Board Of Trustees

June 21, 2018
Community Clinical Linkages

Pathways HUB Model
Kathy Burgoyne, Ph. D.
Foundation for Healthy Generations
Pathways HUB Timeline

• **October 2017**
  - SWACH released a Request for Applications to identify potential Care Coordination Agencies (CCAs)
  - 3 community based agencies were selected: Sea Mar, Community Voices Are Born (CVAB), and Council for the Homeless.

• **November 2017**
  - Per project plan approved by Health Care Authority:
  - SWACH will serve as the Community Pathways HUB, providing implementation training, development of workflows and policies related to HUB operation, and provide critical tools
  - SWACH has chosen to work with Care Coordination Systems (CCS) to develop the Pathways Community HUB data platform.

• **December-March 2017**
  - Transition period
Opportunities and Risks

• Care Coordinating Agencies (CCA) are prepared for next steps.
  – CCAs have organized some of their operations around this opportunity and are concerned they will/have lost internal trust and expenses

• Statewide collaboration with DOH and ACHs
  – Increased training and implementation costs
  – Risk losing shared learning opportunities
  – Risk losing cross ACH evaluations-increase SWACH cost

• Increased value to work across the state with other ACHs

• Potential loss of incentive funding based on project plan proposal and approval-unknown risk

• Breakdown of community trust for SWACH
Kathy Burgoyne Ph.D.
Foundation for Healthy Generations
Community HUB Example

- EMS: Emergency Medical Services
- MSS: Maternity Support Services
- Pathways
- Health Homes
Endorsement of Pathways Community HUB Model

The CMS Innovation Center

Ohio Commission On Minority Health

Institute for Healthcare Improvement

CDC
Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People™

NIH
National Institutes of Health
Turning Discovery Into Health

Ohio
Department of Medicaid

National Science Foundation
WHERE DISCOVERIES BEGIN

HRSA
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care
Community Care Coordination – care coordination provided in the community; confirms connection to health and social services.

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results
Regional Organization and Tracking of Care Coordination

COMMUNITY HUB

Agency A  Agency B  Agency C  Agency D

CARE COORDINATION AGENCIES

• Demographic Intake
• Initial Checklist -- assign Pathways
• Regular home visits – Checklists and Pathways completed
• Discharge when Pathways completed (no issues)

Source: Sarah Redding, MD
January 26, 2017
20 Core Pathways - National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum
20 Standard Pathways:
- One risk factor at a time
- Outcome achieved = finished PW & Payment!
- Outcome not achieved = finished incomplete PW

Risk = Pathways

![Diagram of Pathways Process]
Example - Pregnancy Pathway

Identify / enroll at risk population

Care Coordination

Initiation Step
Defined “at risk” pregnant woman engaged and enrolled in care coordination

Determine and document barriers:
1) Insurance status
2) Transportation
3) Importance of prenatal care

Final outcome

Prenatal care provider established
First and ongoing visits confirmed

Completion
Healthy baby > 5 lbs 8 oz (2500g)
The HUB Data Infrastructure
HUB: Processes Payment, Referral, Metrics

- Health and Human services
- Housing
- Area Agency on Aging
- Medicare/Medicaid
- Managed Care
- State Agencies
- County Departments
- Clinics
- Federally Qualified Health Centers
- Hospitals
- Physicians
- Private Health Plans
- Foundations

CCAs

14
## Tracks Milestones

**Recently Viewed Clients**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Type</th>
<th>Client Profile</th>
<th>Initial Checklist</th>
<th>RQ</th>
<th>Status</th>
<th>Enroll Date</th>
<th>Program</th>
<th>Coordination</th>
<th>Next Visit</th>
<th>Last Home Visit</th>
<th>CTD</th>
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<tr>
<td>Adams</td>
<td>Amy</td>
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<td>Partially Complete</td>
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<td>Urgent</td>
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<td>Minority Health, U.S. Way</td>
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<td>Jane</td>
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<td>Complete</td>
<td>Complete</td>
<td>Moderate</td>
<td>Active</td>
<td>1/30/18</td>
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<td>Adam</td>
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<tr>
<td>Doe</td>
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<td>Adam</td>
<td>2017-11-</td>
<td>2017-11-</td>
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Track and Measure Progress with Pathways

