Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

North Central Accountable Community of Health

SAR 6.0

Reporting Period:

July 1, 2020 – December 31, 2020

DY4 Q3-Q4

ACH contact information

Include in the semi-annual report the 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, also include their information.

ACH name:	North Central Accountable Community of Health
Primary contact name **Phone number** **E-mail address**	John Schapman 509-886-6435 john.schapman@cdhd.wa.gov
Secondary contact name **Phone number** **E-mail address**	Linda Evans Parlette 509-886-6438 linda.parlette@cdhd.wa.gov

Section 1. ACH organizational updates

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

Foundational ACH requirements	Yes	No
1. 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	
2. The ACH has an Executive Director.	x	
3. 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 • 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	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	x	
5. Meetings of the ACH's decision-making body are open to the public.	x	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits.[1]	x	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	x	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	x	

[1] https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26

If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

Documentation

The ACH should provide applicable documents or additional context for clarity that addresses the following:

9. **Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

    - Include staff names and titles in the organizational chart. For vacant positions, mark each applicable position as "vacant" on the organizational chart.
    - Provide a narrative explanation of the organizational changes.

    See Attached: NCACH.SAR6.Attachment A.2.01.21

10. **Budget/funds flow.**

    a) Financial Executor Portal activity for the reporting period. The Independent Assessor will receive an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report.

    No action is required by the ACH for this item.

    b) The ACH is asked to provide additional context to add clarity about the portal activity payments made outside the portal.

    - For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[2]
    - For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[3]

    NCACH Response:

    During this reporting period, NCACH did not transfer funds from the Financial Executor Portal into another NCACH account. Any funds used for COVID-19 related efforts made outside of the portal used Design funds that were already in NCACH's account. NCACH followed the direction received by Meyers and Stauffer from SAR 5.0 that no reporting was required for expenditure of Design funds used for COVID-19.

[2] The HCA issued COVID 19 reconciliation spreadsheet can be found at the following link: https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx.

[3] The HCA issued non -COVID reconciliation spreadsheet can be found at the following link: https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx.

11. **Incentives to support integrated managed care.** Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support the region in transition to integrated managed care.

    a) List of use and expenditures that reflect a cumulative accounting of all incentives distributed or projected to support the transition to integrated managed care. It is not limited to the reporting period.

        i. ACHs may use the table below or an alternative format as long as the required information is captured.

        ii. Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

        iii. Description of use should be specific but concise.

Use of incentives to assist in the transition to integrated managed care		
Description of Use	**Expenditures ($)**	
	Actual	**Projected**
In 2018, a contract with Feldesman Tucker Leifer Fidell LLP provided technical assistance and review of contracts for behavioral healthcare providers who did not have contracting experience with Managed Care Organizations (MCOs).	**$35,275**	**$35,275** *(updated since SAR 5.0)*
Through 2019, a contract with Xpio provided IT technical support to behavioral health providers who needed assistance in making adjustments to their medical record systems to bill MCOs for services provided. Prior to integration in January 2018, approximately $200,000 was spent on behavioral healthcare providers for technical assistance support by Xpio.	**$23,146.66**	**$23,147**
A contract with the UW AIMS center provided assistance on how to emphasize the behavioral health component of bi-directional integration. This contract was through 2018 but could be extended in the future (and would include additional costs.)	**$41,346**	**$41,346**
Integration incentive payments for partners: Stage 1 funding through the Whole Person Care Collaborative (WPCC) helped behavioral health organizations develop a change plan. The change plans provide a road map for partnering providers to address bi-directional integration and contribute to all 6 Medicaid Transformation Projects selected by NCACH. This funding includes a Learning and Action Network, where providers received assistance in developing their change plans.	**$557,500**	**$557,500**
Integration incentive payments for partners: Stage 2 Funding is for behavioral healthcare providers who are participating in the Whole Person Care Learning	**$945,000** *(updated since*	**$1,897,500**

Community from 2019 - 2021 and after completing deliverables outlined for Learning Community members. This funding supports the continued progression of tactics outlined in the behavioral healthcare providers' change plans.	*SAR 5.0)*	
Payments for consultants and ongoing TA support: This allocation includes project management costs for consultants who support the WPCC, helping both behavioral healthcare providers and physical health providers move closer to bi-directional integration as well as whole person care. The projected cost accounts for what would be the behavioral healthcare providers' share of this work if split evenly across organizations. However, the contractor is paid directly from NCACH.	**$346,252** *(updated since SAR 5.0)*	**$780,000**
Total	**$1,948,519.66** *(updated since SAR 5.0)*	**$3,334,768** *(updated since SAR 5.0)*

Integrated Managed Care funding is also being utilized to support outpatient providers' clinical process improvement efforts to address whole person health, as well as partnerships with community behavioral health providers to collectively achieve the goals of bi-directional integration. The above chart demonstrates the funding that behavioral health providers received or costs incurred as part of this work. NCACH is also working on partnerships with Colville Confederated Tribes, which may include partnering with their behavioral health departments on initiatives such as bi-directional integration.

Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report unless otherwise noted. ACHs may report in the format of their choosing, as long as all required elements are addressed.

Attachments

The ACH should provide applicable attachments or additional context that addresses the following:

12. Implementation work plan

The reporting requirements for the implementation work plan updates are temporarily replaced with COVID-19 related responses in the "Narrative Responses" section. The submission of an updated implementation work plan is considered optional for this reporting period but is encouraged to the extent the ACH has an updated work plan.

