



Medicaid Transformation Project
**Semi-Annual
Report 1**

January 1, 2018 – June 30, 2018



July 27, 2018

Meyers and Stauffer LC
9265 Counselors Row, Ste. 100
Indianapolis, IN 46240

RE: CPAA Semi-Annual Report 1

Dear Semi-Annual Report Review Team Member:

Please find attached a copy of Cascade Pacific Action Alliance's first semi-annual report for the Medicaid Transformation Project. This report summarizes the work of Cascade Pacific Action Alliance through June 30, 2018, in six project areas: Bi-Directional Integration of Care & Primary Care Transformation, Community-Based Care Coordination, Transitional Care, Addressing the Opioid Use Public Health Crisis, Reproductive and Maternal/Child Health, and Chronic Disease Prevention and Control.

As detailed in the report, our region has made good progress with advancing the Medicaid Transformation Project and achieving health care delivery system transformation through cross-sector collaboration. Key accomplishments during the reporting period include, but are not limited to, conducting a Current State Assessment for the region, planning and releasing a Request for Proposals to finalize the selection of paid implementation partners, and preparing the submission of the region's Implementation Plan this fall. During the reporting period, we have also rounded out our staff to make sure a capable staff team and a solid organizational infrastructure are in place to support our partners during the planning and implementation of the Medicaid Transformation Project.

Please do not hesitate to contact us, should you have any questions regarding the enclosed report. We would be happy to provide you with further information.

Thank you for your time and consideration.

Sincerely,

Winfried Danke, CEO
Cascade Pacific Action Alliance

Table of Contents

<u>Section 1: Milestone 1: Assessment of Current State Capacity</u>	5
<u>Section 1: Milestone 2: Strategy Development for Domain 1</u>	18
<u>Section 1: Milestone 3: Define Evidence-Based Approaches, Strategies, and Target Populations</u>	25
<u>Section 1: Milestone 4: Identification of Partnering Providers</u>	45
<u>Section 2: ACH Organizational Updates</u>	46
<u>Section 2: Tribal Engagement and Collaboration</u>	49
<u>Section 2: Project Status Update</u>	55
<u>Section 2: Partnering Provider Engagement</u>	59
<u>Section 2: Community Engagement</u>	64
<u>Section 2: Health Equity Activities</u>	75
<u>Section 2: Budget and Funds Flow</u>	78
<u>CPAA SAR1 Report Appendixes</u>	80
Appendix A: CPAA State Capacity Assessment Announcement	81
Appendix B: CPAA State Capacity Assessment Release	83
Appendix C: CPAA State Capacity Assessment PDF	84
Appendix D: Care Coordination Environmental Scan Outcomes	141
Appendix E: CPAA Assessment Outcomes	147
Appendix F: CPAA RFP Release Email	283
Appendix G: CPAA MTP RFP Instructions	285
Appendix H: Additional Supports Combined Table Response	289
Appendix I: RFP Town Hall PowerPoint	291
Appendix J: LOI Tracker	311
Appendix K: CPAA MTP Program One-Pagers	313
Appendix L: CPAA Consumer Program One-Pagers	325

ACH Contact Information

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

ACH Name:	Cascade Pacific Action Alliance
Primary Contact Name	Christina Mitchell
Phone Number	360.539.7576 ext. 131
E-mail Address	mitchellc@crhn.org
Secondary Contact Name	Jennifer Brackeen
Phone Number	360.539.7576 ext. 105
E-mail Address	brackeenj@crhn.org

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

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

Milestone 1: Assessment of Current State Capacity

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

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

Yes	No
X	

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

ACH Response:

Not Applicable

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

ACH Response:

Cascade Pacific Action Alliance (CPAA) conducted two separate Current State Capacity Assessments. One focused solely on project 2B: Community-Based Care Coordination. The second survey focused on the five remaining project areas selected by CPAA for Medicaid Transformation Project (MTP) planning and implementation. CPAA made the decision to conduct two separate assessments due to readiness to release and topics covered. The Care Coordination survey focused on detailed requirements specific to the Pathways HUB and implementation of that project. Although the second assessment asked about specific project areas, it also asked general readiness questions and questions about integration of projects. Providers were encouraged to respond to both assessments.