**By Community Care Coordinator**

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Worker (CHW) A</td>
<td>5</td>
<td>2</td>
<td>10</td>
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<tr>
<td>CHW B</td>
<td>1</td>
<td>3</td>
<td>4</td>
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<tr>
<td>CHW C</td>
<td>9</td>
<td>15</td>
<td>18</td>
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<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>50</td>
<td>25</td>
<td>22</td>
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<tr>
<td>Agency B</td>
<td>64</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Agency C</td>
<td>40</td>
<td>32</td>
<td>19</td>
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</tbody>
</table>

- Care Coordinator
- Agency
- HUB
- Community
- Region
- Patient
- Program
- Referrals
- Etc…
Care Coordination Systems (CCS) system and security highlights:

Virtual Private Cloud-based
- US based-solely.
- SOC1 (system on chip) and SOC2 environment.
- NIST cybersecurity standards. (National Institute of Standards and Technology)
- Encrypted - volumes (at rest) and in-transit.
- Redundant encrypted backups geographically.

Security compliance
- Third party independent annual audit
- HITRUST certification in process for 2018
- Report available as requested

<table>
<thead>
<tr>
<th>STATUS</th>
<th>COMPLIANCE ITEM</th>
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<tr>
<td>✔</td>
<td>CCS has conducted an &quot;accurate and thorough&quot; risk assessment of the Pathways Community HUB system in accordance with the HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164).</td>
</tr>
<tr>
<td>✔</td>
<td>CCS has conducted a security risk assessment that conforms with The Office for Civil Rights (OCR) &quot;Guidance on Risk Analysis Requirements under the HIPAA Security Rule&quot;.</td>
</tr>
<tr>
<td>✔</td>
<td>CCS has conducted a security assessment utilizing NIST (SP)800-66 r1 and NIST 800-53 r4 frameworks. NIST 800-53 r4 controls can be mapped into ISO 27001, HITRUST, and other certification frameworks.</td>
</tr>
<tr>
<td>✔</td>
<td>CCS has conducted a security assessment that follows NIST SP 800-30 r1 &quot;NIST Guide for Conducting Risk Assessments&quot;.</td>
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</tbody>
</table>
Pathways Community HUB Model

- Removes “silos” and fragmentation
- Uses existing community resources efficiently and effectively
- Focuses on common metrics to identify & track risks (risk reduction)
- Pays for outcomes – sustainable
- Owned by the community
A Statewide Perspective
Six ACHs have adopted Pathways:

- Better Health Together
- Cascade Pacific Action Alliance
- North Central ACH
- North Sound ACH
- Pierce County ACH
- Southwest ACH
• Four ACHs contracted with CCS for the data infrastructure: Better Health Together, Cascade Pacific Action Alliance, North Sound and Pierce County ACH.

• North Central recently chose a community organization to be the regional HUB. One of their next decisions is to establish a contract for the HUB infrastructure.
Cross ACH Pathways evaluation
  o Sustainability
  o Variation across locations and target populations

• CORE
  o Existing contracts with multiple ACHs
  o Data Dictionary from CCS

• Which ACHs
  o Better Health Together, Cascade Pacific Action Alliance and Pierce County ACH have agreed to move forward with the evaluation.
  o North Central and North Sound are in conversations with CORE.
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<tr>
<th>COMMUNITY CARE HUB</th>
<th>CARE COORDINATION AGENCIES</th>
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<tbody>
<tr>
<td>Hub Technology</td>
<td>Community Health Worker (CHW)</td>
<td>67k</td>
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<tr>
<td>150k</td>
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<tr>
<td>Clinical Manager</td>
<td>.2 CHW Supervisor</td>
<td>18k</td>
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<tr>
<td>120k</td>
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<td>Hub Manager</td>
<td>Optional Lap Tops</td>
<td>800</td>
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<tr>
<td>81k</td>
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<td>Hub Staff</td>
<td>Inking DOH Training (CHW)</td>
<td>44k</td>
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<tr>
<td>67k</td>
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<tr>
<td>Total</td>
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Questions?