Implementation plans are "living documents" that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA information to monitor ACH activities and project implementation timelines.

- Optional: The ACH may submit an **updated implementation plan** reflecting *progress made during the reporting period.*

NCACH Response:

Please see our updated implementation plan for our six projects. Note that we are submitting requested implementation plan changes to our Project 2B (Community-Based Care Coordination). Based on program data, extensive conversations, and a formative evaluation report, the NCACH Board of Directors chose to discontinue the Pathways Community HUB model at their March 2020 Board meeting. NCACH staff then worked with the Health Care Authority to discuss options and plan for the organization's future direction. The project modification NCACH submitted in November was approved by the Health Care Authority on 11/24/2020. The proposed updates to the Project 2B implementation plan align with the approved project modification plan.

See Attached: NCACH.SAR6 Implementation work plan.2.01.21

13. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.[4] To earn the

[4] Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).

achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH. ACHs should maintain the roster provided by HCA at the time of the SAR4 release for the remaining semi-annual reporting periods.

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

   i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.

   ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

b) Update partnering provider site information as needed over each reporting period.

NCACH Response:

See Attached: NCACH.SAR6 provider roster.2.01.21

Any providers who were put into the Financial Executor Portal system for supporting COVID-19 work are not included in the partnering provider roster since they were not directly involved in Medicaid Transformation Project work.

Documentation

The ACH should provide documentation that addresses the following:

14. Quality improvement strategy update

The reporting requirements for the quality improvement strategy updates are temporarily replaced with COVID-19 related responses in the "Narrative Responses" section. The submission of quality improvement strategy updates are considered ***optional*** for this reporting period but are encouraged to the extent the ACH has an updated quality improvement strategy to keep HCA and the IA apprised of quality improvement activities and findings. If submitting updates, ACHs may determine the format to convey this information.[5]

NCACH Response: Quality improvement strategy update

As described in NCACH's Quality Improvement Strategy (QIS), NCACH structured and tailored its QIS framework differently for specific types of funded partners, given their unique contributions to our project portfolio. The goal across the board is to promote continuous learning and improvement. There have been no modifications to our strategy, though NCACH relaxed reporting requirements for funded partners during COVID-19. The following are some of the quality improvement efforts and findings from 2020.

[5] Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the "Narrative Responses" section

Whole Person Care Collaborative: Quarterly reports were suspended for the first half of 2020. In the spirit of NCACH's own continuous improvement, NCACH requested feedback in 2019 and learned that partners wanted more time allocated to peer sharing during monthly meetings. The move to virtual-only meetings as a result of COVID allowed us to reimagine peer sharing using breakout rooms, which increased participant engagement (a COVID silver lining!) For example, at the August 2020 meeting, all participants were asked to reflect on the following question: "What did you do differently during the last 4 months, aside from implementing telehealth, that you would hope to carry forward?" Participants were then sent into breakout groups of 2, then 4, and then all came back to the main Zoom room to share highlights of their conversations. This kind of "1-2-4-ALL" structure allowed for rapid sharing and learning and was adopted for the remainder of the year. In July 2020, NCACH's two Practice Facilitators conducted virtual site visits with every partner to discuss what improvement work they would like to undertake in the next 18 months, understand barriers and opportunities, and propose a more consolidated way to structure their work and measures. From these discussions, NCACH learned that WPCC partners were most interested in working on chronic care management (predominantly diabetes), behavioral health integration (predominantly depression) with the focus on telehealth, as well as access and social determinants of health. Proposed common measures included diabetes Metrics (including A1C screening and Uncontrolled), depression screening and follow-up and access to care. These and other insights were shared at the August meeting, and small group discussions using the "1-2-4-ALL" format were used to reflect and shape the collective work ahead.

Transitional Care and Diversion Intervention Workgroup: As mentioned in our QIS, hospital and EMS partners have different QI expectations. Reporting requirements were suspended during the first half of 2020, but NCACH continued to build in shared learning and peer updates into TCDI Workgroup meetings during the second half of the year. NCACH staff reached out to partners individually in June to assess how partners were feeling about re-engaging in their Transitional Care and Diversion Intervention activities and reporting requirements. While some partners could continue much of their business as usual, others had to adapt given ongoing COVID-19 restrictions and disruptions. Most of these partners expressed an ability to re-engage in reporting and workgroup meetings in the second half of the year. Generally, partner updates, quarterly reports and peer sharing show that their internal process improvements around follow-up care continued, and in fact, were leveraged when COVID hit. However, throughout COVID, new partnership-building and staff recruitment, as well as Community-Based Integration work that was incentivized in 2020, were delayed for partnering community-based organizations.

One core lesson NCACH learned in 2020: telehealth visits can play an important role in transitional care work and diverting patients from the ED and clinic during COVID and in the future. Many partners noted that patient access to telehealth can be a challenge in our rural region due to broadband availability and technology barriers.

Opioid Workgroup: Applicants awarded funds in 2019 did their best to move the work forward despite COVID, while school-based prevention contract deliverables were delayed given the upheaval COVID created for school districts across the nation. Typically, partners would be required to submit a mid-point and final narrative report as well as share a verbal update to the Opioid Workgroup. While project activities were delayed or paused and reporting requirements relaxed, NCACH continued to convene the Opioid Workgroup virtually to keep partners connected and learn about opioid-related efforts that were continuing. For example, Chelan

Douglas Community Action Council shared information about their youth and young adult outreach efforts at the May 2020 meeting, and Coulee Medical Center staff shared updates about their Take Home Naloxone Project at the August 2020 meeting. Updates included ways these projects adapted to online and virtual environments.

