Regional collaboration for health system transformation: An evaluation of Washington's Accountable Communities of Health

Center for Community Health and Evaluation
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Contents

Executive Summary

Washington State is pursuing health system transformation through its "Healthier Washington" initiative. The goal is to create healthier communities by taking a collaborative regional approach to enhance the health of state residents, improve quality of care, and reduce health care costs. **At the center of this work are nine regional, multi-sector collaborative organizations known as Accountable Communities of Health (ACHs)** tasked with building the foundational infrastructure for collaboration, developing regional health improvement plans, jointly advancing large scale health improvement and system transformation projects, and advising state agencies on how to best address health needs within their geographic areas.

Collaborative foundation established; significant accomplishments achieved. Our evaluation found that the Washington ACH model that evolved in practice has been largely successful to date. In 2015, ACHs began to build modestly resourced coalitions focused on improving health in their regions, funded under a State Innovation Models (SIM) federal grant. They have evolved into independent organizations who are leading the collaborative design and implementation of $1.1 billion worth of health system transformation projects. While their approaches vary, Washington ACHs:

- **Built trust and collaboration**, which enabled sectors that previously did not interact to come to the ACH table, put aside their individual organizational priorities, and make collective decisions about how to transform the system in an aligned way.

- **Established the infrastructure and capacity to implement large-scale system change** by standing up independent collaborative organizations that have led complex, community-driven planning processes to ready their region for health system transformation.

- **Created a comprehensive, integrated approach to health system transformation.** ACHs brought a collaborative, region-wide, strategic perspective to designing a project portfolio through the coordinated efforts of their multi-sector partners.

- **Incorporated community voice, equity and the social determinants of health.** ACHs have worked to meaningfully engage a wider set of voices into their work, systematically build in a priority of health equity, and maintain a focus on the social determinants of health in their region.

There are regional differences in ACH development, structure, and outcomes, but all have built collaborative organizations and are well-positioned to lead the implementation of health system transformation projects.

Lessons for other states. Washington's experience provides useful lessons for other states investing in large-scale collaborations to improve health. In particular, new state agency approaches and capacities are required to work effectively with regional partners. State agencies should seek a balance between state guidance and community-driven solutions. The presence of a funded development period proved critical for building the foundation that was needed when more significant health system transformation resources became available.

Moving forward. The ACHs' work towards health system transformation continues to evolve. Policymakers, state health leadership and regional stakeholders should consider ways of capitalizing on Washington's successful investment in ACHs to support this ongoing work.

I. Introduction

Since 2012, Washington State has been leveraging several federally-funded initiatives to pursue health system transformation. Collectively branded "Healthier Washington," the goal is to create healthier communities by taking a collaborative regional approach to improving quality of care, enhancing the health of state residents, and reducing health care costs. At the center of this work is a set of nine regional collaborative organizations known as Accountable Communities of Health (ACHs) tasked with building the foundational infrastructure for regional, multi-sector collaboration; developing regional health improvement plans; jointly implementing or advancing local health projects; and advising state agencies on how to best address health needs within their geographic areas.

This report tells the story of early ACH development and outcomes during the period of 2015-2019, describing their role and impact on regional health improvement and Washington's health system transformation effort. During this time, ACHs evolved from modestly funded coalitions focused on building collaboration among regional organizations under the State Innovation Model grant (SIM), to independent organizations leading and managing the implementation of $1.1 billion worth of Medicaid Transformation Projects (MTP).

The ACH evaluation was conducted by the Center for Community Health and Evaluation (CCHE) working in collaboration with the University of Washington and the state Department of Social and Health Services to evaluate the State Innovation Model (SIM) grant described below. Qualitative and quantitative data were collected from multiple sources to document ACH progress and impact from 2015 to 2019. These data included extensive meeting observation, annual site visits, regular interviews with key stakeholders, annual surveys of ACH participants, and extensive document review (see Appendix B for more details). As an evaluation partner, CCHE worked closely with the Health Care Authority (HCA) to provide timely feedback about success factors, challenges, and lessons learned. The goal was to support strategic learning about ACH development and to identify how Healthier Washington could continuously improve its support of ACHs.

What is an ACH?

An ACH is a regional collaborative organization consisting different sectors working with the community to improve health in their region. ACHs vary widely in terms of geography, population, and size. Seven of the nine ACHs are multi-county areas, ranging from two to ten counties. Washington's two most populous counties – King and Pierce – each comprise their own region. While some regions have a history of collaboration, others incorporated

Figure 1. Map of ACH regions
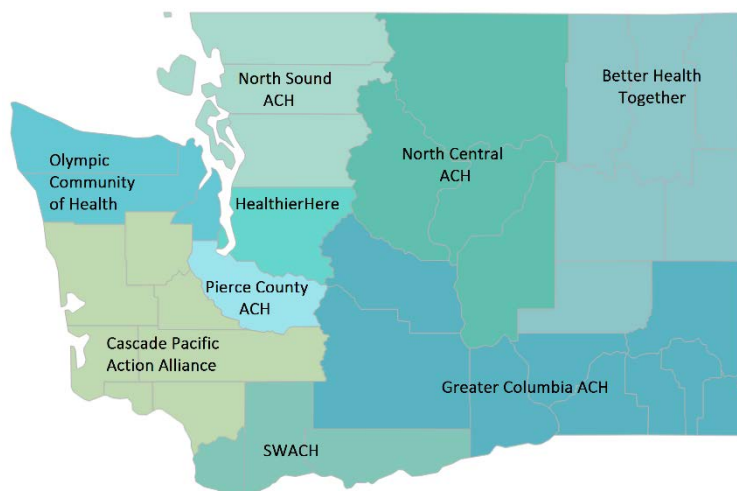
new communities or counties into their identities as ACHs. For more information on individual ACHs, see Appendix C.

Washington ACH roles have evolved over time. Currently, ACHs play a variety of roles within their regions to facilitate health systems change, including:

- **Convening & connecting –** serving as neutral conveners to bring together partners from multiple sectors who have a role to play in health systems transformation. ACHs can also play a brokering role between local partners and state agencies.
- **Providing strategic regional leadership –** bringing a region-wide strategic perspective to prioritize and integrate the work of partners across sectors and smaller geographies (e.g., county, city, community) so that the region is moving forward in an aligned direction.
- **Translating large-scale initiatives into action –** coordinating the planning and implementation of large-scale health improvement projects and making innovative, system transformative efforts a reality.
- **Supporting regional capacity building -** providing cross-sector training, information sharing, and support to improve clinical and community-based organizational capacity, communication, and coordination.
- **Bringing in funding to the region –** advocating for needed funds and supporting the region in developing funding sources, including supporting collaborative grants that involve a cross-section of regional stakeholders, and developing new funds to address social determinants of health.
- **Influencing policy change needed to support transformation –** partnering with state-level agencies and other organizations to bring a regional/local perspective to broader policy efforts.

How do ACHs achieve their impact? ACH Theory of Change

The ACH model below gives a visual representation of the ACH role and the process by which they influence health system transformation. By developing as strong collaborative entities they are able to bring about systems, practice, and policy changes that can be scaled and spread to create a transformed health system.

Figure 2. ACH Theory of Change
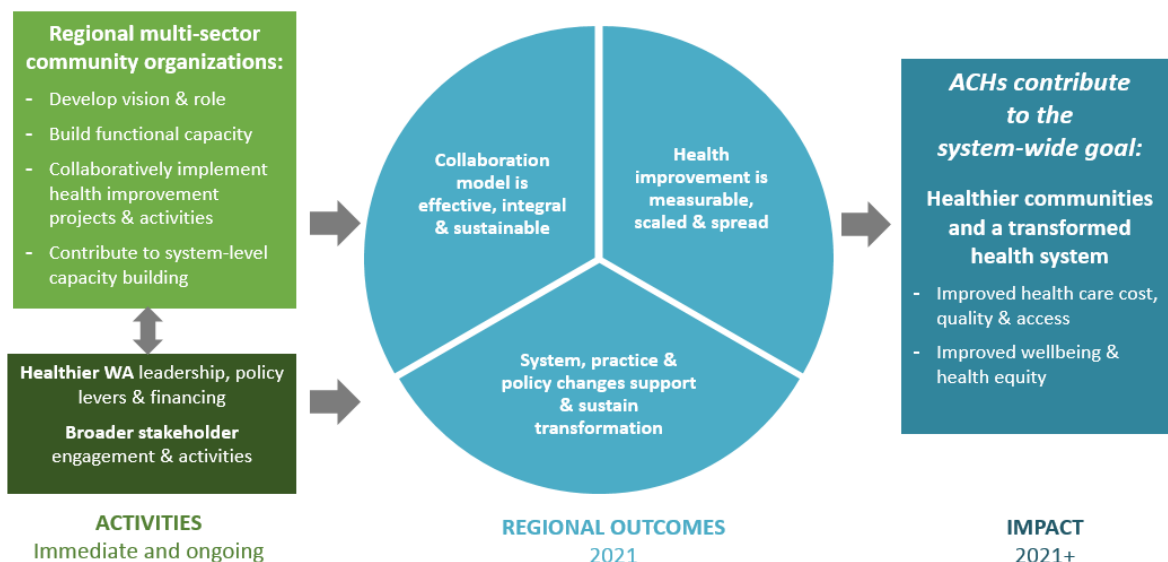
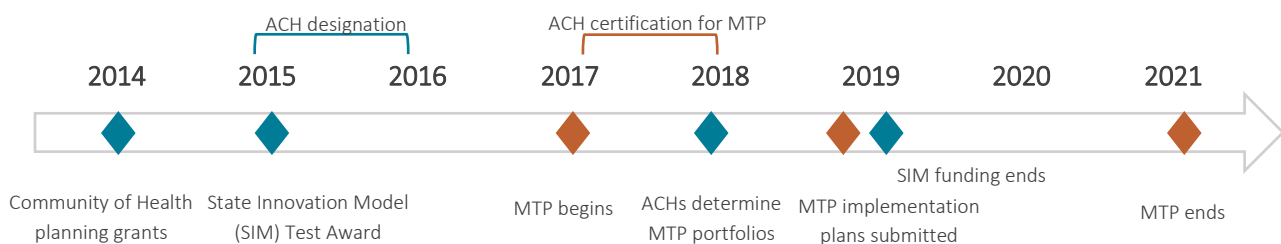## How have ACHs evolved? Changes in role, activities, funding and scope

ACHs launched under SIM. The conception of ACHs began with Washington's 2013 State Health Care Innovation Plan, which called for the creation of a new partnership between the state and community-oriented organizations. Washington began developing this partnership in 2014 with limited Community of Health funding and some state legislation guidance for two pilot sites. The role was formalized when ACHs were included as an essential component in the $65 million State Innovation Models (SIM) federal grant that began in 2015. In addition to $7.3 million in ACH funding, SIM funded several other large-scale initiatives, including improving how Washington pays for health care services by testing models that emphasize paying for value, integrating physical and behavioral health care, and implementing a practice transformation hub to improve health care delivery.

During their first two years (2015-16), ACHs focused on establishing operational and governance infrastructure to support regional, cross-sector collaboration. Under SIM guidance, the ACHs focused on how to improve health in their regions broadly defined, including addressing the social determinants of health and health equity. ACHs engaged stakeholders from across their regions, many of whom had never worked together before. They began to develop regional health needs inventories to understand local health priorities. As a result, nine collaboratives were officially designated as ACHs during this time period.

In 2016, each ACH selected a health improvement project designed to address one of their identified regional priorities. Additional resources available for these projects were modest—$50,000 in dedicated funds. Despite the limited funding, ACHs undertook important health improvement projects that allowed them to develop their abilities to work collaboratively.

> **SIM health improvement projects**
> - **Six ACHs initiated new projects** including: a pilot project promoting behavioral health coordination in schools, a community-based blood pressure screening project, and a pilot of a care coordination model.
> - **Three ACHs developed projects designed to support larger efforts in their area**, including: convening region-wide efforts around opioid response, supporting an existing effort to link housing & health, and moving health care clinical practices to a whole person care model.

| ACH designation | | ACH certification for MTP | |
| 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |

Community of Health planning grants — State Innovation Model (SIM) Test Award — MTP begins — ACHs determine MTP portfolios — MTP implementation plans submitted — SIM funding ends — MTP ends

ACHs scope and role expanded under MTP. A major shift in the ACH role occurred when Washington's Section 1115 Delivery System Incentive Payment Project (DSRIP) waiver launched in January 2017. Initiative 1 of the wavier, known as the Medicaid Transformation Project (MTP), provided up to $1.1 billion for regional health system transformation projects that benefit Medicaid consumers ("up to" because a significant portion of the MTP funding is performance-based). More details about the MTP are in Appendix A.

Under MTP, the state reinforced the policy direction that these evolving collaborative organizations are a central component of health system transformation in Washington. ACHs became responsible for the design and implementation of the health transformation projects that came with a significantly greater amount of funding. The goal changed from a broad definition of improving population health in regions, to a more clinical definition of transforming the health system. MTP also focused on a narrower population (Medicaid beneficiaries) and is more prescriptive in nature than SIM (see Table 1 for a summary).

This shift required ACHs to refine governance, greatly expand their operational structure with new engagement mechanisms, develop executive leader and staff capacity, and develop collaborative project selection and planning processes. All nine successfully developed complex project plans that were submitted for approval and funding in November 2017. Planning continued in 2018 and now all ACHs have begun distributing funding to their regional partners that range from health systems and providers to community-based organizations. Regions are now beginning the challenging stage of project plan implementation.

> **MTP projects in three domains:**
> 1. **Health systems capacity building as a foundation across all projects**, including workforce development; system infrastructure technology and tools; and support for providers in adopting value-based purchasing and payment.
> 2. **Care delivery redesign projects**, including integrated delivery of physical and behavioral health services; care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach, engagement, and recovery supports.
> 3. **Prevention and health promotion projects**, including prevention activities for targeted populations and regions.

Table 1. Comparison of ACH requirements under SIM and MTP

Category	SIM	MTP
Organizational structure	No requirements regarding formal organizational type, other than having a designated backbone organization to serve as a fiscal agent.	Required to be an independent organization, including Board membership requirements. Seven ACHs are non-profits (501(c)3s) and two are LLCs housed within existing non-profits.
Project focus	Required to design and implement one health improvement project, either building on existing work or starting a new project. Topics could range from clinically-focused to social determinants of health.	Required to convene regionwide process to select, design, and implement at least 4 of 8 MTP projects, each with a detailed set of project design and reporting requirements, and clinically-focused metrics. (See Appendix A for project and selection details)
Resources	$7.3 million in SIM funding allocated comparably across ACHs for collaboration and development; including $50,000 for their selected project.	Total of up to $1.1 billion in project funding, allocated across ACHs in proportion to the number of Medicaid members in the region.

