top priority Tactics for the next 6 months?
	  3) Thinking about the Outcomes/Tactics in your Change Plan, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources…)?
	  4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your Natural Community of Care in the previous six months (for example: signed agreement, etc.).
	  5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months?
	  6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6
		Progress-to-date-narrative updates will be entered directly by Implementation Partners biannually in ORCA.

months – increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

Figure 4. Snapshot of Progress to Date Narrative Updates

1) Please describe the top priority Tactics you worked on during the previous 6 months in this domain. What are you most proud of?

2) What are your top priority Tactics for the next 6 months in this domain?

3) Thinking about the Outcomes/Tactics in your Change Plan for this domain, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources...)?

4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your NCC in the previous six months (for example: signed agreement etc.).

5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months?

6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6 months - increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

Provide **data for quarterly quantitative performance measures** associated with Outcomes, Tactics and milestones. Performance measures will be developed in a collaborative process by the members of the OCH Performance Monitoring and Evaluation Committee from August to November 2018 and may include population served, intermediary process measures and measures of health care access/utilization, health status or health outcomes, number of new procedures and protocols implemented, number of new partnerships. These measures will serve as timely indicators and provide opportunities for quality improvement or other course corrections.	Quantitative performance measures will be tracked and entered directly by the provider quarterly in ORCA.

Acronyms used in this table:
OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, VBP – Value-based payment

After provider reports containing the above key indicators are collected and assessed, the OCH Director of Programs and Program Coordinator will conduct, at a minimum, bi-annual on-site visits with all Implementation Partners to assess organizations' progress on chosen Change Plan Outcomes/Tactics and associated milestones. OCH staff will use this time to address organization concerns and connect organizations with appropriate technical assistance resources. The site visit will also be used to evaluate the Implementation Partner's areas of focus, within the Change Plan, for the next six-month

reporting period, as well as evaluate progress made on the previous six month's reporting period identified activities. In the OCH QIP model, through the plan-do-study-act cycle, OCH may reach out to Implementation Partners if data review suggests delays or issues with project implementation.

Acronyms used in Section 4:

APCD – All Payer Claims Database, MCO – Managed Care Organization, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, QI – Quality improvement, QIP – Quality improvement plan, P-TCPi – Pediatric Transforming Clinical Practice Initiative, VBP – Value-based payment

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

   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 implementing integrated managed care in its region on January 1, 2019. If the ACH checked "Yes" in item A.1, respond "Not applicable."

   ACH response:

   Not applicable.

Master acronym list:

ACH – Accountable Community of Health, APCD – All Payer Claims Database, BH – Behavioral health, BHA – Behavioral health agency, CBO – Community-based organization, EHR – Electronic medical record, HCA – Washington State Health Care Authority, IMC – Integrated managed care, KMHS – Kitsap Mental Health Services, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PCMH-A – Patient-Centered Medical Home, PMEC – Performance Measurement and Evaluation Committee, QI – Quality, PDSA – Plan-do-study-act, P-TCPi – Pediatric Transforming Clinical Practice Initiative, PTSH – Practice Transformation Support Hub, SAR – Semi-annual report, SBHO – Salish Behavioral Health Organization, TA – Technical Assistance, VBP – Value-based payment

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