Community-Based Care Coordination: As mentioned in SAR 5.0, NCACH engaged the Center for Community Health and Evaluation to complete a formative evaluation of the Pathways HUB pilot drawing on stakeholder interviews. The summary of successes, challenges and recommendations from this report informed discussions of a HUB subcommittee which continued to meet in January 2020. The Pathways HUB project and community-based care coordination was a major focus at the NCACH Governing Board retreat in January 2020, and in March 2020 our Board voted to discontinue the Pathways Community HUB pilot. NCACH's lessons learned and rationale for this project modification are outlined in the Project Plan Modification request which can be found here: https://ncach.org/wp-content/uploads/NCACH-Project-2B-project-plan-amendment-request-FINAL-signed.pdf

Coalitions for Health Improvement: Generally, partners funded through the CHI Community Investment Process are expected to submit quarterly narrative reports designed to surface lessons learned and barriers as well as provide two verbal reports to increase peer sharing and strengthen relationships between the network of providers. Because COVID delayed the eight CHI-funded projects, NCACH relaxed reporting requirements and welcomed adjustments to project plans and deliverables.

Narrative responses

ACHs must provide ***concise*** responses to the following prompts:

15. COVID-19

a) Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have changed (i.e., which projects remain on track, which projects or areas of focus have expanded, which capacity building efforts have emerged, etc.).

NCACH COVID Response:

During the July-December 2020 reporting period, NCACH continued supporting our local public health jurisdictions while also transitioning back to the Medicaid Transformation Project/DSRIP activities. Reporting requirements were reinstated for this period, though accommodations were made for clinical partners whose efforts continued to be diverted away from MTP projects and focus on COVID-19 response.

NCACH continued to partner with all three of our Local Health Jurisdictions (LHJ) to support their community mitigation response needs, including funding a variety of activities ranging from direct response, PPE, and supporting regional Spanish-language messaging to promote COVID-19 safe communities. The LHJs and a dedicated group of regional partners continued to guide weekly public service announcements that were shared with eight Spanish language radio stations. NCACH helped organize several longer radio segments in partnership with a local doctor from Confluence and La Pera radio, including a segment with WA State Labor & Industries and WA Employment and Securities Department to talk about paid leave provisions for workers. NCACH also helped organize video Public Service Announcements (PSAs),

featuring a doctor and student, for schools to share information on social distancing guidelines on why and how to mask.

A total of $16,058 was distributed in funding to the LHJs over the reporting period, funding activities such as the COVID-19 safety messaging above and using local EMS services to provide in-home support for people in quarantine or isolation due to COVID-19. NCACH also helped coordinate orders and delivery of PPE on behalf of Health Care Authority (and through shipments coordinated by other partners, including North Sound ACH), as well as food and care kits for community members in need through the Department of Health Care Connect initiative.

DSRIP Activities: The table below outlines our DSRIP activities and summary update re: timelines.

Project	**Overall Status (Impacted? On Track?)**	**Notes**
Whole Person Care Collaborative (addressing 2A, 2C, 2D, 3A, 3D)	Degree of impact was different amongst provider organizations	COVID-19 infections surged in the second-half of 2020. While the beginning of the pandemic left organizations scrambling to set up telehealth and rethink delivery of care, the latter half stretched organizations in how to manage their chronic care populations in the midst of the surge and decreased staffing. Organizations employed population health management strategies to recall patients due for immunizations and chronic care management. Techniques and strategies emphasized during our population health learning and action networks (LAN) assisted organizations in managing their panels in a time when their focus was pandemic response. In September, NCACH staff reengaged our WPCC clinical partners in the Population Health LAN focusing on behavioral health integration and chronic disease management, primarily depression and diabetes respectively. It is evident through reporting that many of our organizations have become more skilled at pulling data by population of focus and using that data for improvement work.
Community-Based Care Coordination (2B)	On hold since March 2nd	On March 2, NCACH's Governing Board made the decision to discontinue the contract for the Pathways Community HUB after June 2020. NCACH's focus on COVID-19 placed planning efforts for CBCC project modifications on hold through this reporting period.

Transitional Care (2C) and Diversion Interventions (2D)	Some impacts, but most work able to continue	Initiatives summary: • Transitional Care Management programs are on track. Most of this work was already established as remote outreach so COVID-19 did not cause agencies to delay this work. • Emergency Department Diversion strategies were on track until late Spring, when patient ED visits declined due to COVID. Work still continued, but with lower volumes. Since July, providers have re-engaged in their work with Emergency Department diversion at a reduced volume due to either having to switch gears to focus on COVID-19 as outbreaks increase, or due to patient concerns about receiving medical care in person due to the virus. • The ability to build partnerships with community members was greatly impacted during the COVID-19 period due to the inability to meet in person. With the ongoing pandemic, this did not improve all year. Partners hope to continue this work in 2021, but there are some concerns that it will be mid-2021 until this will be a possibility.
Opioid Project (3A)	The degree of impact varied by initiative and was dependent upon funded partners' ability to continue the work as planned.	Initiatives Summary: • Rapid Cycle Opioid Funding: Following reopening this funding in July, there was limited community engagement with the opportunity, due to the all-encompassing pandemic response, however, NCACH received and funded a regional opioid outreach project request that served to educate youth, adults, and seniors on opioid use and misuse. NCACH staff is reimagining this funding scope in 2021. • Recovery Initiatives: In September 2020, NCACH helped to organize a virtual "Hands Across the Bridge" event (usually held in person) to help mitigate the social isolation of the pandemic. People in recovery across our four-county region attended the event to share their stories and connect with others on their recovery journeys. In September 2020, NCACH hired a Recovery Coach Network Coordinator to stand up the Recovery Coach Network in the second quarter of 2021. This position has been instrumental