ACH spotlights. This report describes ACH outcomes in aggregate, elevating the most consistent themes to tell the overall story of what ACHs have accomplished and how they built the foundation for collaboration. A cornerstone of the ACH approach, however, is the ability for regions to approach their work and development differently so that they accomplish similar goals in a way that meets the needs of their individual regions. To showcase this variation, individual ACH efforts are included as spotlights throughout the report to provide examples of what this work can look like on the ground at a specific ACH. There is significant variation across ACHs; other regions may not be employing these same tactics or approaches to reach their goals.

Spotlight: Cascade Pacific Action Alliance (CPAA)

In January 2015, as part of SIM, stakeholders from across the CPAA region identified improved behavioral health care coordination for children as a high need in local schools and undertook an effort to reduce the number of children with unmet behavioral health needs. The result was CPAA's Youth Behavioral Health Coordination Pilot Project. The project addresses behavioral health issues, including Adverse Childhood Experiences (ACEs), through prevention and mitigation using school-based behavioral health services and referrals.

This project coordinates key stakeholders (school districts, clinicians, and behavioral health care providers) to identify students with behavioral challenges as early as possible and connect the children and their families to community-based interventions and treatment services. This collaboration among non-traditional partners was key to success. Additionally, the project had components that varied slightly by implementation site; CPAA recognized that needs and assets vary by county in their region, and the project would be even more successful if these variations were taken into account.

CPAA's vision of promoting whole person care connects this project with their work under the Medicaid Transformation. The foundational work that occurred under SIM and the early outcomes that they achieved allowed them to apply lessons learned from this project to their more recent work. The collaboration that began under SIM for this project continues, with over 200 students referred for the program per year in school years 2016-2017 and 2017-2018.

The remainder of this report will look at the early outcomes ACHs have achieved, and how they have created the collaborative structure, trust, and regional relationships needed to implement an ambitious health transformation initiative. It will also detail lessons learned for other states, foundations, and communities investing in health improvement and system change, particularly through the vehicle of regional, multi-sector collaboration.

II. ACH outcomes: Significant accomplishments and building strong collaborative organizations

This section elevates key ACH outcomes, starting with an overview of the significant accomplishments achieved to date, and then describes how the ACHs developed the necessary collaborative structure, engagement, and capacity to succeed. These outcomes were relatively consistent across all ACHs. There were many regional differences in collaborative development and structure and the shape the outcomes took, but all are poised for health system transformation and have built strong collaborative organizations.

Significant accomplishments

Although MTP implementation is in the early stages, the ACHs have achieved significant accomplishments that set the stage for successful system transformation: building trust and collaboration; establishing infrastructure and capacity; creating an integrated regional approach; and bringing in community voices and a focus on equity and social determinants of health.

1. Built trust and collaboration

A precondition for effective multi-sector collaboration is building the trust, relationships, and structure necessary to make joint decisions, align activities across organizations and work together effectively. SIM provided the time, policy direction, and resources for ACHs to begin building the key elements of collaboration. Once MTP began, ACHs were able to quickly move to action because of this foundational work.

Through their role as regional neutral conveners, ACHs enabled sectors that previously did not interact to come to the ACH table, put aside their individual organizational priorities, and make collective decisions about how to transform the system in an aligned way. It was not a foregone conclusion that trust and collaboration could be built – many ACHs described significant challenges working across sectors, clinical/non-clinical divides, and geographies that did not have a history of working together.

> We're going to partner together, we're going to collaborate together, we're going to agree to disagree sometimes but do it as a respectful way, we're going to learn as we go. It's been fantastic to watch those partnerships and those relationships grow.
>
> – ACH lead

Participants now report that ACHs have increased collaboration across organizations and sectors, are helping to align resources and activities, and have begun to reduce duplication of efforts by forming linkages between organizations in their regions. Stakeholders from different sectors and organizations are more able to see interconnections, increase region-wide awareness of central issues, and build essential new partnerships, including those with community-based organizations and consumers often missing from these conversations.

2. Established the infrastructure and capacity for large-scale system change

Over the past four years, all nine ACHs have stood up independent collaborative organizations with the capacity to successfully complete a complex, community-driven planning process. They are now ready to

lead the implementation of $1.1 billion of health system transformation projects through the coordinated efforts of their multi-sector partners. They achieved this by:

- Developing the significant organizational capacity and infrastructure to succeed. For seven ACHs, this including the challenging task of converting their ACHs into stand-alone organizations (501(c)3 or LLC). All ACHs are serving as fiscal agents, entering into contractual relationships with a diverse array of community partners, and meeting all MTP requirements around project content and measurement.
- Leading a strategic, region-wide process to identify needs, select MTP projects, allocate funds, determine key partnerships and design concrete action plans.

ACHs were uniquely positioned to reach across community and county boundaries, gather disparate plans and ideas, and then lead conversations about how those efforts could be integrated into a single set of regional priorities to transform the health system. ACHs are now moving into implementation and are distributing funds to their partnering providers. All of this was accomplished in a dynamic environment in which Health Care Authority, the lead agency for MTP, made continuous adjustments to MTP project content, structure and process.

> We are tackling the challenges as a community, not in silos.
> – ACH participant

3. Created a comprehensive, integrated approach to health system transformation

The goals and structure of the MTP were prescribed in considerable detail to elevate common project categories and evidence-based approaches (see Appendix A). However, regional needs and capacities vary widely and a key role of the ACHs was to bring their region-wide strategic perspective to designing projects that will promote greater long-term impact and sustainability. Health system transformation requires a high degree of synergy between activities that is not possible without a collaborative foundation. Early indications are that ACHs have been effective in this role, although ultimate success can only be judged in several years when population-level impact can be measured, and sustainability assessed.

> [ACHs are] creating the system level view and approach that I think is different...One of our jobs is to not let folks get away with status quo or making minimal change, but to really push towards the transformation.
> – ACH leader

ACHs are now poised to lead the implementation of the health system transformation projects, through a coordinated set of activities that will be carried out by regional partnering providers and organizations. Strategies vary across ACHs, but generally include supporting behavioral health integration, building care coordination infrastructure, promoting practice transformation, developing systems for regional data sharing, building the capacity of providers and organizations to transform, and contributing to transformation-related policy change.

4. Incorporated community voice, equity and the social determinants of health

A key rationale for the central role of ACHs in SIM and MTP was to change the conversation about health system transformation and health improvement by including a wider set of voices, building a focus on health equity, and addressing the social determinants of health. Instead of treating these issues in an ad hoc way, successful ACHs have systematically incorporated them into how they structure their organizations and governance.

While community engagement continues to be challenging, many ACHs have brought the community voice to the ACH table through securing governing board representation, creating specific committees, and developing subgroups that leverage grassroots representation. Many ACHs have maintained a focus on health equity through mechanisms that include: utilizing equity tools in decision-making, providing trainings, bringing a focus on health disparities, and designing activities that increase the awareness of equity within the region.

Although the MTP funding and goals are clinically focused, ACHs remain committed to the broader vision of addressing upstream social determinants of health. They have incorporated this focus into their organizational structure by including providers of social services as essential participants, and into their activities through a commitment to developing clinic-community linkages. Many ACHs are also using a variety of creative methods to set-aside or secure funding that will allow them to reach beyond the clinical focus of the MTP and address upstream issues such as housing, transportation and food security.

Spotlight: North Sound ACH

The North Sound ACH strives to improve the health of the people who live in Island, San Juan, Snohomish, Skagit, and Whatcom counties. To achieve this goal, they recognize that they must work with and for the community. They aspire to address inequities within the healthcare system and embed targeted universalism into their strategies. The North Sound ACH's work begins with themselves: 10 members of their team attended the 2018 Equity Summit, at which they learned how to integrate equity into all levels of their work and explored tangible examples on how to achieve equity.

Addressing equity requires North Sound ACH to keep community at the center of their vision and activities. They are requiring every Medicaid Transformation Project Partner to participate in an equity and Tribal learning series as part of their collaborative work together. For their board and team meetings, they rotate locations among the five counties to ensure that no community organizations or members are inhibited from participating due to transportation, distance, etc. Additionally, the start of each meeting begins with a land acknowledgment statement to pay tribute to the original inhabitants of the land.

Keeping equity at the center is part of North Sound ACH's structure. Historically, their program council drew on community expertise across fields and sectors; as their work continued, they became an integral advisor to ACH staff because of their broad and unique perspectives. North Sound ACH engaged community members and community agencies/organizations in their Community Leadership Council to ensure that underrepresented voices' needs are heard. The board's Tribal Alignment Committee ensures that North Sound ACH decisions examine the impact on the Tribes in the region. Meeting at least quarterly, the Tribal Alignment Committee includes representatives from 6 Tribes and board members who are not Tribal members. The Tribal Alignment Committee has used the stated values of the North Sound ACH to discuss distribution of funds to Tribal partners to support their work under the Tribal-specific projects. They have also led recommendations about the Tribal learning series and how the ACH team reviews contractors to assure that they understand and respect Tribal sovereignty before doing work in the region.

Building the foundation: Strong collaborative organizations

This section describes the ACHs' process of developing the collaboration, structure, and capacity to succeed as regional, multi-sector, collaborative organizations under SIM and MTP. It is organized around a model that CCHE developed to understand and track the elements central to building and supporting successful collaboration. While interconnected, each element is essential in its own right – without one of the elements, partners cannot effectively work together to achieve their desired outcomes. This section describes ACHs' successes and challenges with building each of these elements in their pursuit of health improvement. This is what enabled ACHs to accomplish the outcomes described in the previous section.

Collaborative vision & mission
Joint priorities
Sense of ownership

Multi-sector, diverse representation
Key stakeholder engagement

Shared purpose

Essential people at the table

Community & Equity

Active participation in planning & work
Operating in the shared interest

Active collaboration

Adequate structure & support

Dedicated staff with adequate capacity
Appropriate structure
Clear decision-making
Effective communication
Data/analytics capacity
Adequate resources

Effective leadership

Taking action

Facilitative leadership
Fosters trust & collaboration
Effective communicator

Community & equity at the center – informing how all the elements develop

Concrete action plan
Resources identified
Measurement & QI
Collective progress & achieving outcomes

Shared purpose: Creating common priorities for working together

One of the initial steps for emerging ACHs was to refine and agree on a mission and vision to guide their new regional collaboration, and define their regional ACH identity. Partners started with overall SIM grant guidance from HCA, but then quickly moved to developing a shared purpose that reflected their individual regions. ACHs described significant challenges building a shared sense of purpose among new sectors and counties that did not have a history of working together.

During the first year under SIM, ACH participants dug into regional and county-level health data and developed regional health needs inventories to identify common priorities across the region. These joint priorities continued to be valuable guidance as ACHs first developed regional health improvement plans and later selected MTP projects. As part of this process, many ACHs utilized town halls, outreach, and online surveys to include the community needs and hopes as they refined their ACH goals.

> **ACH promising practices**
> - Use a shared purpose development process that is collaborative, community-wide, and ongoing, i.e., treated as a living document
> - Develop a purpose with enough detail to be relevant to operations, priority-setting, and decision-making
> - Refer back to the shared purpose regularly, (e.g., put on agendas, reference in meetings) so that it can frame discussions, decisions and actions of staff and participants

The launch of MTP required ACHs to revisit their shared purpose and reconcile the broader focus of SIM with the MTP's focus on the state's Medicaid population. This continues to be a tension for many ACHs as they work to build a sense of ownership in ACH work across all regional stakeholders.

Spotlight: North Central ACH

Early in their formation, North Central ACH united around the shared purpose of Whole Person Care in their four-county region, creating a collaborative to bring this vision to life. The Whole Person Care Collaborative (WPCC) strives to improve the capacity of primary care and behavioral health providers in the NC region to effectively develop and implement processes within their clinical operations that take care of the whole person. The WPCC not only works on processes improvement efforts within the walls of primary care and behavioral health, but also seeks to partner with key stakeholders in the region such as hospitals and community-based organizations to ensure that social needs are addressed.

The WPCC has evolved to become not only an advisory group to the NCACH governing board, but also a regional community to support providers. For example, the WPCC supports the counties' providers in their transitions to fully integrated managed care as middle-adopters. With national expertise brought in by the Center of Collaboration, Motivation, and Innovation (CCMI), NCACH developed a Learning Collaborative model through which regional partners share best practices and receive additional consultant and coaching support. Additionally, NCACH partnered with Qualis (through the Healthier Washington Practice Transformation Hub) to support providers in implementing the patient-centered medical home model and the Maine Health Access Foundation assessment. Through the WPCC, providers work toward the goal of whole person care and explore solutions to challenges they are facing while receiving support on their organizational "Change Plans" for the Medicaid Transformation Projects (MTP). Although the MTP has many different metrics that need to be met, North Central ACH sees this work as all in service of the vision of whole person care.

Essential people at the table: Building regional, multi-sector engagement

Under SIM, HCA set broad requirements including governing boards with "balanced, multi-sector engagement" and "participation from key community partners representing systems that influence public health, health care, and the social determinants of health (SDOH)." HCA

left the definition of a multi-sector table up to each region which resulted in significant variation in how ACHs formally defined and engaged "sectors." Creating the best mix of sector and organization engagement took time but ensured that the ACH represented a broad array of perspectives.

Under MTP, the state provided more specific guidance around sector engagement; a specific sector seat approach that included requiring seats for a Medicaid consumer and Tribes. This change was a challenge for many ACHs because it required reorganizing their governance structures. ACHs began to more formally define the proportion of board representation held by different sectors and clarify expectations for representing a sector.

As the scope of the work expanded under MTP, so did the definition of an ACH table. ACHs developed multi-tier structures so that more stakeholders could actively engage in the ACH. ACHs highlighted the challenge of getting organizational representatives effectively engaged in the right level of the ACH table. Sometimes ACHs needed representatives that could make decisions on behalf of their organizations, other times they needed people that brought on the ground experience. As ACH structures evolved, educating new participants was time- and resource-intensive but necessary.

> **ACH promising practices**
> - Clearly define the stakeholders (sectors and communities) to be formally represented on the board and/or committees, e.g., proportions held by certain sectors
> - Create a formal structure and process to facilitate participation of diverse people and organizations from all parts of the communities served, e.g., multi-tier structures or sub-regional groups, open board nomination process
> - Define responsibilities of being a sector representative that include eliciting feedback from others in the sector

Appropriately engaging community members in the ACH governance structure has been challenging. Early on, ACHs looked to representatives of existing multi-cultural or population-specific coalitions or consumer groups to represent Medicaid consumers on their governing boards. Over time, ACHs began to create ways for consumers to be more directly engaged.