The Community-Based Care Coordination assessment was released on February 5, 2018. This Care Coordination Environmental Scan was administered using Survey Monkey, with scheduled follow-up interviews with organizations interested in becoming Care Coordinating Agencies (CCAs). The survey was

distributed via email to all Care Coordination Work Group members and posted on www.cpaawa.org. Additionally, survey respondents were asked to identify additional agencies providing care coordination services that should be interviewed. This resulted in increased interest in participating in care coordination and additional providers completing the assessment.

The second assessment focused on the other five MTP project areas selected by CPAA: Bi-Directional Care Integration, Transitional Care, Addressing the Opioid Use Public Health Crisis, Reproductive and Maternal/Child Health, and Chronic Disease Prevention and Control. CPAA received input from Providence CORE (CORE), the University of Washington AIMS Center (AIMS Center), work groups, and council members to develop a composite survey aimed at identifying gaps and opportunities in the region and informing regional health decisions.

This assessment was also developed using Survey Monkey and incorporated a skip-logic design. Partners answered questions based on care setting: clinical, medical, behavioral health, hospitals, syringe exchange, public health, and community-based or social service organizations (Table 1). The final section of the assessment, Care Infrastructure, identified Domain 1 needs and interests and was completed by all provider types.

Table 1: Current State Capacity Assessment Settings

Assessment Settings

- Demographics (Question 1 – Q8)
- All Clinical Providers (Q9 – Q18)
- Primary Care (Q19 – Q59)
- Behavioral Health or Substance Use Disorder (Q60 – Q87)
- Skilled Nursing or Long Term Care Facility (Q88 – Q92)
- Hospital Partners - In-patient (Q93-Q103)
- Syringe Exchange Services (Q105-Q128)
- Community Paramedicine Questions (Q129-Q131)
- Community Based Organizations (Q133-Q147)
- Care Infrastructure (Q148 – Q164)

The Current State Capacity Assessment was advertised in various settings including work groups, council meetings, Clinical Provider Advisory Committee, and during one-on-one meetings with regional partners. An informational letter was emailed to partners on February 28, 2018, and announced on CPAA's website one week prior to the assessment's distribution (Appendix A). The survey was officially released to the region on March 5, 2018, through email (Appendix B) and was posted on the CPAA website. Although the survey was published via Survey Monkey, a PDF version (Appendix C) was provided, allowing providers to review questions and collect data prior to online submission. The survey was originally scheduled to close March 26, 2018, but CPAA extended the deadline to March 30 to ensure maximum participation.

CPAA closely monitored the assessment throughout the process to ensure no critical gaps in reporting, and completed assessments were cross-referenced with major Medicaid providers in the region. CPAA individually reached out to partners who had not yet completed the assessment. Through this process, the majority of critical partners completed the assessment, and CPAA is confident all areas in the region are covered to maximize impact. CPAA's outreach proved successful when all provider types (Table 2) from all seven counties (Table 3) completed the assessment.