		in revising the opioid project's goals in the coming years, electing to view the project "Through A Recovery and Resiliency Lens" for each initiative within the project. • Narcan Training and Distribution Local distribution efforts have been stymied due to the pandemic and reduced capacity of Local Health Jurisdictions, however, NCACH staff purchased inventory of Narcan and is working with other county-specific distribution planning efforts to distribute this medication to a wide variety of community groups and stakeholders, especially as overdose potential increases. • School-based Prevention: After a long delay in the ability of our partners to assess curriculum and opportunities for implementation, NCACH is continuing these contracts, with some minor project amendments, in 2021. • Opioid Public Education and Awareness: While delayed, NCACH staff and the selected contractor put a plan in place to extend this contract and achieve the contract deliverables in the first quarter of 2021.

b) Describe any DSRIP activities that enabled the ACH and partners to respond to and navigate the COVID-19 pandemic (e.g., care coordination, information exchange, telehealth access, data analytics, population health training and technical assistance, etc.), as applicable. If applicable, indicate whether certain activities applied to specified sub-populations within your region. Describe any lessons learned that the ACH will use to support projects and partnerships moving forward.

NCACH Response:

The WPCC has engaged our collaborative in Population Health Learning and Action Networks (LANs) focusing on using population of focus to identify improvement opportunities. With the knowledge of stratifying populations and creating registries, clinical organizations were able to identify at-risk populations. This identification enabled primary care organizations to track patients who were infected with COVID, allowing for more organized and efficient outreach to monitor long-term symptoms. Secondly, it allowed all clinical organizations to reach out to their vulnerable populations to ensure individual needs were met. As a collaborative that meets monthly, we were able to use this opportunity for open discussion on alternative modalities of care to meet the needs of patients, including parking lot clinic and drive-up laboratories.

While not a formal intervention, the Coalitions for Health Improvement (CHI) and NCACH staff continue to support COVID-19 response efforts and activities through partner convenings and meetings. The CHIs have provided an important forum for

partners to connect with public health's pandemic response efforts, including information sharing and action planning. The Okanogan County CHI hosted a series of COVID-19 panel discussions, exploring topics like COVID-19 impacts and wildfire, Q&As with local public health officials, and even hosted a candidate forum in November focused on community health and COVID-19.

Finally, at the start of quarter 4 of 2020, NCACH hired its Recovery Coach Network Coordinator. This work was originally focused on transitions of individuals with substance use out of the justice system. However, COVID-19 caused this process to slow down due to how jail systems have minimized arrest, which in turn has decreased releases from jail. NCACH shifted its focus to support recovery as a whole across the community. It is becoming more commonly known that COVID-19 is increasing issues with mental health and substance use disorder and that individuals with addiction are in need of a strong peer support system as an addition to their long-term recovery goals. As NCACH has started to build out the Recovery Coach Network in our region, we have brought numerous community stakeholders to the table and engaged them with the goals of the Recovery Coach Network through Recovery Coach trainings, outreach to community-based organizations, and Opioid Workgroup meetings. Partnership recruitment is ongoing but staff are currently working within the recovery continuum of care which includes Chelan County Drug Court, the Regional Central Washington Recovery Coalition (branches in Chelan-Douglas, Grant, and Okanogan), treatment centers, and other coalitions that interact with those who have substance use outside of the jail setting.

c) Describe how your ACH included Tribes/IHCPs in your COVID-19 response activities.

NCACH Response:

During this reporting period, NCACH reached out to Colville Confederated Tribes (CCT) contacts in August 2020, as part of mask distribution efforts that the Health Care Authority asked ACHs to take on. Given increasing numbers, CCT was grateful to have access to more masks. NCACH staff personally delivered 3,000 cloth and 3,000 KN-95 masks to the reservation (which continues to be closed to non-essential visitors.) Outside of COVID-19 response activities, NCACH also focused on maintaining our partnership given leadership changes at the Colville Confederated Tribes Health and Human Services. NCACH reached out to the new Health and Human Service Director and met several times via Zoom to bring him up to speed on the existing MOU and partnership, making necessary adjustments to the MOU and reporting template based on shifting priorities. An MOU amendment was officially approved by Tribal Council resolution in December 2020, and NCACH looks forward to supporting their health system improvement efforts in 2021.

d) Specific to partnering providers, describe how the ACH has adjusted contracts, reporting, type of provider engaged, and/or payment strategies.

NCACH Response:

NCACH reached out to partners in quarter 2 of 2020 to notify them that contract work would resume starting July 1st, 2020. This meant that exemptions from reporting deliverables were no longer allowed and any challenges that an organization had in achieving the deliverables in the MOUs needed to be resolved by changing the scope of

work, potentially adjusting the contract amount, and/or adjusting the length of MOUs between NCACH and partners.