A key learning for both ACHs and Healthier Washington was how to respectfully collaborate with Tribes as sovereign nations. Tribes and Urban Indian Health Programs (UIHP) are not simply another sector, and there was significant confusion about how to appropriately invite them to participate in the ACHs. A series of structured learning opportunities helped to open communication, shift expectations, and eventually, revise state guidelines. Through amended relationships, many ACHs are more actively partnering with Tribes and UIHPs when priorities align and learning from their significant experience in integrated and whole person care.

Currently, all ACH governing bodies include local public health, multiple health system partners (hospitals, primary care and behavioral health providers, Medicaid managed care plans, and community health centers), community-based organizations that provide social services, Tribes, and consumers or community members. Many ACHs also include a selection of the following on their governing body, with most including all of these sectors within their larger structure: education, oral health, housing, first responders, long-term care, employers or business, local government representatives, philanthropy, and seats for existing local coalitions that work on equity.

Spotlight: Olympic Community of Health (OCH)

3 County Coordinated Opioid Response Plan (3CCORP) is a comprehensive, collaborative initiative designed to coordinate and implement a community response to the opioid crisis in Kitsap, Jefferson, and Clallam counties. Additionally, OCH works within the territorial lands of eight Tribal nations. OCH began the 3CCORP planning process as its SIM grant project in 2016, and the work is now also integrated into OCH's approach to the MTP. The long-term goals of 3CCORP range from preventing opioid misuse and overdoses to expanding access to best practices and supporting long term recovery. Many 3CCORP partners participate in OCH's three Natural Communities of Care (NCCs) as well.

To build collaboration, OCH facilitated regional opioid response summits in 2017 and 2018. The summits brought together partners from the fields of primary care, mental/behavioral health, substance use disorder and dental health, as well as Tribal partners, public health, local government officials, law enforcement, fire/EMS, elected officials, and other community members from the region and across the state to discuss the opioid crisis, network, and learn about the coordinated regional response.

3CCORP has allowed for new and more robust cross-sector coordination, as well as shared learning about how local Tribes are responding to the opioid epidemic in the community, while providing access to updated regional data. Notable successes include:

- Implementing the Six Building Blocks in the region (6BB is a team-based approached to Improve Opioid Management in Primary Care);
- Establishment of a regional Opiate Treatment Network with a hub & eight spokes across the region;
- Improved collaboration and coordination between medication-assisted treatment providers and substance use disorder providers, including the transformation of the outpatient SUD system from predominantly abstinence only care to a more robust, evidenced-based practice system;
- Development of a roster and survey to assess naloxone access.

In addition, data presented at the 2018 opioid summit indicated a decrease in fatal overdoses, improved opioid prescribing practices, and an increase in waivered providers allowing easier access to treatment. 3CCORP will be reviewing the regional opioid response plan to identify new priorities and strategies in early 2019.

Effective leadership: Operationalizing the vision

Effective leadership can take many forms and changes over time as collaboration evolves. Under SIM, leadership came from the founding ACH participants and the governing board, as well as staff at the designated backbone organization who provided on-the-ground support for ACH development. Over time, backbone staff assumed more of a leadership role, often becoming the voice of their ACH in statewide conversations.

The MTP requirement for all ACHs to become independent organizations resulted in a formalization of a lead staff role, generally as ACH executive directors (ED) and CEOs (referred to here as EDs). Boards retained decision-making

ACH promising practices

- Design the ED selection process to value previous experience, e.g., prior non-profit leadership, content expertise, existing relationships in the region
- Choose an ED who can be both visionary and operationalize the work; uses a collaborative approach that brings people together; and has the skills needed to build relationships
- ED and board represent the ACH both in the community and at the state level to foster engagement, promote equity, and provide strategic leadership
- Systematically maintain institutional knowledge, trust, and relationships that can mitigate the potential impact of leadership changes within staff or board

authority for the organization, while also setting policy direction, advising the ED, representing the ACH in the community, and providing leadership for ACH work streams or aligned statewide efforts.

ACH leadership is most successful when it embodies a commitment to building collaboration into all aspects from designing meetings that encourage dialogue, to developing committee structures that allow for broad participation. The ability of the ACH to live out its shared purpose hinges on how the ED and board's leadership guides the ACH. Successful leadership requires the capacity to communicate an innovative vision and engage the community, while also developing detailed plans. ACH leader transitions have been challenging for regions and are least disruptive when the overall ACH staffing and operational structure is sufficiently developed to support the change.

During the past year, the definition of leadership has evolved again to include a statewide leadership component. ACH EDs have also begun working more closely together as a cohort to identify issues that cross ACH regional boundaries, look for ways to jointly address issues. and align their work to support transformation. When appropriate, the cohort designates individual ACHs to participate in broader statewide efforts on behalf of the group and provides feedback to HCA about needed changes, clarification, and additional direction required for MTP to be successful.

Spotlight: HealthierHere

Eliminating disparities, promoting equity, and prioritizing community engagement and partnership are core values that drive HealthierHere's work. HealthierHere's vision for a transformed system includes effective mechanisms for meaningful community and consumer involvement and voice in system improvement work. HealthierHere is operationalizing that vision in both its organizational structure and through its program implementation.

Organizationally, HealthierHere first established a Community and Consumer Voice Committee (CCV) of its governing board. The CCV is made up of community members and representatives from local community-based and consumer advocacy organizations, and its goal is to ensure that community voice, knowledge, experience, and expertise is included in planning and decision-making. Monthly meetings are open to the public, and community members are encouraged to attend. Second, one-third of HealthierHere's governing board is made up of consumers, Tribal leaders, and community-based organizations ensuring that community voice is part of all decision-making. Finally, HealthierHere has a Director of Equity and Community Partnerships and two Community and Tribal Engagement Manager positions to support the work with community and Tribal partners, and to ensure that HealthierHere continues to lead with equity.

Programmatically, the CCV developed an Equity Tool used by the ACH's design workgroups to assess impact and consumer voice in early MTP planning. The CCV also championed HealthierHere's Small Grants Program, administered through a contract with the Center for MultiCultural Health, which funded 22 community-based social services organizations and grassroots community groups to engage with community members, and capture insights and feedback about their experiences with Medicaid and accessing care to inform the ACH's work. The program acknowledges the value of community organizations in providing a trusting, culturally relevant forum for community members to share what matters to them. The CCV also developed an official Equity Definition and Guidelines, adopted by the governing board. The 8-month development process intentionally elevated community voice and involved authentic community engagement. The document explains what HealthierHere means by the term "equity," articulates the organization's commitment to operationalize equity, and outlines how an equity lens will be applied to planning, programs and partnerships.

Adequate structure and support: Increasing capacity to accomplish large-scale change

The definition of adequate ACH structure and support evolved over time based on the level of funding and capacity needed to accomplish the scope of work. This has led to different types of operational and governance structures now than in 2015.

An early ACH success was forming and documenting multi-sector governance structures to oversee ACH regional decision-making and priority setting. Each ACH approached governance differently. While all ACHs included a governing board, most also included an advisory group and/or county-level group for broader input.

Under SIM, an appointed backbone organization performed operational functions, helped develop the governance structure, and supported the neutral convening of stakeholders. There were three types of organizations that served as backbones. At seven ACHs, backbone services were provided by either local public health agencies or community-based organizations. For the two ACHs that were already independent organizations, these non-profits served as both the backbone and the ACH, adding ACH activities into an existing portfolio of programs.

With the dramatic expansion in scope, funding, and requirements under MTP, ACH governance and operational structures had to be revisited.

Becoming independent organizations. The MTP requirement for all ACHs to become independent entities was challenging and time consuming for the seven ACHs that stood up new nonprofits (501c3s) or limited liability corporations (LLCs). Governing boards assumed fiduciary responsibility for the organizations, a significant shift from the board role in a coalition. Operational capacity needs expanded dramatically at all ACHs given the increased scope. ACHs hired EDs and built out staff capacity to support the aggressive MTP timeline and decision-making requirements. Staffing shifted from 1-2 dedicated backbone staff to 9-16 staff per ACH organization.

Developing multi-tier structures. An ongoing challenge for ACHs is to involve enough stakeholders in governance and operations to appropriately represent regional multi-sector interests, while keeping the structure functional and nimble enough to make decisions effectively. The board remains the decision-making body, but many ACHs established a range of broader advisory or workgroups to contribute project ideas, develop partnerships, and feed input to the board. Most multi-county ACHs developed sub-

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ACH promising practices

Multi-tiered governance structure to promote broad representation

- Clearly distinguish between board decision-making role and staff responsibilities
- Institutionalize communication between levels of governance
- Tailor the additional tiers to the regional context; e.g., advisory committee / workgroups with broader representation, sub-regional groups to address geographic diversity and leverage local efforts
- Establish formal ways for community members and consumers to participate; e.g., a consumer voices council, dedicated board seat

Effective, transparent decision-making process, governance, and operations

- Design effective decision-making processes to support transparent recommendations and decisions
- Establish formal and living conflict of interest rules and discuss them frequently and openly
- Create mechanisms for community input, e.g., town halls, online feedback, community surveys
- Communicate key information effectively using a variety of approaches; e.g., robust website; active outreach

regional groups to bring local partners to the table. At two ACHs, these county-level groups will be jointly planning and implementing MTP projects.

ACHs continue to explore how to meaningfully engage community members in their structures and are currently different levels of development in reaching this goal. All are required to have a Medicaid consumer or community member on their board. In addition, many have developed community voices councils or purposefully work to integrate community members into all of their existing committees.

Ensuring transparency. Communication and transparency are paramount within these complex structures. When working well, ACH partners easily understand the flow and content of decisions and the staff support robust communication between governance levels to align efforts. Without transparent processes, it can be difficult for participants to understand and inform ACH decision-making. Bi-directional communication is essential, sharing core information externally while also soliciting community input. Many ACHs have robust websites and newsletters that provide important operational information on staff, project direction, and funds flow, as well as meeting dates and key information in advance of decisions. Many ACHs have developed active outreach strategies to both share and gather information ranging from attending existing stakeholder meetings to administering surveys. ACHs have made great strides in transparency over time as their capacity increased.

ACHs continue to wrestle with appropriate conflict of interest practices since most of the decision-makers will also be recipients of funding through the MTP. Many have developed a variety of formal processes and methods to openly communicate about potential conflicts of interest while making decisions, including robust sector representation.

Spotlight: Better Health Together

Better Health Together (BHT) is an ACH that spans six counties in the eastern part of Washington State: Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens. They have a mix of urban and rural counties, each with different needs and assets. BHT wanted to align their Medicaid Transformation work around strengthening the natural systems of care and partnerships in the region. While retaining policy-level decision-making at the governing board level, BHT is honoring these local needs and assets through the development of Community Transformation Collaboratives.

The Collaboratives are comprised of the key settings needed to make transformation happen and are designed to carry out Transformation projects and distribute earned incentives to partners based on their achievement of metrics. Multi-sector Collaborative partners range from primary care, behavioral health, and health systems partners to partners addressing social determinants of health including housing and transportation. With the Collaborative model, BHT has set out to empower local communities to take ownership of Transformation efforts with the support of the ACH.

Each Collaborative is required to have a county-specific Transformation Plan, which takes into account the individual organization Transformation Plans as well as BHT's overall Medicaid Transformation goals. Collaboratives may also develop activities around locally-identified priorities. They will be structured for success within a model tied to outcomes. By empowering the local and necessary partners for Transformation, BHT aims to position the region for success once Transformation funds are gone.

Active collaboration: Bringing all elements together

Building collaboration is often reported as the most time-intensive and challenging aspect of this work. While it is an essential element in its own right, it relies on all the other elements to come to fruition. This begins with a commitment to building a structure that engages participants from across sectors and communities while also understanding that trust and relationships take time to develop.

When active collaboration is present, ACHs describe seeing participants that are committed and passionate working towards a common goal. A central indicator of success is the level of active collaboration visible on the ACH board, including the ability of board members to have difficult discussions that deepen their understanding of the shared work. Significant decision points such as MTP project selection or funding allocation can provide an opportunity to build trust and strengthen shared ownership in the work. ACHS can facilitate partners working effectively across sectors, for example when jointly considering how to make changes across organizations and sectors to move forward in an aligned way. Building this level of collaboration requires consistent tending by ACH leadership and open communication within the board.

> **ACH promising practices**
> - Develop processes that build trust and engage multiple voices, e.g. set meeting agendas so there is time for robust and difficult discussions about key decisions
> - Encourage the board to regularly reflect on its collaborative leadership and to facilitate engagement across the ACH
> - Understand Tribes are sovereign nations and respectfully engage as priorities align
> - Support community members in becoming actively engaged, e.g., paying community members for their time, conducting orientation for those new to the subject matter
> - Facilitate Board's ability to collectively meet the needs of their region, instead of focusing solely on the needs of their own organization

Effectively supporting community members to engage in collaborative work has been a challenge for ACHs. Many ACHs provide additional supports, including stipends to offset the cost of participating for community members given that organizational representatives are also being paid through their salaries to participate. ACHs may also provide technical assistance to community members so that they can gain the content knowledge needed to participate in the ACH. For example, at some ACHs, a community liaison meets with community member prior to meetings to answer questions.

Spotlight: Greater Columbia ACH

Greater Columbia ACH spans nine counties plus the Yakama Nation, requiring coordination and collaboration to transform the system and improve health across a large geography made up of diverse communities. Recognizing that improving the region's health will require addressing social determinants of health along with transforming the delivery system, GCACH established a Community Health Fund (CHF) to be used through 2020, setting aside nearly $1.4 million of DSRIP funding to address local needs such as housing, transportation, and food insecurity. GCACH is also planning to launch a regional media campaign to bring awareness to the general public about the effects of Adverse Childhood Experiences (ACEs) and the important role resiliency plays in overcoming them.

To distribute this funding in a way that engages community and effectively addresses local issues, GCACH decided to utilize six Local Health Improvement Network (LHINs), which are county or multi-county health coalitions. Some LHINs were existing coalitions, and some formed in response to an opportunity to

form local health networks with financial support from GCACH. They provide local engagement and cross-organizational assistance toward achieving a Culture of Health in their community.

The goal of leveraging LHINs is to allow for more local collaboration and engagement in GCACH's work, and effectively target the CHF to reduce disparities based on local data, and the lived experience of community members. LHINs will do this by conducting needs assessments and Medicaid consumer surveys to gather input and engage the community to identify priorities. GCACH will contract with third party administrators selected by the LHINs to solicit, score, select grantees, fund, and track projects designed specifically to address the social determinants of health.

Taking action: Poised for system change

By definition, taking action requires significant progress in all other areas so that activities reinforce the shared purpose and contribute to collaborative, aligned outcomes. This balance can be challenging - ACHs have continually struggled with when to change focus from building and planning to action and implementation.