Which costs are ongoing and which are one time
Financial Assumptions

Questions?
Which costs are ongoing and which are one time

<table>
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<tr>
<th>ASSUMPTIONS</th>
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<tr>
<td>Estimated Cost - Community Health Worker</td>
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<tr>
<td>Base Salary</td>
<td>$ 50,000</td>
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<tr>
<td>Benefits</td>
<td>35%</td>
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<td>Total</td>
<td>$ 67,500</td>
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<td>Total/Month</td>
<td>$ 5,625</td>
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| Monthly Supervision/Administration Support       |        |
| Estimated .2 FTE Supervisor (per month)          | $ 1,500 |

| Pregnancy Pathway (historical experience)        |        |
| Full Caseload per CHW                            | 30     |
| Average Client Service Duration                  | 7 months |
| Full Caseload (12 months)                        | 51     |
| OBPs generated for completed Pathway (normal risk)| 77     |
| Annualized average OBPs per CHW                 | 3927   |
### Financial Assumptions - Example

Questions?

Which costs are ongoing and which are one time

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<th></th>
<th>February</th>
<th>March</th>
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<th>July</th>
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<th>October</th>
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<tr>
<td>Baseline %</td>
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<td>100%</td>
<td>90%</td>
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<tr>
<td>OBP%</td>
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<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>25%</td>
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<td>50%</td>
<td>75%</td>
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<td>Earn through OBP's</td>
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<td>$ -</td>
<td>$1,309</td>
<td>$2,618</td>
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<td>$9,818</td>
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<td>Total Payment</td>
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<td>$13,005</td>
<td>$13,005</td>
<td>$13,090</td>
<td>$141,627</td>
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<tr>
<td>OBP Rate to CCA</td>
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<td>$20.00</td>
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<td>$20.00</td>
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<tr>
<td># of OBP's generated</td>
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<td>2651</td>
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<td># of OBP's/CHW (est.)</td>
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<td>164</td>
<td>164</td>
<td>245</td>
<td>245</td>
<td>327</td>
<td>1325</td>
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</table>
What is Possible?
Community HUB Example

Community HUB

EMS
Emergency Medical Services

MSS
Maternity Support Services

Pathways

Health Homes
Community HUB Goals

Develop and facilitate community-based care coordination to:

- Reduce long term skilled nursing home admissions
- Reduce hospital stay and Emergency Department/Emergency Room visits
- Lower other healthcare or ambulatory costs
- Increase primary care utilization
- Improve health and social outcomes
- Provide community-clinical linkages
- Reduce isolation
- Increase quality of life at home
Vertical Integration

EHR = Electronic Health Record

CHR = Community Health Record
Measure

- Identify and prioritize highest at-risk.
- Converges real-time Social Determinants of Health information with clinical, financial and geographic information for risk stratification.
- Risk-adjusted caseloads and metrics for operating performance.
- Risk-adjusted performance payments for Pathways outcomes achieved.
- Charting visually demonstrates risk reduction/levels over time.
HEALTH ENGAGEMENT TEAM (HET)

- Engage at Hospital; Meet at Home within 48 hours
- Team Assessment with Primary and Behavioral Care
- Avert Skilled Nursing Facility (SNF) admission
- Reduce Hospital readmission
- Reduce Emergency Room/Emergency Department Utilization
- Improve Medication Adherence
- Reduce Ambulatory Services
- Reduce Isolation through high visit frequency
- Reduce Healthcare costs
- Improve community member/patient health

COMMUNITY CARE COORDINATION

Timeline

Transition to Community Health Workers (CHW) and Community Care Coordination
1-2x Month Home visit
Social Determinants of Health Focus

Client Discharge When Pathways Complete
Questions/Discussion
Objectives

• Review HLC’s history and current scope of work
• Overview of HLC’s strategic plan and request for approval
• Connection and enhancement to SWACH
• Plan to further integrate SWACH and HLC
Healthy Living Collaborative of SW Washington

- Community-driven coalition that works together on upstream initiatives that promote health equity and strengthen communities
- 60+ partners from multiple sectors across Clark, Cowlitz, Skamania, Wahkiakum, and Klickitat counties.
- Led by a Policy and HLC Committee
60+ Partners and Growing