Table 2: Assessment Completions by Provider Type

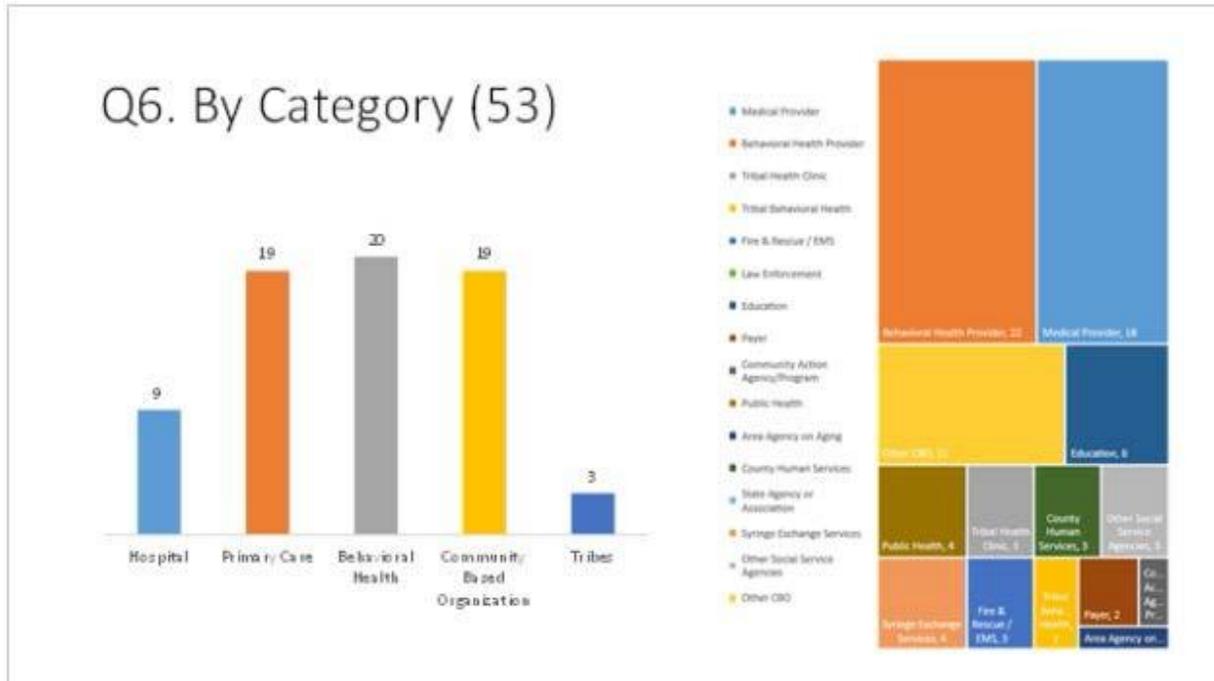
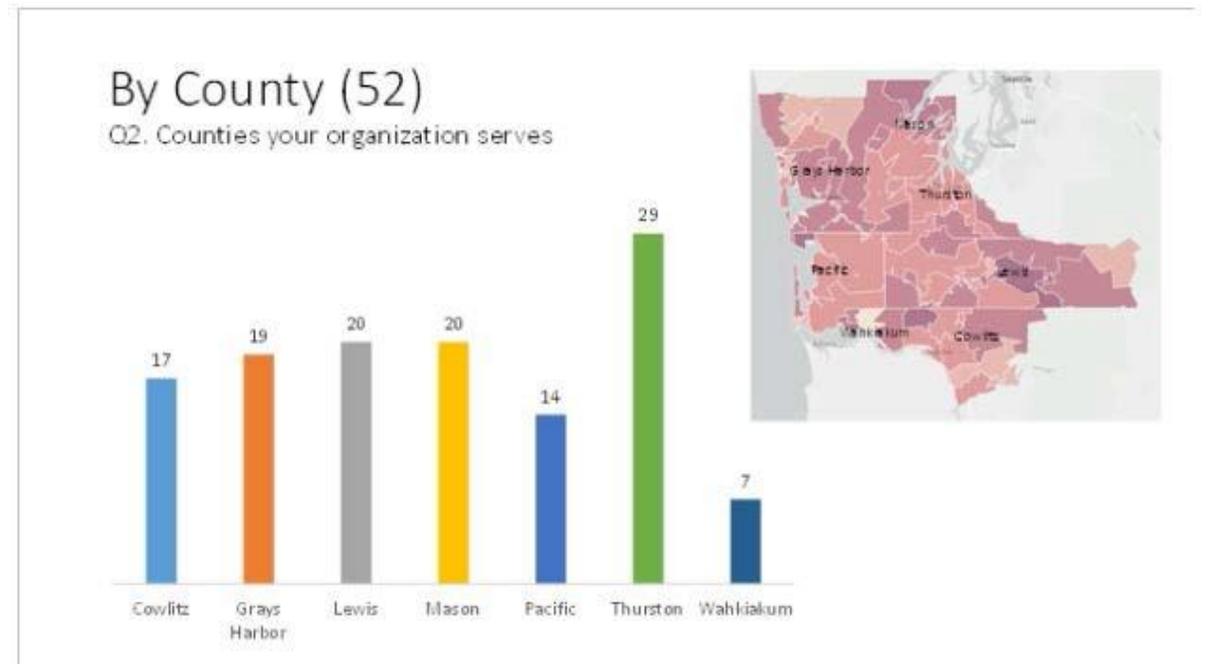