During the first two years of SIM, ACHs developed regional health improvement plans and implemented an aligned pilot project. ACHs described the importance of moving forward with a project as a mechanism for maintaining partner involvement and demonstrating the ACH's value. Although identifying and agreeing on a project took significant time and deliberation, it also helped them build their capacity to coordinate activities across stakeholders to advance a common goal.

ACHs leveraged this experience as they developed intensive MTP project selection processes that engaged hundreds of new participants within their regions through expanded structures.

They are also beginning to think about how they can take action on broader regional issues and populations, both during and after MTP. Many ACHs are considering setting up "health equity" or "resiliency" funds using MTP funding set-asides, braiding funding sources together in the region, and partnering on grants with other regional stakeholders. ACH boards are also beginning to address the question of sustainability – both the sustainability of the investments made through their projects, and the related but separate question of the whether the ACH should be sustained as a long-term organization in the region.

> ### ACH promising practices
> - Focus on developing and implementing concrete action plans
> - Efficiently include community input in project development, e.g. develop workgroups, conduct outreach
> - Use pilot opportunities to test ideas
> - Promote sustainability of system change efforts by identifying partners and resources to sustain effective projects
> - Partner with state agencies to develop key measures and necessary data needed to identify gaps and chart progress
> - Begin to set up health and social equity funds to impact broader community needs

Currently, ACHs are developing concrete action plans and distributing funding to partnering providers as they begin the challenging stage of implementing system transformation projects. ACH approaches to system transformation vary widely, with regions investing in diverse strategies to meet their regional needs. Some ACHs will be implementing key activities themselves while implementation in other regions will primarily be carried out by partnering providers. ACH investments will continue to evolve to meet the

needs of their region. The following summarizes high level categories of strategies and provides some examples to illustrate how ACHs are supporting health system transformation.

Supporting integrated managed care. Integrating behavioral and physical health is a priority under both the SIM grant and MTP. As part of SIM, the state phased in Integrated Managed Care, which is the financial integration of behavioral health and primary care systems. Under MTP, one required project is to promote service delivery integration by bringing about greater coordination/co-location of behavioral health and primary care.

ACHs are moving this work forward in different ways in their regions. Many leveraged their multi-sector voice to advocate for local counties to move forward with Integrated Managed Care on a time frame that brought additional funds to the region. ACHs are using these funds to provide operational support that includes: convening impacted partners for planning, developing early warning systems, and learning about changing payment structures. Some ACHs are also working directly with physical and behavioral health providers to conduct readiness assessments for both service delivery and financial integration, provide the technical assistance needed to transition billing systems, and discuss how to coordinate across siloed systems. ACHs are considering investments in technology to support the transition.

Building infrastructure for care coordination and care transitions. While their approaches differ, all ACHs are focusing on care coordination as a core component of their MTP activities. Many ACHs are building linkages between clinical settings and the community-based organizations that provide social services necessary to improve health. Many ACHs are investing in community health worker strategies for diverse topics from chronic disease to emergency room diversion. Others are considering how to increase capacity at community-based organizations to engage more directly with clinical partners. Some are focused on improving transitions between different care settings by engaging non-traditional partners to align efforts.

As an example, six ACHs are implementing the Pathways Community HUB (HUB), a recommended method in the MTP toolkit (Project 2B – See Appendix A). The HUB model provides a comprehensive patient risk assessment and each identified risk factor is translated into a Pathway that involves coaching and linkages to community and clinical resources, carried out by a community health worker. They have begun building the technology infrastructure, signing up partners and designating lead agencies. These six ACHs have also formed an informal learning collaborative, sharing lessons learned across ACHs and implementing common approaches to evaluating the HUB.

Spotlight: Pierce County ACH

In March 2018, Pierce County ACH launched their Community HUB. The HUB's initial focus was aimed at reducing infant mortality rates in Pierce County by targeting at-risk pregnant women. The HUB model has received national recognition including endorsement by the Agency for Healthcare Research and Quality (AHRQ) and the Institute for Healthcare Improvement (IHI). Pierce County ACH serves as the administrative and fiscal lead for the HUB. As the lead, the ACH coordinates contracts with a wide range of community service organizations and care-coordination agencies to provide services by community health workers to at-risk individuals using the Pathways model.

Since the implementation of the Pathways HUB, they have served 255 at-risk pregnant clients in Pierce County. As of January 2019, over 2,000 Pathways have been initiated with a completion rate of 85%. Social

services and education referrals combined for over 1,400 of these Pathways! Women enrolled in the Pathways program have delivered 63 babies with 86% of the births at a normal birth weight of five pounds, eight ounces or more.

In 2019, the Community HUB will expand to include Health Homes and Complex Care Continuum teams. These teams target high-cost, high-risk, Medicare, Medicaid, and dual eligible enrollees. The expansion of the HUB allows the ACH to magnify their focus on intensive care coordination for those with the greatest needs in Pierce County. The expansion of this program is closely aligned with the other components of the ACH, including the strategic build of the Community Resiliency Fund along with the ACH's development of population health strategies and learning collaboratives.

Supporting practice transformation and capacity building. Some health care and behavioral health practices currently lack the capacity to adopt the Patient Centered Medical Home (PCMH) model and to implement the billing systems necessary in value-based purchasing structures (VBP). Many ACHs leveraged the Healthier Washington Practice Transformation practice coach and hub resources that were a parallel activity under SIM. Some ACHs are now expanding their efforts to invest in support for capacity building, including:

- Providing specific technical support and trainings,
- Investing in practice transformation coaches,
- Providing population health training and tools for providers and community-based organization,
- Creating peer learning collaboratives to support practice change.

Addressing data sharing and technology gaps. ACHs recognize that effective information sharing is at the heart of a transformed health system and that the current data system is flawed and fragmented. ACHs report that the Healthier Washington data integration work has been of limited success in creating adequate platforms for the MTP projects and population health approaches. As a result, ACHs are working individually and collectively to build or expand technology that promotes data sharing across provider types and between community-based organizations and clinical providers. Approaches vary and include: building new referral sharing mechanisms, supporting individual provider EHR adoption, expanding existing technologies that share key data like emergency room usage, and supporting the development of agreements that promote data sharing.

Influencing policy change. ACHs recognize the pivotal role of policy in system transformation and are considering how they can best influence the policy change necessary to support their work and investments. For several years, ACHs have brought a regional voice to the policy change process by participating in multiple state-level initiatives that set policy, such as the Community Health Worker Task Force and the Governor's Health Taskforce. Some ACHs are also beginning to identify and elevate the policy changes needed to sustain MTP-related and other systems changes, including how to align funding, support practices, build adequate workforce, and address related social determinants of health.

Spotlight: Southwest Washington ACH

Southwest Washington Accountable Community of Health (SWACH) is the state-designated ACH for Clark, Klickitat and Skamania counties and partners with the members of the Cowlitz Tribe and Yakama Nation. SWACH describes its shared purpose as creating partnerships and leveraging resources to "create lasting changes and a healthier future – for everyone." One of the ways they accomplish this is through policy change.

The Healthy Living Collaborative (HLC), a partner program of SWACH since 2017, has been shaping policy in southwest Washington through its advocacy work for half a decade. SWACH leverages HLC's policy committee - made up of diverse cross-sectional organization partners and community members - to identify, prioritize and advocate for a set of policy issues each year. This diverse committee reaches out across the ACH region to understand the issues impacting people's lives and brings a policy agenda to the SWACH Board to approve. This year, they will be prioritizing issues such as: affordable housing, opioid prevention, supporting children's mental health and increasing the Medicaid reimbursement rate.

SWACH uses a braided funding model and leverages non-governmental funding to support this advocacy and systems change work at the state and local levels. SWACH staff describe how powerful it is to leverage the strength of multi-sector partnerships when talking to policy makers. They have seen it change legislators' perspectives when representatives from the education sector talk about the importance of affordable housing, or healthcare providers speak to the challenge of stabilizing patients who do not have stable housing. They also bring voices from the community to legislative offices, so legislators can hear from those directly affected by policy.

Their approach has recently had an impact on local housing policy. The HLC successfully advocated for tenant protection laws in the City of Vancouver, and a housing tax levy to support affordable housing.

III. Lessons learned for other states

Health system transformation under Healthier Washington is built around a partnership between Healthier Washington and the ACHs. As lead agency for the SIM and MTP efforts, this partnership approach represents a fundamental shift for HCA from its historical role primarily as a contracting agency that administers health insurance programs, sets terms and conditions for regional health systems and other stakeholders, and monitors compliance. While the state provided essential elements of funding, policy development, statewide guidance, and technical support, the work of building ACHs and moving projects forward was designed and carried out by key stakeholders at the regional level. Given the shared goals but significantly different roles, HCA and its regional partners needed to develop a different way of working together.

During SIM, the state invested in a strategic learning evaluation so that state agencies and ACHs could learn what was working and where course corrections were needed. The evaluation leveraged ongoing data collection to provide real-time feedback and strengthen the initiative as it emerged. Promising practices about ACH development were presented earlier in the discussion of the how ACHs developed the essential elements of collaboration (see Section II). This section synthesizes the key themes from HCA's commitment to continuously improve how they led and supported the work. These lessons learned are useful for other states, foundations, and communities investing in systematic, regional, multi-sector collaboration as an integral aspect of health improvement and system change.

1. Transforming the system requires a different approach: partnership and innovation

Work in partnership, which is a shift from contracting and grant making. From the beginning of SIM, HCA described the work as a partnership between the emerging ACHs and the state. While the agency developed objectives for ACH development, the initiative was designed around the premise that building regional multi-sector collaboration needed to be locally-driven. The need for partnership continued in the design of MTP, with ACHs placed as lead agencies that held project decision-making authority. This new way of co-creating with communities was both rewarding and challenging for HCA given how different it was from the agency's other work.

Building an effective partnership required shared goals across key stakeholders, the development of trust, and robust communication. Given the innovative nature of the work, this partnership worked best when the state was able to work with ACHs in the development of new guidelines, for example by asking for input on what was in process instead of waiting to share final products. Lack of understanding about what the state was moving forward undermined trust, which impacted the ability of ACHs and the state to innovate together.

> Having a dedicated group of staff that was available to the ACHs during our developing stages that we could trust, that was present, was really great.
>
> – ACH leader

Build different agency capacities and approaches. The skills and approach needed to co-create with external partners can be different than those traditionally required for state agencies, such as negotiating detailed contracts around defined policies or implementing agency-led programs. Agency leadership is a key factor in how the agency embraces and grows in its ability to take this new approach. It is important to consider what capacities and culture shifts may need to occur within the agency to provide support for

innovation and close collaboration with external partners. Investing in the staff time required to build relationships, develop trust, and maintain close communication is essential. As an example, at the beginning of SIM, Healthier Washington invested in additional staff members who were encouraged to go out to the ACHs to learn, collaborate, and connect. This regular, in-person interaction supported strong communication and trust building. Maintaining robust formal and informal communication patterns became more challenging as the scope grew under MTP. Trust and partnership were negatively impacted when the communication cycle was less robust.

Align and coordinate efforts across state agencies. Efforts to leverage a regional multi-sector partnership inherently need alignment with and support from a wide array of agency staff. ACH efforts quickly overlapped with the work of multiple state staff, which sometimes resulted in conflicting messages that have been difficult for ACHs to navigate. This was a challenge across state agencies, but also within HCA, where multiple departments worked with ACHs on tasks that ranged from providing essential data to considering how ACHs could be leveraged programmatically. Building formal processes to identify and prioritize potentially competing demands for ACH time and resources supports both internal workflow and external communication. HCA experimented with different ways to coordinate ACH communication to increase efficiency and decrease duplicate or competing requests. Regular weekly calls between ACH staff and key state agency staff became an important way to bring information to the ACHs for feedback and input.

> There's not a sense of shared ownership [across state agencies] … I think there should have been more agency to agency understanding from the beginning.
>
> – Healthier Washington staff

Leverage the state's unique resources to support the partnership goals. One core resource that state agencies are best positioned to provide is timely access to data. Appropriate data are a cornerstone of collaborative work as information enables stakeholders from different sectors to jointly identify and prioritize key health issues, understand health disparities, plan for projects, and track progress. Producing and sharing necessary health system data in a timely way was a continual challenge for Healthier Washington. Data privacy and time lag issues impacted the state's ability to share data at a regional level in the timeframe requested by ACHs. Differences of perspective about the level, type and frequency of data needed for ACH planning continues to be a struggle.

2. Balance community-driven innovation & statewide approaches

One of the most consistent challenges during both SIM and MTP was how to best strike a balance between the need for a strong statewide vision and clear guidance with the investment in community-driven solutions embodied by the ACHs.

Encourage community variation but design statewide solutions when appropriate. State agencies play a unique role in system transformation. In Washington, they purposefully created a central role for ACHs in both SIM and MTP, based on the premise that regional, multi-sector collaboration was the essential element needed for success. By championing this vision, they made it possible for ACHs to develop and progress.

Early in SIM, however, ACHs began to develop differently in response to their regional needs and stakeholders. The issue continued as the ACH scope expanded under MTP. This variation was seen by some stakeholders as appropriate and by others as potentially divisive or inefficient.

The most common tension points occurred in areas where the planning and implementation process raised new questions about how to turn the high-level state vision into concrete programs. In some cases, this lack of specificity was challenging but beneficial. For example, the flexible guidance around how ACHs developed under SIM allowed regions to decide on the best ways to build on relationships and respond to historical or geographic factors within their communities. In other cases, the lack of a standardized or statewide approach created more challenges. For example, complex statewide issues such as workforce development, health information technology or state-level policy changes are difficult to address at a regional level.

> I love that [the state] made the ACHs regional, I love that they house them in community, but you cannot do some of this stuff nine different ways…I guess it goes back to - what's the end game supposed to look like so we can assess ourselves in relation to where are now, and where do we need to get to?
>
> – ACH leader

It is important to consider which areas would be better served by statewide, coordinated approaches to change, rather than risk the potential fragmentation of different approaches across nine ACHs. Addressing this tension has worked best when there has been clear communication between ACHs, state agencies and other key stakeholders about when regional solutions are appropriate and when the issue needs state agency leadership to work with ACHs to create a statewide solution.

Support mechanisms for cross-ACH collaboration. Throughout ACH development, there have consistently been areas where cross-ACH sharing and coordination is valuable. HCA explored different methods of supporting ACH development, including sponsoring statewide convenings that created shared learning opportunities, provided technical assistance and built relationships. Perhaps the most successful form of support was providing funding for monthly in-person meetings where ACH leaders collaborated on statewide solutions, including how to align regional investments, when to elevate issues to the state and other stakeholder groups, and how to support ACHs' mutual development.