Alliance for a Healthier Generation • Area Agency on Aging and Disability of Southwest WA • Clark College • Cascade Pacific Action Alliance • Clark County Food System • Clark County Public Health • Community Foundation for Southwest WA • Consumer Voices Are Born • Community Health Plan of Washington • Council For the Homeless • Cowlitz County Health and Human Services • Cowlitz Indian Tribe • Cowlitz on the Move • Cowlitz Family Health Center • Cowlitz-Wahkiakum Council of Governments • Evergreen Public Schools • Educational Service District 112 • Educational Opportunities for Children & Families • Free Clinic of Southwest Washington • Kaiser Permanente • Legacy Salmon Creek Medical Center • Lifeline Connections • Love Overwhelming • Housing Opportunities of Southwest Washington • Lower Columbia CAP • Lower Columbia Head Start • Molina • National Alliance on Mental Health Illness • NW Seventh Day Adventist Church Health Ministries • Nonprofit Network of SW Washington • Partners In Careers • PeaceHealth • Pathways 2020 • Prevention Alliance • Prevent! • Providence Health & Services • Safe Routes to Schools National Partnership • Sea Mar • Southwest Accountable Community of Health • Support for Early Learning and Families • Skamania Community Health • SW WA Regional Transportation Council • Underwood Community Garden • Vancouver Housing Authority • Vancouver Public Schools • Wahkiakum County Health and Human Services • WA Department of Health • Washington State University Extension • Washington State University Extension • Washington State University Vancouver • YMCA • YWCA
Our History

• April 2012 - First Regional Coalition Meeting
• October 2013 - Collaborative turned over to the community – Policy and Steering Committee begin to form a shared platform focus on policy and CHWs
• November 2013 - First Funders meeting
• April 2014 - started identifying communities for the CHW Pilot
• May 2014 - Hired HLC’s first staff
• October 2014 – Set first policy agenda included both local and state strategies
Our History

- November 2014 - CHWs recruited and started CHW training
- January 2015 - Received Federal Grant 1422
- March 2016 – Kick off meeting for the Peer Network (Community Health Advocates and Peer Supports) CHAPS
- June 2017– Kachina transitions half time with SWACH to assist with merger and integration of HLC SWACH
- October 2017 – HLC fully merges with SWACH
Organizational Principles

Health in all policies and systems
– We support incorporating health considerations into decision-making across sectors and policy areas for long term change.

Connections across diverse organizations and communities
– We work together across diverse sectors and across communities to address the factors that impact health outcomes.

Community engagement and action
– We elevate community voices and support the strength and power of communities.

Shared learning
– We work better together when we share our challenges and opportunities.
HLC Funders

- Cambia Health Foundation
- Community Foundation of Southwest Washington
- Foundation for Healthy Generations
- Kaiser Permanente
- Legacy Salmon Creek Medical Center

- Northwest Health Foundation
- Meyer Memorial Trust
- PeaceHealth
- Group Health
- Washington Department of Health
We incorporate health considerations into decision-making across sectors and policy areas for long term change.

- Organizational Policy
- Local Policy
- State Policy
- Federal Policy
Furthering Equity work

- **Equity training across the region**
  - 8 hour social justice and equity training
  - 4 hour implicit bias
- **Partnership with SW WA Equity Coalition**
  - Work with Center for Equity and Inclusion
  - Developing language and lens
- **Adopt equity lens**
  - Share with partners
Community Engagement and Action

Continuing to Elevate Community Voice and Support the Strength and Power of Communities
Community Health Worker Teams

- Identified three high need communities
- Recruited natural helpers
- Trained as CHWs
- Work as a team to support community health

CHA=Community Health Advocates
Education Community Health Worker Program

• Community Health Advocates help to identify systems barriers of chronic absenteeism
• Work in partnership with:
  – Vancouver Public Schools
  – Vancouver Housing Authority
  – Free Clinic of SW Washington
Community Health Advocate Peer Support Network (CHAPS)

A network of community-based community health advocates and peers serving the communities across the SW region who will come together to learn, support one another, and share ideas and best practices:

• Networking
• Professional Development and Training
• Advocating for Policy and Systems Change
• Community Advisory
• Advocating for More Peer Jobs
Connections across diverse organizations and communities

We work together across diverse sectors and across communities to address the factors that impact health outcomes.
Department of Health Grant – Healthy Communities Grant

Hypertension and Diabetes Prevention

• Promote Healthy Environments
• Support Lifestyle Change Programs
• Improve the Quality of Healthcare Delivery through Health Systems Interventions
Community Connections

Sharing cross-sector data to drive shared learning.