Deliverables for 2020 were adjusted to support what was occurring in the Whole Person Care Collaborative and Transitional Care and Diversion Interventions work to reflect the common issues that arose from COVID-19 through 2020. Most contracts with community-based organizations were extended or deliverables were adjusted based on project modification requests. The purpose of those modifications was to support those agencies in implementing the core intent of their projects in alignment with each county reopening plans and current work dynamics.

Moving into 2021, NCACH is using lessons learned during the pandemic to adjust contracts and reporting. For example, the Whole Person Care Collaborative Manager met with all healthcare teams to identify common issues and opportunities for improvement. This led to streamlining the reporting process, reducing the focus from eight different topics down to two: behavioral health integration and chronic disease management. Clinical partners also agreed to a core set of metrics and reporting monthly to ensure partners were focused on what they would achieve for the remainder of the Transformation Project.

e) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access). Also highlight any mitigation strategies or activities that shifted as a result, if applicable. Indicate whether this applied to specified sub-populations within your region.

NCACH Response:

Although communication between primary care and behavioral health has not been optimal, it became even more apparent during COVID. NCACH staff worked with the local behavioral health organization and primary care clinics in Grant County to open communication to identify issues and prioritize areas for improvement. Two organizations were willing to meet with the behavioral health organization and map out internal and external workflows to identify gaps. This exercise enabled each agency to better understand the other's processes and identify how to better work together to improve the system. NCACH is evaluating how this process can be expanded to the other counties in the NCACH region.

The ability for rural providers to remain financially viable during a major pandemic has also continued to be an issue. Many clinical providers in our rural setting have had to rapidly change the way they provide care, including investing in telehealth technology, while seeing significant decreases in revenue due to canceled non-emergent procedures and visits.

With an increase in telehealth services, NCACH partners report behavioral health access has improved, especially in more rural areas of our region that historically lacked robust access to health services. In addition, traditional barriers to accessing health care, including transportation and lack of/inability to pay for childcare was essentially was essentially eliminated. Expansion of reimbursement models through telehealth will continue to help mitigate some of these issues.

The NCACH Board and clinical partners had numerous discussions in quarter three of 2020 to explore access gaps and ways NCACH might expand upon the telehealth supports already provided by the State and Federal government. As a result of these discussions, NCACH developed and released a Request for Proposals (RFP) for a vendor to produce a practical and achievable plan for a community-based solution to enhance telehealth capacity for the North Central Washington region. Proposals are due back to NCACH February 2021, will be evaluated by a committee, and brought to the NCACH Board for approval in March.

With respect to COVID-19 and Community-Based Care Coordination, this reporting period presented an opportunity that was challenging to respond to and surfaced lack of coordination at the state level. In September 2020, most ACH Executive Directors were included in an email from the Department of Health that went out to public health partners in each of the ACH regions for a "COVID Care Connect RFP". In a nutshell, DOH was trying to build a statewide system coordinated at a regional level to help individuals and households successfully isolate and quarantine (I&Q) at home during the outbreak containment period. Many of the elements outlined in the COVID care coordination RFP echoed the Pathways Community HUB, including identification of a regional "COVID-19 Care Coordination Hub", repeated references to "community-based workforce" and "community-based organizations", and required use of the Care Coordination Systems (CCS) IT platform. NCACH supported the underlying goals of this COVID care coordination opportunity, and our already under-resourced Local Health Jurisdictions voiced strong support, as they were stretched thin and needed help. That said, this opportunity caught ACHs and the HCA by surprise. This is somewhat understandable given the urgency of a COVID emergency response, but it highlighted weak communication channels between DOH and HCA, especially in light of the potential alignment with DSRIP community-based care coordination efforts. NCACH worked closely with a community-based organization best positioned to be the lead applicant, but with limited capacity to organize the application effort on such a tight timeline. NCACH staff assisted with regional organizing and strategizing with public health partners, researching of questions and implications, convening conversations with critical partners (including major health systems and managed care organizations), bringing all of these pieces together towards an informed decision, and pulling together application materials.

This was a monumental lift. NCACH supported the eventual decision of our community partner to withdraw their letter of intent to partner with DOH. We shared their concerns that this rapid implementation of a system would only repeat and aggravate issues that surfaced in the Pathways HUB pilot. We stand by our concerns and this decision, while understanding that some of our public health partners may have felt let down. For the North Central region, this experience underscored that without a robust community health workforce and community-based care coordination network in place (and in the absence of a well-functioning Pathways Community HUB infrastructure), our region was not well positioned to respond to this opportunity. Building the infrastructure needs to come first, but it takes time and can't be done on COVID timelines. The COVID emergency care coordination response model would have detracted our attention and resources from this goal. Filling this gap continues to be a motivation for NCACH's future community-based care coordination investments and work.

f) Highlight one best practice or "bright spot" that emerged during this reporting period as a result of COVID-19, if applicable.

NCACH Response:

While COVID-19 has presented many challenges for our partners and for our organization, there are a few bright spots that have emerged. For example, we have seen higher rates of participation with our workgroup and Coalition for Health Improvement meetings since going fully virtual. Our behavioral health care providers have also seen successes with the acceleration of and reimbursement of telehealth services in the region, which was something that was previously a challenge prior to COVID-19. Community paramedicine, a model embraced by several of our EMS providers, is proving to be a critical part of Okanogan County's COVID-19 response, which shows the impact of some of NCACH's prior investments in Transitional Care and Diversion Intervention efforts.