> I think it's important for all nine ACHs to have a venue to come together, learn from each other, talk, and then have a collective voice for a larger impact too.
>
> – ACH leader

3. Recognize the need for continuous improvement and comfort with disruption

System transformation is inherently disruptive. In Washington, it has been compounded by the pace of change demanded by MTP and the complexity of weaving together SIM goals with MTP requirements.

Commit to continuous improvement. Under SIM, HCA invested in a strategic learning process to support ACH development and the emerging partnership with ACHs. HCA saw this as a cornerstone of how to successfully implement an innovative approach. Healthier Washington leadership met several times a year to hear real-time feedback about what was working well and where internal HCA course corrections were needed. At a fundamental level, the strategic learning approach bolstered HCA's understanding of what was occurring on the ground so that they could respond from a more informed position. It also resulted in tangible changes to the agency's approach, including responding to requests for clearer

statewide guidance on key issues, increasing communication, altering the type and frequency of technical assistance, and improvements in reporting requirements.

Clearly identify and communicate the roles and end goals when navigating a dynamic process. For example, under SIM, the ACHs' role to develop multi-sector tables was well-defined and successfully accomplished. On the other hand, how ACHs could work on the original goal of addressing the social determinants of health was less clearly defined and did not include significant project funding, which made it difficult to move this goal forward. This remains an unfunded mandate given the more clinical focus of MTP.

The ACH role in the MTP was developed and robustly funded, which allowed ACHs to quickly begin planning in their regions. After MTP launched, however, major aspects of projects, reporting, metrics, and operations still needed to be developed. Key areas of confusion included understanding the tangible functions that HCA expected ACHs to provide in supporting broad system efforts, like the move to value-based purchasing. It also became clear that HCA needed to more concretely outline the details of what a transformed system looks like in practice, including what policy, contracting, and programmatic choices it would employ. Without this, it is difficult for ACHs to effectively invest their resources in efforts that will be sustainable in the long term.

Such shifts in strategies and roles are often part of multi-year, complex initiatives. Successful navigation requires trust and the ability to have candid and confidential conversations so that partners can elevate issues, the state can provide additional direction, and investments can be strategically aligned with a more fully defined vision. State agencies need to take the lead in this effort given their unique roles in setting state policy direction and administering key funding streams such as Medicaid. As HCA develops new strategies it is important to provide consistent messages to stakeholders about emerging policies, structures and decisions. This requires additional agency staff capacity to both identify and troubleshoot issues, and work collaboratively with external stakeholders as partners.

4. Carefully design key features of the model

While there are many options for how to design an ACH model, three elements of Washington's model stand out as key considerations for other states.

Thoughtfully select regional boundaries. While many ACH efforts across the nation are built on selecting pilot or exemplar communities to invest in, Washington chose to divide the state into nine regions that included all communities in the state. Stakeholders consistently reported that this was important because it indicated the significance of the intended effort and created a way for the whole state to move forward together. When working well, this approach allowed stakeholders to look as appropriate beyond the local community or county level to thinking more broadly about how to improve health across the region.

> If you really want the emergency room down to the housing provider [to be] connected, you need to know what that flow of referral is.
>
> – ACH leader

To achieve this goal, stakeholders commented on a few key considerations in developing regions:

- It is important to align with regional health system referral and service delivery patterns across primary care, hospital, and behavioral health services, as well as the interconnections with community-based organizations and social services.

- The geographic size and diversity of regions impacts their ability to work together. The sheer geographic size of multi-county rural regions presents challenges to collaboration, such as how to engage multiple county governments and the significant time to travel between distant communities. Urban areas also faced challenges with understanding how this effort fit into existing collaborations and coordinating the number of stakeholders interested in participating.
- While regional boundaries are necessary for ACH development, it is important to recognize that these boundaries are inherently porous. There will always be a need to support cross-ACH regional work to address the health needs of communities that don't stop at ACH boundaries.

Consider the impacts of requiring ACHs to become independent organizations. While most ACHs started out as collaborations supported by an independent backbone organization, HCA required ACHs to become independent organizations under MTP. Stakeholders reported benefits and implications of this significant requirement.

Many stakeholders suggested this step was important and described how having a distinct identity allowed the ACH to be a neutral entity that was not aligned with any one sector's or organization's interests. They saw this development as an essential element in building the necessary trust and collaboration to move system transformation forward and suggested that ACH progress would not have been possible if they were not independent organizations. Others were not sure that being a separate entity was necessary, but there was not a consistent theme in what existing organization could have played this neutral role effectively.

> For the ACHs, I would have a neutral organization that has no connection or affiliation to any one sector or organization so that it can really operate in the interest of the region and the people, and not any organizational self-interest.
>
> – ACH leader

Regardless of their position, stakeholders consistently raised the substantial impact of this requirement on ACHs' development. Becoming independent organizations took significant time and resources, dominating much of the ACH agenda for many months as they considered how to create boards with fiduciary responsibility, incorporate into non-profits (501c3s) or limited liability corporations (LLCs), hire formal leadership and staff, and figure out all the other logistical aspects of standing up new organizations.

Requiring the creation of independent organizations also has long-term implications for the role these organizations will play in Washington. While ACHs were launched based on direction from the state and are certified as ACHs, they are now independent and autonomous organizations with governing boards, identities, and staff. Many ACHs are exploring broader focuses, roles, and funding streams as they consider how their organizations can continue to live out their shared purpose. The state will need to work collaboratively with ACHs to determine a continued role they can play after MTP concludes.

Understand that Tribes are sovereign nations. Washington's experience with engaging Tribes in collaborative multi-sector efforts provides key lessons learned for other states' design approach. One of the most significant challenges in ACH development was how best to work with the 29 federally-recognized Tribes and the two Urban Indian Health Programs (UIHP) in Washington state. Initial guidance directed ACHs to work with Tribes and UIHPs as they built their multi-sector tables, similar to how they engaged other regional sectors or stakeholders. Under MTP, ACHs were required to have Tribal

representation as part of their multi-sector governing boards. This approach was not successful because it did not consider the fact that Washington Tribes are sovereign, independent governments, with unique healthcare infrastructure, community health priorities, and decision-making norms/practices that did not always align with the structure of the ACHs. In addition, Tribal boundaries did not always align with ACH regions – one Tribal jurisdiction may intersect with multiple ACHs. This mis-aligned approach presented challenges for ACHs in engaging Tribes in their MTP work in a meaningful way. After significant feedback and structured learning opportunities, the state revised their required approach to collaborating with Tribes.

The SIM grant provided the time, policy direction, and funding necessary for ACHs to build the essential elements of collaboration that have positioned them to support health system transformation in their regions. While some ACH regions had a history of working together at a regional level, most did not. Without SIM, newly formed ACHs would not have been able to develop and be ready to meet the aggressive planning phase milestone required in MTP.

> I think we've had a great opportunity to learn during these last four years and I would hope that another state doesn't form something with Day 1 being Day 1 of the Medicaid Transformation project...having that kind of time to think through things has been invaluable.
>
> – ACH leader

States that are interested in building multi-sector collaborative efforts should understand the investment required and clearly communicate with stakeholders about appropriate outcome expectations and time frames. Aspirational goals can be useful in showcasing a vision for the work, but also can lead to dissatisfaction if outcomes are impossible to achieve within the time frame or funding available. For example, while the SIM grant provided sufficient funding to support ACH development, there was not enough funding for the ACHs to undertake large scale health improvement efforts. This caused some stakeholders to conclude that the ACHs were not meeting their goals during the early years of SIM. Emphasizing the central role that the state expects ACHs to play in the system over time will help stakeholders understand why they should engage with the emerging entities.

Conclusion

This report provided an interim assessment of the ACH role and impact on the long-term process of health system transformation under the Healthier Washington Initiative that began with the launch of SIM in 2015 and will continue through the end of the MTP in 2021. The ACH model that evolved in practice was to first form multi-sector regional collaboratives and provide them relatively limited resources to develop effective structures, engage partners and develop capacity. The second step was to give them a central role in the large-scale MTP initiative. Given the interconnection of these two efforts, it is not possible to understand the impact of each separately and instead we consider the effectiveness of this overall approach.

Our evaluation found that this model has been largely successful to date, and that the ACHs are well-positioned for the next phase of system transformation. These outcomes were relatively consistent across all ACHs. There were regional differences in collaborative development, structure, and outcomes, but all are poised for system transformation and have built strong collaborative organizations. The extended development time during the first two years of SIM proved critical for building the foundation needed when the MTP resources become available.

ACHs have achieved critical outcomes including: building trust and collaboration; establishing infrastructure, capacity and comprehensive implementation plans; creating an integrated regional approach; and bringing in community voices and a focus on equity and social determinants of health.

Washington's experience with implementing this transformation effort provides useful lessons for other states investing in large-scale collaborations to improve health. In particular, new state agency approaches and capacities are required to work effectively with regional partners, and state agencies must be comfortable with the disruption inherent in the effort. State agencies should seek a balance between state guidance and community-driven solutions.

While SIM funding concluded in January 2019, the MTP and the ACHs' work will continue to evolve. ACHs will finalize plans and begin the challenging work of implementing project portfolios and strategies through the work of their regional partners. They will measure progress through a set of statewide pay for performance metrics, as well as regionally developed intermediate and process reporting systems.

During the next few years, both the state and ACHs will continue exploring the long-term roles ACHs will play in their regions after MTP concludes. Although the MTP funding stream ends, the work of system transformation and regional health improvement will remain a critical priority. Policymakers, state health leadership and regional stakeholders should consider ways of capitalizing on Washington's successful investment in ACHs to support this ongoing work.

Appendix A: Medicaid Transformation Project Overview

Healthier Washington is a multi-sector partnership to transform the health system to achieve better population health, reward high-quality care, and curb health care costs. Accountable Communities of Health and the Medicaid Transformation are part of Healthier Washington's portfolio of strategies to achieve these goals.

This Appendix provides high-level summary details for the complex Washington State Section 1115 Delivery System Incentive Payment Project (DSRIP) waiver, known as the Medicaid Transformation Project (MTP). The MTP was approved in September 2016 and went into effect in January 2017, providing up to $1.5 billion for regional health system transformation projects that benefit Medicaid clients. More details are available on the Health Care Authority website.

The Medicaid Transformation Project includes three initiatives, the largest of these (up to $1.1 billion) is using the ACHs to transform the Medicaid delivery system to support whole person care and use resources more wisely. The specific objectives of the initiative are:

- Create appropriate health systems capacity to expand effective community based-treatment models; reduce unnecessary use of intensive services, and supporting prevention through screening, early intervention, and population health management initiatives.
- Move the state forward on value-based payment (VBP) - ACHs are required to design project plan activities that enable the success of Alternative Payment Models required by the state for Medicaid managed care plans.
- Promote integration of physical and behavioral Health through new care models, consistent with the state's path to fully integrated managed care by January 2020.
- Implement community-based Whole-person Care - promoting care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
- Improve health equity and reducing health disparities – implementing prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity.

The Medicaid Transformation Project Toolkit details the milestones, metrics and timelines for the eight potential projects within Domains 2 and 3 from which ACHs select and will implement (Table 2). Two of the eight projects were required (2A and 3A), and each ACH had to implement a minimum of four projects to participate in the MTP. Table 3 shows the project portfolio choices made by each of the nine ACHs.

The following links provide more information about the MTP:

- MTP documents submitted by ACHs (e.g., implementation plans, semi-annual reports)
- MTP metric specifications

Table 2. MTP Projects

MTP project	Description	Target population
Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Project 2B: Community-Based Care Coordination	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).
Project 2C: Transitional Care	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
Project 2D: Diversion Interventions	Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.	Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement
Project 3A: Addressing the Opioid Use Public Health Crisis	Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Project 3B: Reproductive and Maternal/Child Health	Ensure that women have access to high quality reproductive health care throughout their lives and promote the health safety of Washington's children.	Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0 – 3, and children ages 0 – 17.
Project 3C: Access to Oral Health Services	Increase access oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.	All Medicaid beneficiaries, especially adults.
Project 3D: Chronic Disease Prevention and Control	Integrate health system and community approaches to improve chronic disease management and control.	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Table 3. MTP Project Selection by ACH

Project	BHT	CPAA	GCACH	HealthierHere	NCACH	NS ACH	OCH	PCACH	SWACH
2A: Bi-directional Integration of Care	•	•	•	•	•	•	•	•	•
2B: Community-based Care Coordination	•	•			•	•		•	•
2C: Transitional Care		•	•	•	•	•			
2D: Diversions Interventions					•	•	•		
3A: Addressing Opioid Use	•	•	•	•	•	•	•	•	•
3B: Reproductive and Maternal and Child Health		•				•	•		
3C: Access to Oral Health Services						•	•		
3D: Chronic Disease Prevention and Control	•	•	•	•	•	•	•	•	•

Appendix B: Evaluation Design and Methods

In May 2015, the Health Care Authority (HCA) contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the Accountable Communities of Health (ACHs) as part of the broader evaluation of SIM. CCHE closely coordinated the ACH evaluation with the evaluation the overall Healthier Washington initiative, led by a team at the University of Washington. CCHE worked most closely with the Health Care Authority (HCA), the lead agency for SIM and MTP implementation.

CCHE takes a collaborative, utilization-focused approach to evaluation and partnered with key stakeholders at Healthier Washington to develop a theory of change for ACHs within Healthier Washington and a framework for measuring the short-, intermediate- and long-term impact of ACHs' work. These documents informed the development of an evaluation plan for the four-year initiative. This plan was adapted as the initiative evolved, with particular attention paid to adapt it after the ACHs became the lead organizations for the Medicaid Transformation Project (MTP).

The goals of the evaluation were to:

1) Evaluate the extent to which ACHs completed activities and achieved short-, intermediate- and long-term initiative goals/outcomes.
2) Support Healthier Washington and ACH continuous strategic learning by a) identifying emerging issues in the ACH landscape including barriers and success factors affecting ACH development and b) facilitating understanding about how these issues may affect the implementation of the initiative and how Healthier WA could continuously improve its support of ACHs.

Design

The evaluation used a case-study, logic model design to assess the development and impact of the ACHs on Healthier Washington goals. The ACH logic model is shown in Figure 1 in the Introduction Section; it gives a high-level view of the ACH activities and intended short-, intermediate-, and long-term outcomes. It was revised as needed to incorporate the launch of MTP. The design did not include evaluating the entirety of the MTP initiative, instead focusing on how MTP impacted ACH development, including the significantly larger scope, funding, role and activities.

The case study approach involved systematically collecting information from a wide variety of sources across all 9 ACH sites. Data were collected using a standardized set of domains and indicators to generate cross-ACH synthesis findings within that framework. The domains used for tracking ACH development were drawn from a CCHE collaboration model that identifies six essential elements needed for a successful collaboration; a description of those six domains is provided in detail in the body of the report (see Section II on ACH outcomes).