Continuous engagement and collaboration with partners (Data and Learning Team)

- Secure Transfer
- Connected data infrastructure and analytics
- Aggregate Reporting
- Planning
  - Evaluation
  - Program Design
  - Shared Learning
  - Policy & Systems Change

Data from Partners

Community Connections

Securing cross-sector data to drive shared learning.
Focus on Evaluation

- Three years of outside evaluation
- Providence Center for Outcomes Research and Education
- Multnomah County Community Capacitation Center
- Year 3 Focus
  - Partner survey
  - CHW Activity Tracker
  - Tracking HLC Policy and Systems Efforts
  - CHW Structured Interviews
Strategic Plan - Values

• **Equity and Social Justice** - We recognize that everyone’s voice matters and seek to engage all members of the community in our collective work.

• **Collaboration and Inclusion** – Our work is done in partnership with the community, identifying and implementing innovative solutions, sharing ideas and approaches that work for the community.

• **Innovation and Sustainability** – Collectively, we focus on policy and systems change in order to sustain innovative improvements and enhance our community’s resilience.
Policy change at the local, state, and federal levels

• **Strategy #1: Develop a policy agenda and take action on for Southwest Washington at the local, regional, state, and federal levels.**
  
  – Ensure connection and feedback loop to RHIP, SWACH committees and work
Improved health outcomes through organizational and community engagement and partnerships

STRATEGY #1: Increase organizational partners understanding and willingness to incorporate health, equity, and community considerations in organizational practices and funding opportunities.
Elevation of community voice and engagement

• **STRATEGY #1:** Promote health equity in Southwest Washington neighborhoods by recruiting, training, and coaching Community Health Workers who work on wide array of health promotion activities at the individual, family, community and policy level.

• **STRATEGY #2:** Address barriers to school attendance at McLoughlin Middle School.

• **STRATEGY #3:** Support growth of CHAPS network (namely Advocates, Community Health Workers, Certified Peers and their organizations) serving Southwest Washington to improve holistic health outcomes for the community.

• **STRATEGY #4:** Work with the community and key partners to identify additional community engagement opportunities and partnerships.
Long term sustainability and shared learning

• **STRATEGY #1:** Project and secure nimble and braided funding for HLC long term sustainability.

• **STRATEGY #2:** Sustain the shared learning infrastructure to support community-driven priorities and share learning lessons both locally and statewide. Create necessary feedback loops that support partners in understanding how the work impacts each other’s organizational practices and community partnerships.
Next steps in further integrating with SWACH

• Ensure stability and value alignment with new SWACH leadership
• Continue to integrate:
  – Work
  – Staffing
  – Governance
Transformation
Plan
Clinical Transformation Plan

- **Goals of the Clinical Transformation Plan are to:**
  - Help SWACH gain an understanding of and align with partner work towards Medicaid Transformation
  - Highlight the partners’ work and resource needs in order to facilitate investment
  - Gather information to meet HCA’s needs in the Implementation Plan

- **Our guiding principles for the template include:**
  - Provide enough structure to facilitate partner entry of key information
  - Identify tactics that SWACH feels are important for the health of the Medicaid population
  - Ensure that partners have flexibility to suggest innovative tactics

- **The Clinical Transformation Plan template is open for Public Comment until June 28th**
Important Upcoming Dates

June 11
Draft Transformation Plan released for Public Comment
Send comments to: transformation@southwestach.org
Comment period ends June 28th

June 15
Public Comment
Transformation Plan Webinar
Join Skype Meeting
206-402-1934
Passcode 3735705

June 21
Transformation Plan Webinar for Clinical Integration Workgroup
Join Skype Meeting
206-402-1934
Passcode 98882903

June 28
Clinical Integration Committee Meeting (Children’s Center)
All providers who have completed an assessment and plan to complete a Transformation Plan should attend

July 2
Release of Final Transformation Plan

July 13
Providers need to be registered in the PCG portal in order to receive initial payments by July 13th

Aug. 17
Transformation Plan Due to SWACH

Aug.–Oct.
SWACH evaluates transformation plans
Goal is to get all providers to a ‘met’ criteria

Oct.–Dec.
SWACH and Organizations develop mutually agreed upon binding agreement
Clinical Transformation Plan Overview

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Tactic Measures</th>
<th>Key Tasks for this Tactic</th>
<th>Phase</th>
<th>Completion Date</th>
<th>Type of Assistance</th>
<th>Assistance Description</th>
</tr>
</thead>
</table>

We also want you to have flexibility regarding which tactics you select. However, there are three tactics that we are requiring all clinical partners to select.