With rapid change comes the need for innovation, and our partners have become very adept at innovating. For example, some organizations within the Whole Person Care Collaborative report that their ability to pivot and adapt to changes, such as adding new patient screening protocols, testing sites, and soon vaccine sites caused by COVID-19, can be attributed to quality improvement methods emphasized throughout learning activities they have previously participated in.

16. Scale and sustain update

Per the Project Toolkit, ACH SAR 6 must include a section on scale and sustain activities undertaken by ACHs during the reporting period. This section will appear in each SAR thereafter, with questions revised and added to reflect the current phase of work. In answering these questions, please focus on activities that took place during the six-month reporting period. Recognizing P4P incentives for DY4 and DY5 will be paid out in 2022 and 2023, have these funds been obligated? In addition to answering yes/no, please provide relevant context regarding this question and each of the following components.

i. What types of entities are those funds obligated to?

ii. Will the ACH retain some of this funding for post-2021 admin?

iii. Are providers receiving any of these funds for P4P or for future deliverables?

a) If applicable, describe how any other P4R or P4P funds (already earned or to be earned before the end of the DSRIP period) have been obligated for ACH or provider payments post-2021.

NCACH Response:

At the start of the Medicaid Transformation Project, the NCACH Governing Board did not feel that they had enough information to adequately estimate the amount of P4P funding earned, and they also had concerns with the State achieving their metrics. Therefore, NCACH did not originally budget to received P4P funds and did not obligate P4P funds to any of its partnering providers.

Due to the complexity of attributing P4P metrics directly to partners, NCACH continues to not attribute payments to partners based on P4P metrics but rather based on the specific deliverables outlined in each partner's contracts. As P4R and P4P payments are earned by the NCACH, our region will continue this practice for current and future deliverables that partners need to achieve as part of their engagement with our organization. In other words, P4P funding for DY4 and DY5 is currently not obligated to any agencies or any specific agency type (e.g. clinical partners), and none of our current MOUs obligate funds for partner payments post-2021.

As stated in previous SARs, NCACH utilizes a global budgeting approach for MTP funding and the way funding is earned does not necessarily drive how it is expended. NCACH plans to utilize any earned P4P funds to support regional priorities identified by the NCACH Governing Board and its stakeholders, as they related to both MTP project objectives and future strategic plans. In 2020, NCACH adopted a new mission statement and guiding principles to support its work through the end of the MTP and into the future. This includes shifting its focus from clinical metrics and partners and placing more of an emphasis on the Social Determinants of Health (including community-based organizations) to promote whole person health. Funding earned by NCACH in the future will support those objectives while also ensuring sufficient administrative infrastructure to keep the work moving forward. Given our global budgeting and planning framework, we are unable to predict a detailed and direct attribution of P4P funds to future administrative expenses.

a) Assessment of DSRIP sustainability:

   i. Describe activities and/or conversations, if any, your ACH has supported with partners related to sustainability priorities and mechanisms. For example, have there been activities or conversations around defining sustainability, evaluating results, or establishing criteria to determine what DSRIP activities would continue post-DSRIP funding?

   ii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation of DSRIP funded activities (e.g., capacity building, practice transformation, and collaboration among partners), beyond waiver funding. If you have not supported related activities and/or conversations during the reporting period, please explain why.

   iii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation and/or scaling of specific DSRIP project toolkit evidence-based models and/or pilots (e.g. Community-Based Care Coordination, CoCM). If you have not supported related activities and/or conversations during the reporting period, please explain why.

NCACH Response:

One of the key NCACH principles adopted by the Governing Board at the start of the MTP was that partners receiving funding should be able to outline a path toward sustainability or sustained change. To support the path towards sustainability for clinical partners, NCACH has focused on quality improvement work, data collection, partnership/collaboration building, and population health management. These building

blocks contribute to longer term results and sustainability, because they support readiness and capability to engage in VBP during and post DSRIP.

For example, we are providing ongoing supports to our WPCC providers for continuation of Project 2A and 3D, including continued learning activities. During the reporting period, WPCC partners reengaged in our Population Health Learning and Action Network (LAN) focused on behavioral health integration and chronic disease management, including a deeper dive into telehealth solutions for diabetes and depression management. Tracking of quality measures on a monthly basis is an expectation of this LAN.

NCACH engaged in conversations with TCDI partners to consider how they might build on their work while continuing to bake-in processes to improve follow-up and facilitate smoother transitions. Partners would like continued assistance with building partnerships and promoting collaborations. This feedback shaped the way the 2021 TCDI funding was structured, in that funding applications will incentivize joint applications including at least two of the following: EMS, Healthcare System, Community-Based Organization. The primary focus of their efforts in 2021 will be making connections with agencies outside of the healthcare setting. These kinds of partnerships are critical to the sustainability of Transitional Care Management and Emergency Department Diversion mechanisms. The primary focus of their efforts in 2021 will be making connections with agencies outside of the healthcare setting. These kinds of partnerships are critical to the sustainability of Transitional Care Management and Emergency Department Diversion projects.

With respect to community-based organizations and social service partners applying for funding through the Coalitions for Health Improvement (CHIs) community investment process, applicants were asked to explain how their project will lead to lasting and self-sustaining improvement. We plan on providing technical assistance and support to these partners (e.g. data tracking, marketing and communications) to help them build or strengthen their road to sustainability.