The strategic learning component of the evaluation used the same information that was gathered to assess impact to also engage as a thought partner with the HCA. CCHE provided timely formative feedback (success factors, barriers, and lessons learned) on mutually agreed upon strategic learning questions and participated in ongoing strategy sessions to inform key HCA decisions regarding the ACHs. CCHE also looked for opportunities to present evaluation findings on emerging best practices, barriers and lessons learned to ACHs during the regularly scheduled cross-ACH convenings and meetings. To

support individual ACH continuous improvement, CCHE leveraged the ACH-specific annual participant survey findings to facilitate strategic learning sessions at ACH board and staff meetings.

Data sources and methods

Qualitative and quantitative data were collected from multiple sources to understand ACH capacity and progress. CCHE took both a planned and an opportunistic approach to data collection, conducting pre-planned annual interviews, observation, and document review, while also leveraging existing structures and convenings of ACH participants to increase understanding of relevant context and to minimize burden on the ACHs. This approach generated a rich set of qualitative data but resulted in some inconsistency in the timing and level of detail of information collected from each individual ACH. All qualitative data gathered were considered confidential and reported in aggregate as themes in this report. At key points through this time, CCHE presented interim results to both HCA and ACH leaders to ensure that participants felt that the findings reflected their experiences and that they had an opportunity to provide feedback.

ACH observation. Site visits to all nine ACH regions to observe ACHs in action at least once a year, and frequent ACH Board and committee meeting observation for all nine ACHs. Meeting observations were conducted via telephone and webinar. The purpose of these observations was to understand meeting structure, decision making processes, participant engagement, and quality of discussion/collaboration.

Annual interviews with ACH staff and participants to understand ACH development, regional ACH activities, and ACHs' role in state-level Healthier Washington activities, including the MTP. Interviews were also conducted with key Healthier Washington staff, including technical assistance providers and key statewide stakeholder groups with members active in ACHs.

Annual online survey of regional stakeholders engaged in the ACHs to solicit individual ACH participants' opinions and perspectives about how each of the nine ACHs are developing and functioning. For additional information on results and methodology, please see the published survey report on the HCA's website.

Observing cross-ACH meetings where ACH staff and participants convened to discuss both ACH development and the statewide initiative (e.g., quarterly ACH convenings, weekly conference calls with state agency and ACH staff, etc.) to document ACHs' evolution individually, as a cohort, and as participants in Healthier Washington, including reported success factors, challenges, and lessons learned.

Document review of ACH grant applications, designation proposals, and reports submitted to HCA, as well as of the broader Healthier Washington initiative materials necessary to understand the context in with the ACHs are developing.

Qualitative data from interviews were analyzed thematically with the aid of Atlas.ti. Quantitative data were compiled and analyzed with Microsoft Excel and STATA where appropriate.

Appendix C: About the Accountable Communities of Health (ACHs)

An ACH is a regional collaborative organization consisting of leaders from a variety of sectors working together to improve health in their region. Each ACH is now a collaborative organization with a governing board, staff team, and different structures for engaging stakeholders and partners in the work of transforming the health system and improving community health in their regions.

The following attachments were created by the ACHs as part of their communication efforts in the state and provide an overview of their organizations, including their counties, selected Medicaid Transformation projects, and contact information.

ACH	Counties
Better Health Together www.betterhealthtogether.org	Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens
CPAA www.cpaawa.org	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Greater Columbia ACH www.gcach.org	Asotin, Benton, Columbia, Garfield, Franklin, Kittitas, Walla Walla, Whitman, Yakima
HealthierHere www.healthierhere.org	King
North Central ACH www.ncach.org	Chelan, Douglas, Grant, Okanogan
North Sound ACH www.northsoundach.org	Island, San Juan, Skagit, Snohomish, Whatcom
Olympic Community of Health www.olympicch.org	Clallam, Jefferson, Kitsap
Pierce County ACH www.piercecountyach.org	Pierce
SWACH www.swach.org	Clark, Klickitat, Skamania

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems, to benefit Apple Health (Medicaid) clients.

This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

ABOUT US

Local communities are best positioned to identify their own needs and drive solutions for change.

Better Health Together serves as the Spokane region's Accountable Community of Health, with a focus on improving health outcomes for people receiving Medicaid/Apple Health, by:

- **Improving coordination** among primary, behavioral, and oral health providers and community resources like housing, food, and transportation so people can have all of their needs addressed in a coordinated manner;
- **Strategies to help Medicaid adults** prevent and manage diabetes, and other chronic diseases.
- **Opioid responses for Medicaid beneficiaries** who use, misuse, or abuse prescription opioids and/or heroin.

BOARD MEMBERS

Tom Martin	Lincoln County Public Hospital District
Sharon Fairchild	Providence Health and Services
Antony Chiang	Empire Health Foundation
Lynn Kimball	Aging and Long-Term Care of EWA
Peter Adler	Molina
Alison Boyd-Ball	Colville Confederated Tribes
David Crump	Spokane County Schools
Greg Knight	Rural Resources
Luis Manriquez, MD	WSU Elson S. Floyd College of Medicine
Commr. Mike Manus	Pend Oreille County
Capt. Marcus	David C Wynecoop Memorial Clinic
John McCarthy, MD	Spokane County Medical Society
Kai Nevala	Unify Community Health
Jessica Pakootas	Camus Path, Kalispel Tribe of Indians
Blake Redding	Spokane Treatment & Recovery Services
Torney Smith	Spokane Regional Health District
Pam Tietz	Spokane Housing Authority
Jeff Thomas	Frontier Behavioral Health
Aaron Wilson	CHAS Health

OUR PROJECTS

Bi-Directional Integration of Care
We are building linkages between physical, behavioral, and oral health care so patients can more seamlessly access care for their whole bodies in one system. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services through Managed Care Organizations.

Community-Based Care Coordination
Our region benefits from a wealth of great social services, but without coordination, people often fall through the cracks. This project works towards promoting and standardizing care coordination activities for Medicaid beneficiaries with complex health and social needs, to ensure people can easily connect to the services and benefits needed to improve their health. Our target populations include people transitioning out of jail, and high-risk pregnant Medicaid women.

Addressing the Opioid Crisis
In alignment with local and statewide initiatives, we aim to reduce opioid-related morbidity and mortality through strategies that target prevention of opioid misuse and abuse, treatment of opioid use disorder, overdose prevention interventions, long-term recovery, and whole-person care.

Chronic Disease Management and Support
We are facilitating linkages between clinical services and social services to support better promotion and access of supports for chronic disease management and prevention, especially related to Diabetes.

FUNDS FLOW

Accountable Community of Health regions earn dollars by meeting CMS/HCA agreed upon milestones including:

- Development of an accountable organization to govern and manage funds and programs (in the Spokane region, this organization is Better Health Together)
- Development of a Regional Health Improvement Plan utilizing agreed upon models from the CMS approved Tool Kit
- Achievement of CMS approved metrics for reporting and performance

Better Health Together is allocating its earned incentives via county-based **Community Transformation Collaboratives.** Each Collaborative is comprised of organizations delivering services to the Medicaid population including primary care, behavioral health, pharmacy, housing, and transportation. These Partnering Providers are eligible to earn dollars based on the achievement of metrics, as approved by the Better Health Together Board.

ADAMS	FERRY	LINCOLN	PEND OREILLE	SPOKANE	STEVENS
9,977	2,485	3,224	4,574	162,432	14,720
7 unique partners	11 unique partners	11 unique partners	12 unique partners	50 unique partners	8 unique partners
13 settings	18 settings	17 settings	19 settings	72 settings	17 settings
Funds earned YTD: $247,000	Funds earned YTD: $337,000	Funds earned YTD: $158,000	Funds earned YTD: $266,000	Funds earned YTD: $2,654,000	Funds earned YTD: $238,000

CONTACT US

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Website:
www.betterhealthtogether.org

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems to benefit Apple Health (Medicaid) clients.

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Cascade Pacific Action Alliance (CPAA) Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum Counties

Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinault Indian Nation, Skokomish Indian Tribe, Shoalwater Bay Tribe, and Squaxin Island Tribe

ACH Regions Map

BOARD MEMBERS*

Commissioner Bud Blake	Thurston-Mason BHO
Carole Halsan	Willapa Harbor Hospital
Chris Bischoff	Wahkiakum County PHHS
Danette York	Lewis County PHHS
Dave Windom	Mason County PHHS
Denise Walker	Confederated Tribes of the Chehalis
Dian Cooper	Cowlitz Family Health Center
Jon Tunheim	TC Prosecuting Attorney's Office
Karolyn Holden	Grays Harbor PHHS
Laurie Tebo	Behavioral Health Resources
Kat Letet	Community Health Plan of WA
Mary Goelz	Pacific County PHHS
Michelle Richburg	Consumer Representative
Mike Hickman	ESD 113
Steve Clark	Valley View Health Center
Tom Jenson	Grays Harbor Community Hospital

*2 seats vacant at this time.

01/10/2019

CPAA PROJECTS

Bi-Directional Care Integration focuses on delivering whole-person care, addressing physical and behavior health in an integrated system where medical and behavioral health providers work together to coordinate and deliver care. Moving into an integrated system means closing the gap between primary care and behavioral health services and implementing Collaborative Care principles, including patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care.

Care Coordination brings a structured, standardized approach to care by connecting high-risk individuals to physical health, behavioral health, and social support services with the help of a care coordinator. The Pathways model is a community-wide, evidence-based approach that emphasizes empowered patients, ensures those patients at greatest risk are identified, and that individual's medical, behavioral health, and social risk factors are addressed.

Transitional Care focuses on coordinating services when a patient moves from one health care setting to another, ensuring patients get the right care in the right place at the right time. Many patients are not fully recovered when they leave the hospital, and increasing access to care to reduce adverse health events and coordinating transitional care services results in lower health care costs and healthier, more satisfied patients.

The Opioid Response Project address the opioid epidemic in our region and reduces the burdens this crisis places on individuals, families, and communities. It is an opportunity to use practical, evidence-based approaches to prevent initiation of use by changing the way opioids are prescribed, prevent overdose deaths, reduce stigma and judgement, and increase recovery supports and access to medication assisted treatment (MAT).

Reproductive/Maternal & Child Health works with partners to support healthy families, which are the center of a healthy community. CPAA intends to help young men and women, mothers, and children access health services, mitigate the impact of adverse childhood experiences (ACEs), and build resilience in our region.

Chronic Disease Prevention and Control focuses on educating our communities about health risks and chronic disease prevention: our community members eat healthy, exercise, and practice other healthy lifestyle behaviors (e.g., not smoking) to prevent chronic diseases, our workplaces and built environments support them in doing so, and community members who suffer from chronic diseases have the tools, resources, and motivational support systems to successfully manage their conditions.

FUNDS FLOW

If CPAA meets all its milestones and the state meets all their metrics, CPAA will earn up to $51.4 million for the region.

CPAA's funding allocation principals:

- Support sustainability
- Improve health equity & reduce health disparities
- Reward relative contribution of desired outcomes
- Invest to both rural and urban areas
- Invest in all seven counties
- Reward truly transformative efforts
- Establish a Regional Wellness Fund to support investments in key health improvement areas
- Address social determinants of health

Social Determinants of Health
It's harder to be healthy if you don't have a home, you don't have food, or you don't have a job. CPAA's cross-sector stakeholders and partners address social determinants of health, the social and environmental conditions that influence a person's health:

- Prevent and mitigate adverse childhood experiences (ACEs)
- Decrease the impact of socioeconomic factors like poverty, chronic pain, untreated depression and anxiety, unstable housing, food insecurity, insufficient health literacy and self-management training, and substandard working conditions
- Increase access to care, including oral health, primary care, behavioral health, regular check-ups and preventative screenings, and transportation to appointments

CONTACT INFORMATION

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Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems, to benefit Medicaid clients.

This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

ABOUT US

Vision: The Greater Columbia Accountable Community of Health (GCACH) region is a vibrant, healthy community in which all individuals, regardless of their circumstances, can achieve their highest potential.

Population: The GCACH covers nine counties and over 710,000 lives. Approximately 255,000 or 35% receive Medicaid benefits. The largest ethnic group is Hispanics who comprise 50% of the GCACH Medicaid population. The Yakama Nation is the largest Native American Tribe in the state of Washington with 13,000 members.

OUR PROJECTS

2A: Bi-Directional Integration of Physical & Behavioral Health
The focus is to address physical and behavioral health needs through an integrated network, better coordination and seamless access.

2C: Transitional Care
The focus is to reduce avoidable admissions/readmissions to intensive care settings such as hospitals, psychiatric hospitals, skilled nursing facilities and prisons or jails.

3A: Addressing the Opioid Public Health Crisis
The focus is to reduce opioid related morbidity and mortality through prevention, treatment and recovery supports.

3D: Chronic Disease Prevention & Control
The focus is prevention and treatment for chronic disease in relation to individuals with diabetes and obesity.

GCACH THEORY OF ACTION

Greater Columbia ACH developed its Theory of Action after an intensive study of our region's strategic issues. Systems integration, community engagement, coordination of care and health equity/social determinants have remained the pillars of our work. Led by the primary care team, Patient Centered Medical Home organizations work in teams of integrated specialists and with community partners to address chronic illness, social determinants, patient engagement, and proactively manage their patients using population health management tools.

FUNDS FLOW

The table below details potential dollars that Greater Columbia ACH could earn through 2022:

Potential Project Earnings	Behavioral Health Earned Integration Incentives
$71.9M	$10.18M

The following funds will be distributed to community partners to address social determinants of health.