Table 3: Current State Capacity Assessment by Region

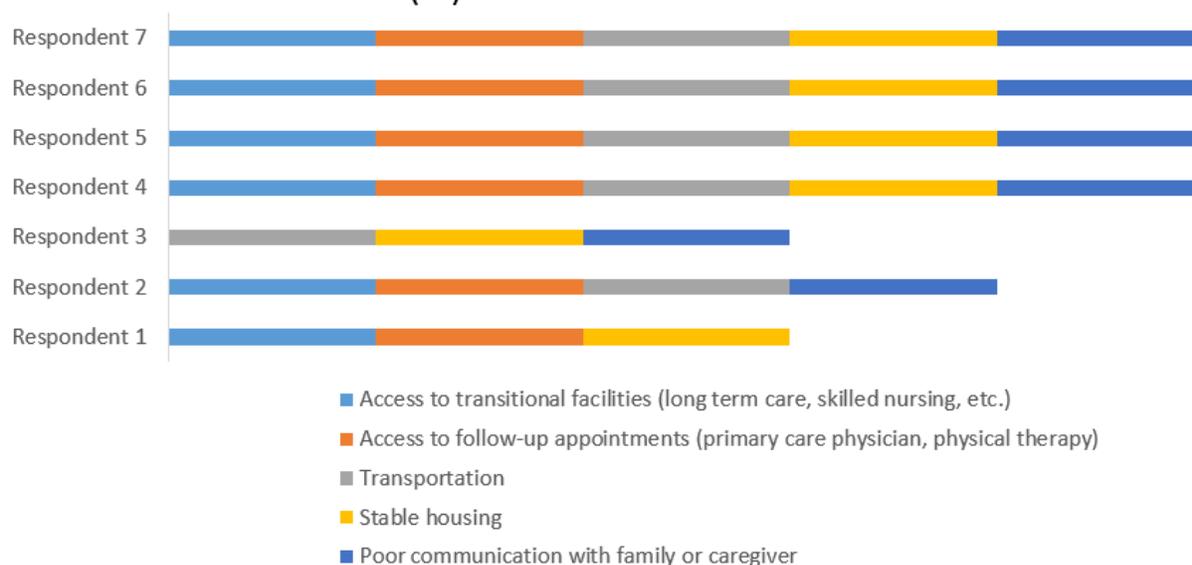


Key findings, which will be discussed in greater detail throughout the Current State Capacity Assessment section of this semi-annual report, include confirmation that our partners are committed to all six project areas selected by CPAA, an understanding of which target populations are already a priority for our partners, awareness of the importance of foundational community supports to improve health outcomes across the region, identification of barriers to access such as workforce shortages and a lack of communication between providers, and gaps in services, particularly housing and transportation.

CPAA was able to identify potential gaps in available services by analyzing the results of the Current State Capacity Assessment. One example of a critical gap identified relates to Project 2C: Care Transitions. The primary barriers to transitional care are access to transitional facilities and access to follow-up appointments (Table 4). CPAA recognizes increasing capacity is a slow process with many barriers. One mitigation strategy is to increase the number of care managers by training and employing Community Health Workers; patients can be closely monitored to reduce risk while increasing patient health and satisfaction. CPAA will continue to work with providers to redefine care team roles and expand the scope of practice for existing resources.