In general, NCACH reporting expectations continue to reinforce continuous quality improvement methods while encouraging providers and partners to apply process improvements and whole person health initiatives across all patient populations and payer types. This has promoted spread to additional high-risk non-Medicaid populations. Through regular reporting, NCACH asks partners to reflect on lessons learned and challenges, and identify assistance and resources they might need from NCACH to break down barriers to project objectives. NCACH continues to communicate and coordinate with MCO partners (via monthly or bimonthly meetings with each MCO from our region) to see where our practice transformation and quality improvement efforts might align.

Community Based Care Coordination has been a significant topic of conversation at the Governing Board level regarding sustainability and how our ACH can best make an impact in our region. Originally, NCACH adopted the Pathways Community HUB model as part of our region's community-based care coordination model. As we built out and piloted the model, it was obvious that this approach was not going to be sustainable in our region. However, NCACH recognized that care coordination is still a key priority for our region to address the whole person health of our residents. While NCACH did sunset the Pathways HUB, it has been developing plans to strengthen the Health Home program while also targeting funds to support a broader care coordination infrastructure in our region. It is anticipated funding will be utilized past 2021 to support the continued

build out of this work as we spend additional time defining sustainability of planned investments in our region.

During 2020, NCACH initiated conversations with Coalitions for Health Improvement (CHI) stakeholders to determine if they should (1) continue operating as a part of the current NCACH governance model, (2) become an independent coalition separate from NCACH, or (3) discontinue after the Medicaid Transformation. Each Coalition is currently receiving funding from NCACH for dedicated local staff capacity that can support the Coalition's activities. NCACH has contracted with a consultant who will support each Coalition as they evaluate the value they bring to their local community and determine the best appropriate structure to maintain that value in 2021 and beyond.

In summary, NCACH is continuing discussions with its partners and providing ongoing support around sustaining and scaling health improvement efforts post-MTP. COVID-19 delayed a number of these conversations and slowed down sustainability and strategic planning at the ACH level. However, HCA has requested to CMS that the MTP be extended for an additional year, since HCA themselves feel that their ability to demonstrate sustainability and outcomes has been delayed. If approved, this would provide partners the opportunity to claim back the time that was taken by COVID-19 and give NCACH the opportunity to continue building partner needs into our long-term vision and region's sustainability planning.

17. Regional integrated managed care implementation update

a) For **2020 adopters**, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken, in partnership with providers and MCOs, to address these challenges?

b) For **all early- and mid-adopters**, briefly describe any challenges the region continues to experience due to the implementation of integrated managed care. What steps has the ACH taken during the reporting period, or what steps does the ACH plan to take, to address these challenges?

NCACH Response:

Chelan, Douglas, and Grant counties transitioned to integrated managed care on January 1, 2018. Okanogan County transitioned to integrated managed care on January 1, 2019. Since the transition, there have been no significant issues that have arisen. The standing issue in our region continues to be behavioral health organization rates. NCACH engaged in separate conversations with HCA and a CEO of a local behavioral health provider to better understand the process. HCA was able to educate NCACH staff on how the process worked and how we can provide guidance to the behavioral health organization. NCACH staff was able to provide those instructions to our provider. This process helped NCACH enable the new CEO to advocate for their agency, and behavioral providers learned more about the kind of support available to them through NCACH staff. NCACH continues to offer a single point of contact or liaison for our behavioral health providers if they need it. The primary venue for providers to voice their concern is our Whole Person Care Collaborative, consisting of physical and behavioral health providers who meet regularly, providing opportunities for collaboration through monthly meetings and learning activities. This forum for collaboration has allowed NCACH to both help

providers identify, gather, and discuss issues they are having across the region as well as voice those collective concerns to the Health Care Authority based on provider input.

c) For **all regions**, what steps has the ACH taken, or what steps does the ACH plan to take, to support coordination with local, regional and statewide partners to design and implement strategies to address gaps and barriers impacting the health system in response to integrated managed care implementation?

NCACH Response:

NCACH organized an interlocal leadership group in partnership with Beacon Health Options to bring regional key stakeholders together to discuss major behavioral health issues in Chelan, Douglas, Grant, and Okanogan Counties. This group includes county officials, law enforcement, behavioral providers, hospitals (e.g., Confluence Health Medical Unit 1 (MU1)), primary care providers, and administrators of our crisis stabilization units (Parkside and Crisis Collaborative). The initial focus of this group has been to look at the continuum of care across the region to determine what's working well, what is missing, and where there is room for improvement.

Due to COVID-19, this group has been unable to meet, however NCACH staff continues to work with Beacon Health Options to identify services available in each county and how they fall on the continuum of care. This work includes identifying which population the service targets including age, county service is available, payers, inclusion/exclusion of specific diagnosis, availability of interpreters and translated material, etc. As the project continues, we will not only be able to identify general gaps in services, but can stratify the services to identify gaps for particular populations. In 2021, NCACH plans to re-engage the full interlocal leadership group to continue to expand upon the work that has occurred both before and during the pandemic.

d) For **all regions**, how are you supporting efforts to measure and report on clinical integration?

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

	Yes	No
18. 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: • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.	x	

	Yes	No
• 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.		