COMMUNITY HEALTH FUND

LHIN	Population	Medicaid Population	SDOH WTSA* Measures	Population Funds	WTSA* Funds	Total Funding	$ Per Consumer
BFCHA	279,170	94,605	25	$185,191	$32,078	$217,269	$2.30
BMRCHP	60,730	17,155	29	$33,581	$37,210	$70,792	$3.86
KVHN	43,710	10,436	23	$20,429	$29,512	$49,940	$4.79
SEWARHN	28,400	8,705	30	$17,040	$38,494	$55,534	$6.38
WCHN	47,940	8,392	18	$16,427	$23,096	$39,524	$4.71
YCHCC	250,900	116,133	29	$227,332	$37,210	$264,542	$2.28
Totals	**710,850**	**255,426**	**154**	**$500,000**	**$197,600**	**$697,600**	**$2.73**

*Social Determinants of Health, Worse Than State Average

BOARD MEMBERS

Brian Gibbons	Healthcare Provider	Astria Sunnyside Hospital	Yakima County
Caitlin Safford	MCOs	Amerigroup	Statewide
Carrie Green	Philanthropy	Three Rivers Community Foundation	Benton County
Dan Ferguson	Workforce Development	Yakima Valley College	Statewide
Darlene Darnell	FBOs/CBOs	Catholic Charities	Regional
Dana Oatis	Mental Health Provider	Lourdes Health Network	Franklin
Vacant	Public Safety	Kittitas Valley Fire & Rescue	Kittitas County
Julie Petersen	Hospital	Kittitas Valley Healthcare	Kittitas County
Les Stahlnecker	Education	ESD 123	Regional
Susan Grindle	Social Services	HopeSource	Regional
Lottie Sam	Tribes	Yakama Nation	Yakama Nation
Madelyn Carlson	Transportation	People for People	Regional
Martha Lanman	Public Health	Columbia & Garfield Counties	Walla Walla/Columbia Counties
Rhonda Batchelor	Consumer	Lutheran Community Services	Benton/Franklin Counties
Rhonda Hauff	Housing	Yakima Neighborhood Health Services	Yakima County
Ruben Alvarado	Local Government	City of Pasco	Franklin County
Sandra Suarez	FQHCs	Yakima Valley Farm Workers Clinic	Benton/Yakima/Walla Walla/Whitman

CONTACT US | 720 W Court St, Pasco | info@gcach.org | gcach.org | 509-546-8934

Medicaid Transformation

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This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

ABOUT US

We are HealthierHere, a new non-profit organization dedicated to improving the health and well-being of all people in King County, Washington.

We are proud to serve as the Accountable Community of Health for King County.

We believe that if we work together with our partners, we can create a connected system of whole-person care that will improve health and health equity. No matter where someone enters the system, they get connected to the right care and community supports, in the right place, at the right time.

BOARD MEMBERS

Teresita Batayola, International Community Health Services

Elizabeth Bennett, Seattle Children's Hospital

Roi-Martin Brown, Washington Community Action Network

Molly Carney, Evergreen Treatment Services

Elise Chayet, Harborview Medical Center

Kristin Conn, Kaiser Permanente of Washington

Shelley Cooper-Ashford, Center for MultiCultural Health

Steve Daschle, Southwest Youth and Family Services

Ceil Erickson, Seattle Foundation

Patty Hayes, Public Health – Seattle & King County

Sybill Hyppolite, SEIU Healthcare 1199NW

David Johnson, Navos Mental Health Solutions

Cathy Knight, City of Seattle Aging and Disability Services

Stephen Kutz, Cowlitz Indian Tribe

Laurel Lee, Molina Healthcare of Washington

Betsy Lieberman, Affordable and Public Housing Group

Esther Lucero, Seattle Indian Health Board

Daniel Malone, Downtown Emergency Service Center

Adrienne Quinn, King County - Community & Human Services

Jihan Rashid, Somali Health Board

Jeff Sakuma, City of Seattle – Human Services Department

Erin Sitterley, Sound Cities Association

Sherry Williams, Swedish Medical Center

Giselle Zapata-Garcia, Latinos Promoting Good Health

OUR PROJECTS

Integrating Physical and Behavioral Healthcare
Today, people have to navigate many disparate systems – medical, behavioral health, government, and social services- with little or no coordination among them. That makes it hard or even impossible for people to access the full range of care and support services they need to improve their health. HealthierHere is partnering with behavioral health and primary care provider organizations to increase access to necessary services, screenings, and care regardless of whether they enter the system through a primary care or a behavioral health setting. To maximize impact and best use of resources, we are aligning with the county and statewide transition to integrated managed care as well as other related initiatives.

Assuring Safe and Successful Care Transitions
The days and weeks following a person's discharge from a hospital, psychiatric hospital, or jail is a time of great vulnerability and risk. It is common for high risk patients to rebound back into these high-cost, high-intensity settings for preventable reasons. HealthierHere is bringing together hospital, psychiatric hospital, jail, and community-based organizations to implement solutions that have been proven to better address patient needs during this transition time. By doing so, we will reduce unnecessary readmissions and increase safer, healthier transitions for individuals returning home to their community.

Preventing and Managing Chronic Conditions
Untreated or poorly managed chronic diseases can cause unnecessary suffering and health complications. HealthierHere is partnering with health care provider and community-based organizations to improve health outcomes for community members living with or at risk for asthma, chronic obstructive pulmonary disease, diabetes, and cardiovascular disease. Our evidence-based strategies will increase the identification of individuals living with or at risk for these conditions, improve the coordination of their care, and provide the tools and empowerment they need to successfully practice self-management techniques for sustainably improved health.

Reducing Opioid Use
We are in an opioid crisis. To address this complicated problem head-on, HealthierHere is aligning closely with county and statewide efforts, and working with medical, behavioral health, government, social services, and community partners to implement strategies to improve access and accessibility to screening and appropriate treatment for opioid use disorder, and reduce opioid-related harms, overdoses, and deaths. With the help of our partners, we will also increase the number of medical and dental providers trained on opiate prescribing practices, support the distribution of life-saving naloxone kits, and support overdose prevention education and awareness efforts.

The King County region serves the highest number of Medicaid enrollees, about 23% (433,000) of the total statewide enrollees.

HEALTHIERHERE FUNDING

HealthierHere's Governing Board has approved the budget below to support and incentivize transformation initiatives and HealthierHere's operations.

Year Dollars are Earned	Potential Incentive Dollars – Projects *	Behavioral Health Integration Incentive
2017	$20.4 million	$6.0 million
2018	$28.5 million	
2019	$26.4 million	$9.0 million
2020	$23.0 million	
2021	$18.7 million	
Total	$117.0 million	$15.0 million

This assumes that HealthierHere and Washington State both meet all of their metrics.

CONTACT US

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North Central Accountable Community of Health

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems, to benefit Apple Health (Medicaid) clients.

This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

Grand Coulee Dam, one of the many hydroelectric powered dams along the Columbia River in the North Central region

ABOUT US

We are a local group of community leaders focused on health, policy, and data-driven approaches. We use collaborative partnerships and innovative solutions to improve the health of our communities as **a part of the state's Healthier Washington Medicaid** Transformation. Our goal is to activate Medicaid beneficiaries, health and social service providers, payers, and other community members to join in building a healthier region together.

- NCACH is the most rural Accountable Community of Health by population with 255,000 people across four counties
- 37% of NCACH residents (95,000 people) currently receive Medicaid (Apple Health) benefits
- Notable accomplishments include the formation of the Whole Person Care Collaborative, which engages 17 Medicaid-serving outpatient provider organizations across our four-county region

BOARD MEMBERS

Blake Edwards	Columbia Valley Community Health
Rick Hourigan, MD	Confluence Health
Doug Wilson, MD	Confluence Health
Rosalinda Kibby	Columbia Basin Hospital
Scott Graham	Three Rivers Hospital
David Olson	Columbia Valley Community Health
Carlene Anders	Mayor, City of Pateros
Senator Judy Warnick	WA State 13th Legislative District
Michelle Price	North Central Educational Service District
Barry Kling	Chelan Douglas Health District
Bruce Buckles	Aging and Adult Care of Central WA
Nancy Nash-Mendez	Okanogan Housing Authority
Andrea Davis	Coordinated Care
Molly Morris	Confederated Tribes of the Colville Reservation
Ray Eickmeyer	North Central Emergency Care Council
Brooklyn Holton	City of Wenatchee
Kyle Kellum	Samaritan Healthcare
Mike Beaver	Okanogan County Juvenile Department

OUR PROJECTS

Bi-Directional Integration of Physical and Behavioral Health
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.

Pathways Community Hub
Promote community-based care coordination across the continuum of health for Medicaid beneficiaries utilizing the Pathways Community HUB model. This will ensure that those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Transitional Care
Improve transitional care services for Medicaid beneficiaries moving from intensive medical care or institutional settings. Improving these services will lead to a reduction of unnecessary hospitalization by ensuring patients who leave the hospital are getting connected to the right care.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased connections to primary care and social services, patient education on appropriate care utilization, and redirecting non-acute patients who come into contact with ambulance providers to the appropriate care setting.

Addressing the Opioid Use Public Health Crisis
Reduce opioid-related morbidity and mortality through strategies that target prevention of opioid misuse and abuse, treatment of opioid use disorder, overdose preventions, long-term recovery, and whole person care.

Chronic Disease Prevention and Control
Improve chronic disease management and control by using the Chronic Care Model. The Chronic Care Model is an organizational approach to caring for people with chronic disease in a primary care setting. The CCM identifies essential elements of a health care system that encourage high-quality chronic disease care: the community; the health system; self-management support; delivery system design; decision support; and clinical information systems.


NCACH Medicaid Transformation Project Funds	
Year Dollars are Received	Potential up to Dollars Received
2017	$6 M
2018	$13 M
2019	$9.3 M
2020	$3.9 M
2021	$3.3 M
2022	$3.3 M
2023	$2.4 M
Total	$41.2 M

*NCACH is working directly with Providers through established Project workgroups. Those workgroups develop the funding allocations for implementation partners involved in those projects. Distribution of funding to partners varies based on the workgroup funding methodology.

CONTACT US

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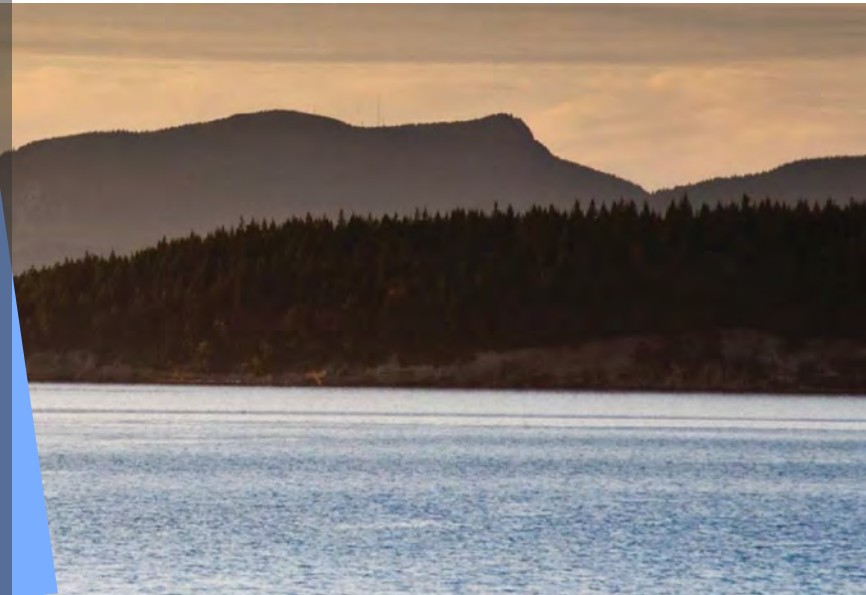
North Sound ACH

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health delivery systems, to benefit Apple Health (Medicaid) clients.

This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a Board of Directors, with staff responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care and related services to achieve better health, advance equity and bend the cost curve across the North Sound region.

ABOUT US

We have made commitments to:

- work with public and private sector partners
- create innovative and community-led solutions
- advance equity
- embed the perspective of clients, patients and community members
- look for solutions that include and go beyond traditional health care
- use ACH funds to leverage other opportunites in the region
- operate in a lean, efficient manner
- be accountable and transparent

BOARD MEMBERS

Kenneth Dahlstedt	Skagit County Commission
Conner Darlington	Community Member
Anne Deacon	Whatcom County
Robin Fenn, PhD (Chair)	Verdant Health Commission
Cammy Hart-Anderson	Snohomish County
Shanon Hardie	Unity Care NW
Jennifer Johnson	Skagit County
Jill Johnson	Island County Commission
Debbie Jones	Samish Nation
Nickolaus Lewis	Lummi Nation
Caitlin Safford	Amerigroup
Marilyn Scott	Upper Skagit Tribe
John Stephens	didgwálič Wellness Center
Jim Steinruck	Tulalip Health System
Bill Watson	San Juan County Council
Kim Williams	Providence Health and Services
Open	Stillaguamish Tribe
Open	Nooksack Tribe
Open	Sauk-Suiattle Tribe
Open	Behavioral Health Provider

OUR PROJECTS

Care Coordination
Improve care coordination and communications across care settings and sectors, implement strategies to improve care for patients during periods of transition, and support ways to divert community members from avoidable emergency department, inpatient and jail experiences. Examples of strategies include:
- Integration of PreManage
- Community paramedicine
- Cross sector collaboration for complex cases

Care Integration
Align bidirectional clinical integration with efforts to integrate behavioral health in managed care, working with physical and behavioral health providers, and integrating oral health care in primary care settings. Examples of strategies include:
- Medication Assisted Therapy for depression and opioids
- Improving opioid practices
- Medication Assisted Therapy (MAT) for depression, opioids
- SBIRT – Screening, brief intervention, and referral to treatment
- Expand and enhance community recovery services

Care Transformation
Implement targeted initiatives that transform the delivery of care in primary care, oral health and community-based settings, implement regional opioid plan. Examples of strategies include:
- Increased access to LARC
- One Key Question
- Healthy Steps
- DHAT in tribal clinics
- Mobile opioid treatment and outreach

Capacity Building
Supporting partnering providers on strategies to address workforce challenges, to take on more outcomes-based contracts, increase use of population health assessment and tools, and advance use of information sharing technology.

FUNDS FLOW

The North Sound region, with more than 1.2M residents, is the second largest ACH in number of Medicaid lives at more than 270,000. We have the potential to earn up to $100M for the region over the next five years if we are successful in our implementation.

The North Sound Board of Director directed that earned funds be used to support partnering providers in the five-county region. The Board set broad direction, including:

- *No more than 10% can be used for administration*
- *10% will be allocated to a community resilience fund*
- *2% will be put in a reserve/contingency fund*
- *The balance will be used for the four initiatives and be shared with partnering providers to lead that work.*

In April 2018, the Board approved allocation of up to $18.2M for the ACH and partnering providers in 2018. In October 2018, the Board approved allocation of an additional $18.2M in 2019.

CONTACT US

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![Olympic COMMUNITY of HEALTH]

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems, to benefit Apple Health (Medicaid) clients.