Table 4: Transitional Barriers to Care

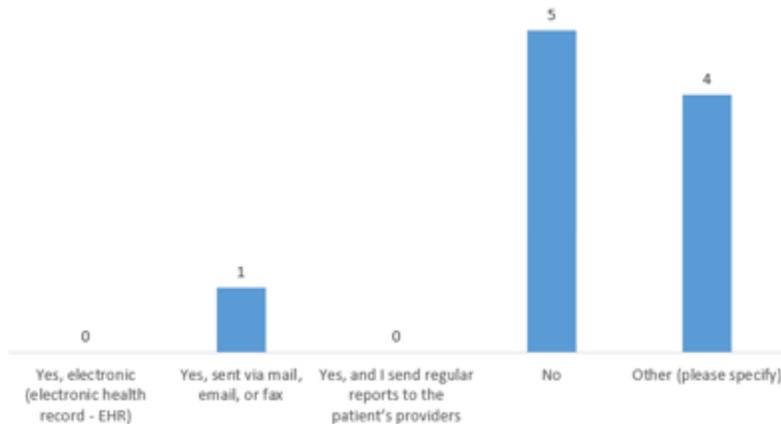
Q102. What barriers do you face when coordinating transitional care? (7)



Lack of regular and deliberate communication between community-based organizations (CBOs) and clinical providers was also identified as a critical gap in all six project areas. The majority of CBOs that responded to the assessment reported they do not regularly communicate with medical providers (Table 5). As a mitigation strategy, CPAA continues to convene both CBOs and clinical providers during monthly council meeting and work group meetings. CPAA will continue to research the possibility of shared care plans between CBOs and clinical providers and how information critical to patients' health may be shared.

Table 5: Community-Based Organization Care Plans

Q145. Do you have access to patient’s treatment or care plans? (10)



Additionally, CPPA recognized the assessment was an opportunity to collect organizational information needed to register providers in the Financial Executor Portal. Providers completing the assessment were asked to provide organization legal name, EIN, and other information required for registry with the portal. CPAA dedicated five percent, or \$176,384, of DY1 funding for organizations that completed the Care Coordination Environmental Scan and/or Current State Capacity Assessment. Based on the total number of respondents to both surveys, each organization received \$3,753. In May 2018, the CPAA Board approved the first round of Transformation payments, and CPAA began payment disbursement to providers registered in the portal.

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

ACH Response:

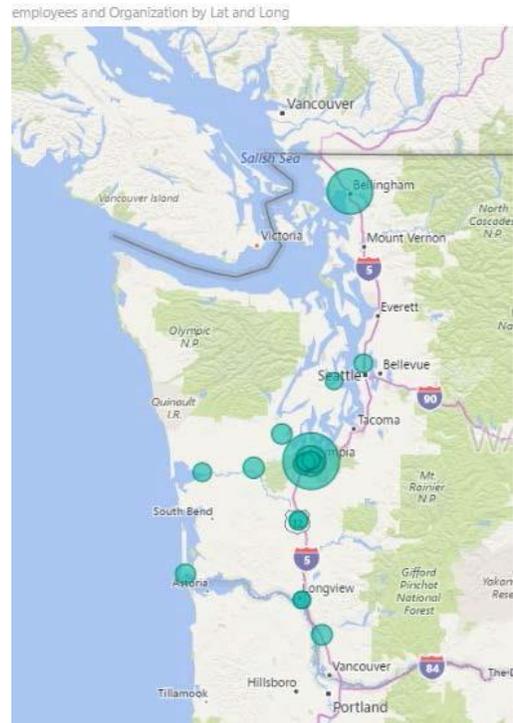
The Care Coordination Environmental Scan (Table 6) resulted in 22 unduplicated responses and 10 agencies completing follow-up interviews. The Pathways Program Manager analyzed the survey responses to better understand the current workforce in care coordination, current practices around care coordination to identify which target populations agencies are already working with, and to map readiness to implement the Pathways model in the region (Appendix D). Survey respondents who indicated interest in becoming a Care Coordinating Agency (CCA) received a follow-up interview to understand in greater detail the organization’s potential alignment with CPAA’s MTP goals and, more specifically, to assess their potential to become a CCA for Pathways.