1. Bi-Directional Clinical Integration: **Move along the SAMSHA six levels of integration continuum (including solidifying a level)**
2. Community-Based Care: **Increase/enhance partnerships with community partners through policy, protocol or formal agreement**
3. Opioid Use: **Promote culture shift to understand and treat Opioid Use Disorder as a chronic disease affecting the brain**
Semi Annual Report
• First Semi-Annual Report (SAR) due to HCA on July 31st
  – Covers reporting period Jan 1 – June 30th
  – Includes required milestones (e.g. assessment) and organizational updates
  – Builds on November 2017 Project Plan - what is the current status of ACH projects?
  – Required template for report
    https://www.hca.wa.gov/assets/program/semi-annual-report-template.docx

• Draft SAR will be available for RHIP Council discussion in July
  – RHIP and Board approval not required for report submission, but review and input appreciated
  – SAR responses may highlight gaps (e.g. partnering providers, certain populations) – opportunity for RHIP to shape future
    engagement and outreach strategies moving forward
Funds Flow
Four High Level Funds Flow Categories

ACH Admin

- Administrative operating expenses of SWACH
  - Legal
  - Financial
  - Facilities
  - Equipment

Community Resiliency Fund

- Investments impacting social determinants of health and innovative solutions.

Regional Capacity Investments

- Funds for ACH to make regional investments that support partners for specific purposes including workforce, health information, training, and other infrastructure funds.
- Funds will be used to promote large scale transformation and sustainability across the region.

Transformation Plan Implementation

- Funds paid directly to partners to plan for and achieve DSRIP goals and overall transformation.
  - Assessments
  - Transformation plans
  - Implementation support
How Many Dollars Are There?

$8.7M
Fully Integrated Managed Care (FIMC)

To support bi-directional integration across Clark, Skamania, and Klickitat Counties

$8.7M
Year 1
2018

$9.2M
Year 2
2019

$7.8M
Year 3
2020

$7.3M
Year 4
2021

$5.9M
Year 5
2022

Projects

Regional Capacity Investments

$1.8M
(25%)

$?
$?
$?
$?

$721,217 – Year 1
(10%)

$?
$?
$?
$?

Partners Transformation Plans/Implementation

$4M
(55%)

$?
$?
$?
$?

$721,217 - Year 1 (10%)

$?
- Year 2

$?
- Year 3

$?
- Year 4

$?
- Year 5

$?

% to the Community Resiliency Fund

$4M
(55%)

$?
$?
$?
$?

% to the Community Resiliency Fund

$721,217 - Year 1
(10%)

$?
- Year 2

$?
- Year 3

$?
- Year 4

$?
- Year 5

$?

ACH Admin
Year 1 = $721,217 (10%)
## Year 1 Transformation Plan Implementation

### $1.7M Planning

<table>
<thead>
<tr>
<th>Activity</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Information Assessment</td>
<td>$210,000</td>
</tr>
<tr>
<td>Clinical Assessment</td>
<td>$260,000</td>
</tr>
<tr>
<td>Transformation Plan Submission</td>
<td>$900,000</td>
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<tr>
<td>Non-Clinical Partner Engagement TBD</td>
<td>$330,000</td>
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</tbody>
</table>

### $2.3M Binding Agreements

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binding 2019 agreements negotiated</td>
<td>September through December</td>
</tr>
<tr>
<td></td>
<td>These funds will combine with year 2 funds to support 2019 contracts</td>
</tr>
<tr>
<td></td>
<td>Contracts will take into account Medicaid lives served and can support</td>
</tr>
<tr>
<td></td>
<td>equity/anti-stigma work as well as partnerships needed to achieve</td>
</tr>
<tr>
<td></td>
<td>transformation outcomes</td>
</tr>
</tbody>
</table>