This work is led by nine Accountable Communities of Health (ACH) regions, each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.
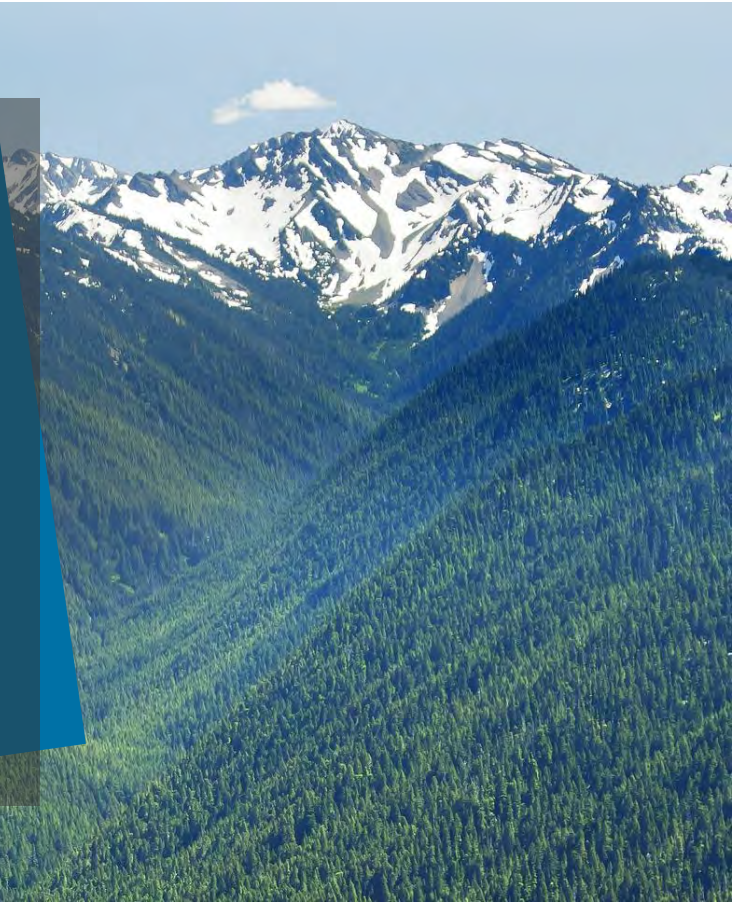
ABOUT US

Olympic Community of Health (OCH) is an accountable community of health, one of nine in the state. Our region includes Clallam, Jefferson and Kitsap Counties and we are in the territorial lands of the Sovereign Nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, Quinault and Suquamish Tribes. The OCH Board of Directors is diverse, consisting of leaders from tribal nations and health sectors.

Olympic Region

BOARD MEMBERS

Stephanie Lewis	Salish Behavioral Health Organization
Joe Roszak	Kitsap Mental Health Services
Gill Orr	Cedar Grove Counseling
David Schultz	CHI Franciscan Harrison Medical Center
Gary Kriedberg	CHI Franciscan Harrison Health Partners
Bobby Beeman	Olympic Medical Center
Hilary Whittington	Jefferson Healthcare
Jennifer Kreidler-Moss	Peninsula Community Health Services
Andrea Tull	Coordinated Care
Thomas Locke	Jefferson County
Katie Eilers	Kitsap Public Health District
Vickie Kirkpatrick	Jefferson County Public Health
Roy Walker	Olympic Area on Aging
Dale Wilson	Olympic Community Action Programs
Michele Lefebvre	Quileute Tribe
Libby Cope	Makah Tribe
Brent Simcosky	Jamestown Family Health Clinic
Jolene George	Port Gamble S'Klallam Tribe
Sammy Mabe	Suquamish Tribe

OUR PROJECTS

Medicaid Transformation Project (MTP)

OCH has incorporated six Medicaid Transformation projects into one provider-centric Change Plan. The Change Plan consists of four domains: Care Coordination, Care Integration, Care Transformation, and Care Infrastructure. Partners may also participate in a Community-Based Organizations Social Services Change Plan, called CBOSS. The MTP projects selected by OCH are:

- 2A Bi-directional integration of physical and behavioral health through care transformation
- 2D Diversion interventions
- 3A Addressing the opioid use public health crisis
- 3B Reproductive and maternal/child health
- 3C Access to oral health services
- 3D Chronic disease prevention and control

Opioid Response

In 2016 OCH launched a three-county coordinated opioid response initiative, 3CCORP. The initiative aligns OCH's efforts with the state's opioid response plan and is integrated with the Medicaid Transformation Project. With the Salish Behavioral Health Organization, OCH hosted the first annual Regional Opioid Summit in January 2017. Over 230 people gathered in Kingston, Washington for the event. The second annual Opioid Summit will be held October 17, 2018.

The 2nd Annual OCH Regional
Opioid Summit
October 17, 2018 | 12:30 – 4:30 p.m.
at the Suquamish Clearwater Resort

CONTACT US

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Natural Communities of Care

OCH regularly convenes three Natural Communities of Care, or NCCs, based in Clallam, Jefferson, and Kitsap counties. Each NCC currently meets individually semi-annually, with all three NCCs convening for a yearly regional meeting.

NCC convenings provide opportunities for partners such as behavioral and physical health providers of all sizes, local government and public health agencies, emergency services, tribal partners and more to collaborate, network and learn about our efforts toward health care delivery transformation and community health improvement.

From left to right: Clallam, Jefferson and Kitsap NCC Convenings.

FUNDS FLOW

OCH allocates MTP payments to implementation partners by Natural Community of Care. Within each Natural Community of Care, MTP implementation partners submit a change plan outlining transform-ation activities through 2021. Payment for each implementation partner is based on the content of their change plan, performance and their Medicaid footprint within their Natural Community of Care.

![Pierce County ACH logo](Pierce County ACH)

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems to benefit Apple Health (Medicaid) clients.

This work is led by nine Accountable Communities of Health (ACH) regions throughout the state, each governed by a backbone organization responsible for convening local leaders from multiple sectors to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

ABOUT US

As the ACH of Pierce County, our mission is to build a transformation strategy that ensures whole-person health and health equity for our entire community.

As our guide, we use the Institute of **Health Improvement's Triple Aim modified to the Quadruple Aim**. That means we focus on contributing to the health of all Pierce County communities through easy access to quality, whole-person care that improves physical, mental and social well-being, decreases disparities, reduces health care costs and enhances provider satisfaction.

We will create transformation through collaborative public-private partnerships and develop long-term strategies, such as shared savings through a **Community Resiliency Fund**, to spread effective and sustainable approaches. This fund allows us to reinvest back into our community, supporting long-term health-generating activities and programs.

Our primary role is to serve as a hub for **Community-Clinical linkages.** This allows us to bring together physical health care providers, behavioral health providers, substance abuse disorder providers, community health workers, county government, the criminal justice system, first responders, human services, public health, organizations addressing social determinants of health, and insurance providers. These groups come together to address challenges and identify solutions to providing equitable and sustainable whole-person care in both the rural and urban communities of Pierce County.

BOARD MEMBERS

Federico Cruz-Uribe, MD, Board Chair	Sea Mar Community Health Centers
Mike Curry, Board Vice Chair	Catholic Community Services
Joe LeRoy, LICSW, Board Secretary	Hope Sparks
Anne M. McBride, Finance Chair	CHI Franciscan Health
Lois Bernstein	MultiCare Health System
Aaron Van Valkenburg	Pierce County Aging & Disability
Dr. Anthony Chen	Tacoma-Pierce County Health
Helen McGovern- Pilant	Food / Human Services
James H. Williams, PhD, MSW	NAMI Pierce County
Sue Dreier	Pierce Transit
Jeffrey A. Plancich	MultiCare Behavioral Health
Sybill Hyppolite	SEIU Healthcare 1199NW
Dr. Jose Mendoza, MD, FAAP	Pediatrics Northwest
Jesse Gamez	Northwest Physicians Network
Dr. Gregory Christopher	Shiloh Baptist Church
Peter Adler	Molina Health Plan
Steve O'Ban	Pierce County's Executive Office
Stuart Battersby	Amerigroup
Emily Reed	Community Advisory Council

OUR PROJECTS

The Pierce County ACH Board of Trustees selected four foundational initiatives. However, to address the full range of potential project areas under the Transformation Project, the board and stakeholders also chose to incorporate the project areas that were not selected—oral health, reproductive and maternal child health, transitions of care, and diversions—by linking them into our planned work.

Project 1: Bi-Directional Integration
We will move toward a comprehensive, whole-person approach to health by integrating experiences within physical and behavioral health settings.

Project 2: Community-Based Care Coordination
Using a Community HUB model, we help underserved populations get the care they need—care that is community-based and culturally-competent. A multi-disciplinary health engagement team will partner with community health workers to support both clinical and social service gaps and coordinate care for these patients.

Project 3: Chronic Disease Management
This project area allows us to move away from responding to sickness and toward creating better health as an organizing principle. It focuses on whole person care, rather than just treating their condition—a move that is an essential element of value-based payment and population health management.

Project 4: Addressing the Opioid Use Crisis
Our goal is to improve system and provider capacity to prevent opioid use disorder, improve our ability to recognize and treat patients and increase identification and treatment of patients at risk.

OUR STRATEGY

To achieve these aims, we are implementing a collective impact strategy built on three gears that turn together to catalyze and drive long-term transformation.

1. A strong and diverse set of community partnerships in health care and other complementary sectors

2. Authentic engagement with the community designed to ensure we remain true to local needs and leverage local wisdom

3. A data and learning infrastructure to help us plan for optimal impact, monitor performance and provide tools and feedback to drive continuous improvement

FUNDS FLOW

- *Pierce County ACH has the opportunity to earn $66 million for the duration of the Medicaid Waiver*
- *Ten percent of earned funding will be directed to the Community Resiliency Fund for a total of $7 million by the end of the waiver*
- *To date, $20.5 million has been awarded to partnering organizations in the ACH*
- *Nearly $10 million is also available to support bi-directional care integration in Pierce County*
- *To date, funds has been distributed to 54 partnering organizations in Pierce County*

CONTACT US

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SWACH

Medicaid Transformation

Medicaid Transformation is a five-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.5 billion of investments in local health systems, to benefit Apple Health (Medicaid) clients.

This work is led by nine regional Accountable Communities of Health (ACH), each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health. These individuals and organizations collaborate on projects that are testing new and innovative approaches to transform how we deliver healthcare.
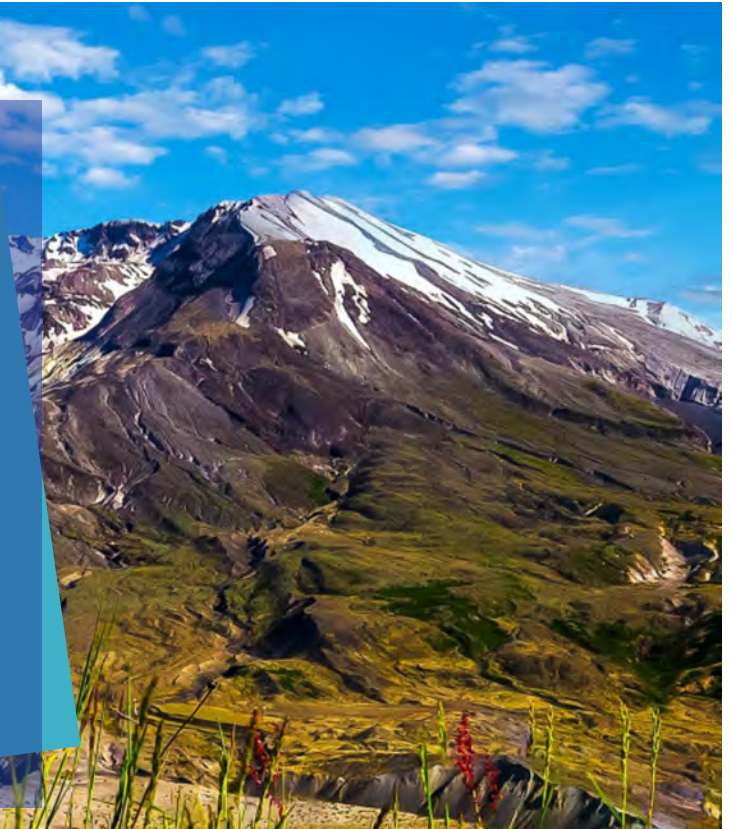
ABOUT US

Southwest Washington Accountable Community of Health (SWACH) is a local nonprofit working to improve health in Southwest Washington.

We bring together community members and other experts to address our region's biggest health challenges. Through innovative partnerships and local resources, we're working to create lasting changes and a healthier future – for everyone.

SWACH is the ACH for the counties of **Clark, Klickitat** and **Skamania**. We partner with the **Cowlitz Tribe** and **Yakama Nation**.

We also work in **Wahkiakum** and **Cowlitz** counties through the Healthy Living Collaborative, a SWACH program.

BOARD MEMBERS

Les Burger	Community Member
Sharon Crowell	The Vancouver Clinic
Danny Fontoura	Peace Health
Jon Hersen	Legacy Health Services
David Kelly	Area Agency on Aging & Disabilities
Robb Kimmes	Skyline Hospital
Steve Kutz	Cowlitz Tribe
Laurel Lee	Molina Healthcare
John Moren	Community Services Northwest
Kirby Richards	Skamania County Public Health
Karen Stral	Community Member
Kevin Witte	Clark College
Roxanne Wolfe	Clark County Public Health

OUR PROJECTS

Opioid Crisis Response
The opioid crisis is one of the biggest challenges faced by our country and region. We partner with community members and other experts to address this epidemic. Our goals include:

- Reducing overdoses and addressing stigma
- Increasing outreach and education
- Working with providers to ensure appropriate opioid prescribing practices
- Reaching more people with care and effective treatment, including evidence-based medication assisted therapy

Community Care Coordination
Research shows that a more coordinated approach to health services leads to better health and lower costs. We partner with care coordinators, providers and community organizations to improve care coordination. Our approach includes:

- Improving coordination with technology (Pathways HUB)
- Enhancing access to support and resources
- Engaging underserved communities

Our vision is a stronger and more seamless system of care coordination in Southwest Washington.

Bi-Directional Integration
Mental and physical health are closely related. Yet they're often treated in siloes. It's inefficient. And research shows that this siloed approach leads to poorer health.

We partner with providers to advance a more coordinated system of care through improvements such as:

- Shared care plans focused on whole-health.
- Systems to coordinate treatment between providers.
- Screening methods that improve prevention/treatment.
- Switching to value-based payment models

Chronic Disease Prevention & Control
Chronic disease is responsible for 7 in 10 U.S. deaths each year and the vast majority of healthcare costs.

We work with regional partners and stakeholders to implement chronic care model elements, such as:
- Strategies aimed at comprehensive system change
- Applying evidence-based guidelines in clinical practice
- Improving clinical information systems
- Leveraging community-based resources

OUR STRATEGY

SWACH's approach to improving health is built on three gears:

- **Whole-person care**. Because good health is about the whole person - from head to toe.
- **Sustainable, large-scale impact.** That means creating lasting solutions that make our communities healthier.
- **Community-clinical linkages** that bridge healthcare with essentials like housing, transportation and education.

FUNDS FLOW

Potential SWACH region funding for Medicaid Transformation projects, five-year total: $50M

Community Resiliency Fund to support projects and partnerships with community-serving organizations:
- Year 1: $721,217 (10%)
- Years 2-5: TBD

Early Adopter Fully Integrated Managed Care Incentive: $8.7M

CONTACT US

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