These summary findings were reported back to the Care Coordination Work Group, and they will continue to inform Care Coordination implementation planning. Also, the environmental scan data will be utilized during review of responses to CPAA’s Request for Proposals (RFPs) to help select up to six initial Care Coordinating Agencies (CCAs).

Table 6: Care Coordination Environmental Scan

Total respondents: 25

- 22 unduplicated organizations
- 31 questions (84 different tabulations)

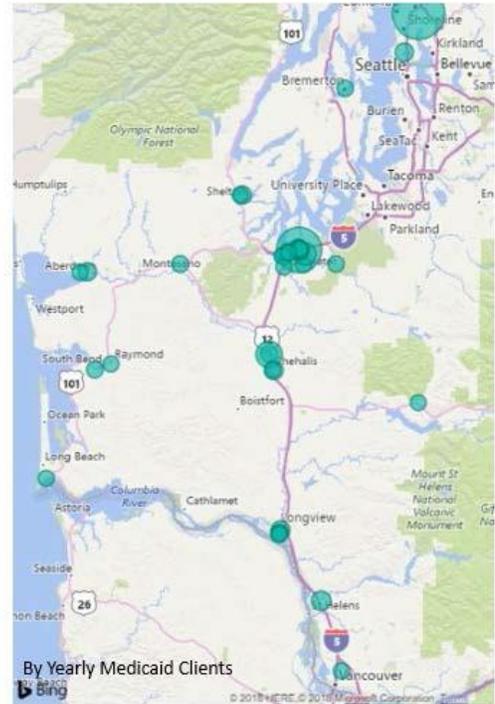


CPAA’s Current State Capacity Assessment resulted in 54 unduplicated responses from a variety of organizations across all seven counties (Table 7). CPAA’s data analyst, working with CORE, provided survey outcomes to CPAA directors and project managers (Appendix E). Specific to each program area, the program managers and work groups reviewed the aggregated assessment results, focusing on current services, opportunities for alignment, and gaps in services. The assessment results determined which target populations are already being served, which helped identify which populations should be prioritized. The assessment also identified what different organizations saw as barriers to implementing evidence-based approaches and value-based payment, which can now be systematically addressed. Assessment results were also used for targeted follow-up interviews with potential partners, using a one-on-one format to explore more deeply opportunities for alignment.

Table 7: CPAA Current State Capacity Assessment

Total respondents: 54

- 54 unduplicated organizations
- 81 duplicated respondents
- 167 questions
(678 different tabulations)



Analyzed assessment results confirmed CPAA will have partners committed to working in all six project areas selected by CPAA (Table 8). In the assessment, CPAA asked about current practices, which evidence-based approaches providers are willing to implement, and what resources they will need to be successful. Table 9 gives a high-level view of interest in each project area. Programs managers were able to look at aggregated assessment results to ensure optimal support for specific strategies and interventions across their respective programs. Although all providers will not participate in every project, CPAA was able to determine that there is sufficient interest and capacity to implement all six projects and the evidence-based strategies outlined in CPAA’s Project Plan.

Table 8: Project Area Participation

Q164. By Project Area (50)

Which project areas are you interested in participating in?