If the ACH checked "No" in item above, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

Section 3. Value-based Payment

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 4, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2020).*

Narrative responses

19. Identification of barriers impeding the move toward value-based care

a) Describe the barriers the region is facing regarding implementation of value-based care and methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

NCACH RESPONSE:

As outlined in the VBP survey, the top 3 barriers identified were (1) 'Insufficient patient volume by payer to take on clinical risk," (2) "Lack of trusted partnerships and collaboration with payers," (3-there was a three-way tie in responses) "Lack of interoperable data systems," "Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data)," and "Lack of timely cost data to assist with financial management." These barriers fall outside the role of the NCACH, nor can we assist with risk-based contracting. NCACH continues to support organizations by providing technical assistance so that they can access data, and support partner organizations transition to new EHRs so that they are better able to understand and use their individual data. NCACH continues to offer technical support and learning activities to assist organizations in using this data to drive improvement throughout their organizations. Quantitative and qualitative reports help NCACH staff identify barriers that keep providers from implementing practice transformation and moving toward value-based care.

20. Support providers to implement strategies to move toward value-based care

a) Describe how the ACH has helped providers overcome barriers; indicate if the scope or intensity of support has been different for small providers (25 FTEs or fewer), or behavioral health providers.

NCACH Response:

NCACH drives practice transformation by assisting each organization with integrating quality improvement efforts into their practice and to use their organization-derived data to drive that improvement. Larger healthcare systems typically have quality improvement methods embedded in their processes, more so than smaller organizations. Sometimes this means that organizations do not want to participate on the same level or intensity as other clinical partners. That said, most organizations attend our monthly learning sessions that focusing on depression and diabetes. The majority of those organizations complete the assigned homework.

Rural Health Clinics (RHC) and Behavioral Health organizations tend to struggle more but for different reasons. RHCs tend to have less staff, leading to capacity issues when trying to implement quality improvement methods. NCACH Practice Facilitators are assisting these organizations with strategies to help them. While primary care has a model, they can look towards and understand what is expected of them, Behavioral Health Organizations do not have the same vision on how VBP will work for them.

Behavioral Health Organizations continue to work alongside primary care partners in the learning and action network, implementing quality improvement strategies and using data as their guide. NCACH has also given partners access to National Quality metrics, specific to behavioral health providers, to help guide their processes.

21. Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey

a) Provide an example of the ACH's efforts to support completion of the state's 2020 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

NCACH Response:

Every year, nearly all partners NCACH works with have been compliant under the Medicaid Transformation Project. When reviewing survey respondents between 2019 and 2020, the only respondents that did not respond in this last SAR reporting period were partner agencies that were no longer providing Primary Care for reasons outside of their engagement with NCACH and therefore less likely to complete a Value Based Care survey. Although no financial incentive was given to providers to complete the Washington State Value-Based Purchasing Survey, NCACH continues to have success every year in getting surveys completed due to the strong relationships NCACH has with our partners. Due to that success, NCACH has not changed its tactics year to year.

State provider VBP survey communication activities		
Tactic	**Incentives offered? (Yes/No)**	**New tactic? (Yes/No)**
Emailed survey to provider groups to encourage completion. Providers were able to email NCACH if they had any questions about the VBP survey, and NCACH directed them to HCA if needed.	No	No
Informed providers at meetings of the NCACH WPCC and Board that the survey was active and encouraged them to complete the survey before the due date.	No	No

State provider VBP survey communication activities		
Tactic	**Incentives offered? (Yes/No)**	**New tactic? (Yes/No)**
Sent individual communication to providers who have not completed assessment during the survey period. This included additional follow-up from the Executive Director to agencies that had not completed the survey closer to the due date.	No	No

b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

NCACH Response:

Each year, NCACH shares value-based payment survey data with providers to gather input. In response to feedback, NCACH has provided basic VBP materials on its Healthcare Communities portal and shared those materials at previous WPCC meetings.

In 2020, NCACH did not utilize the VBP survey data with partners, largely because COVID-19 has caused most providers to focus on other efforts and decreased their focus on VBP during the 2020 calendar year. While this work has picked back up during this reporting period, NCACH's primary focus has been to ensure that all project work was running at original levels and to evaluate how we can expand the work of telehealth that was accelerated under COVID-19 to support provider transformation efforts.

As noted in the 2020 survey, Providers feel that VBP progression and contracts should be limited until the pandemic is over (48 of 97 respondents) and/or pause the expansion of VBP and focus on sustaining access to and improving the availability of provision of telehealth services (57 of 97 respondents). NCACH's approach in the second half of 2020 was to stay in alignment with the general wishes of our providers during this reporting period.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

22. P4R Metrics

The reporting requirements for the P4R Metrics updates are temporarily replaced with COVID-19 related responses in the "Narrative Responses" section. ACHs may use discretion, and will not be penalized, surrounding the timing and volume of P4R metric data collection during the COVID-19 pandemic. For example, an ACH may choose to delay data collection, make participation optional, or target participation. The submission of P4R Metrics are considered optional for this reporting period but are encouraged.

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.[6] Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: How to read metric specification sheets.
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under "ACH pay for reporting metrics."

Instructions:

a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).

b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the reporting template.

Format:

a) ACHs submit P4R metric information using the reporting template provided by the state.

NCACH Response:

NCACH suspended P4R metric data collection for project 3A in 2020 due to COVID-19, and will resume the collection as part of our reporting cadence in 2021. The reporting template for this reporting period includes Project 2A MeHAF data.

See Attached: NCACH.SAR6 P4R metrics.2.01.21

[6] https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121