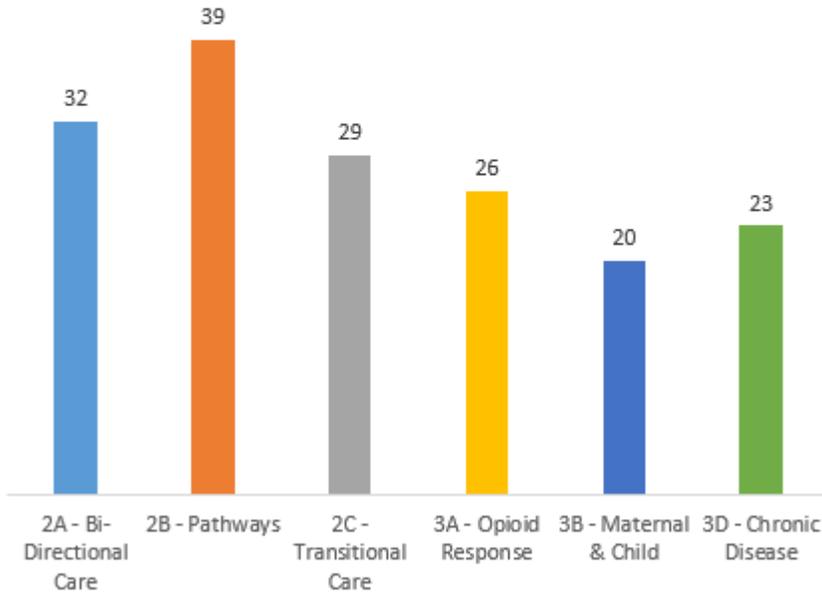
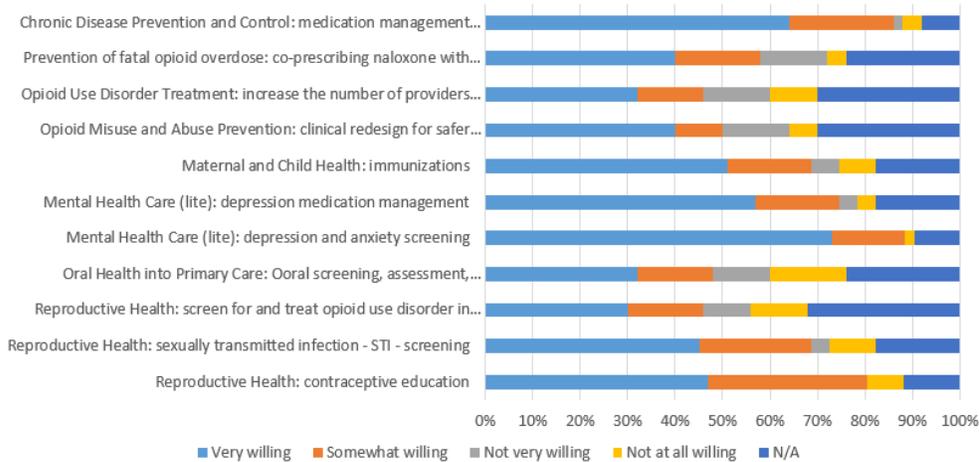


Table 9: Willingness to Perform Transformation Activities

Q154. Willingness to perform (52)



Additionally, the assessment was used to develop CPAA’s Request for Proposals (RFP), which was released via email and posted on the CPAA website May 30, 2018 (Appendix F). Formal instructions, including an off-line version for potential partners to compile before submitting on the form, were also made available (Appendix G). Gaps and barriers identified in the assessment were used to develop the weighted scoring methodology for assessing responses to the RFP; organizations working to overcome the identified gaps and barriers (i.e. transportation, housing) are crucial to successful MTP implementation, and capturing those specific services in the RFP scoring matrix was critical. The assessment question, "Which project areas you are interested in participating in?" helped determine the baseline of the integrated project portfolio and revealed that the majority of providers anticipate participating in at least three project areas (Table 10). In scoring the responses to the RFP to select implementation partners, CPAA determined organizations would receive full points for participation in a minimum of three projects areas, with bonus points for those participating in more than three project areas. Question #163 of the assessment asked, "Do you anticipate submitting a response to CPAA's Request for Proposals?" 72% of respondents said yes, and 26% were unsure. Based on the assessment, CPAA anticipates at least 50 RFP submissions from medical, behavioral health, social services, and community-based organizations (Table 11).

Table 10: Projected Project Areas

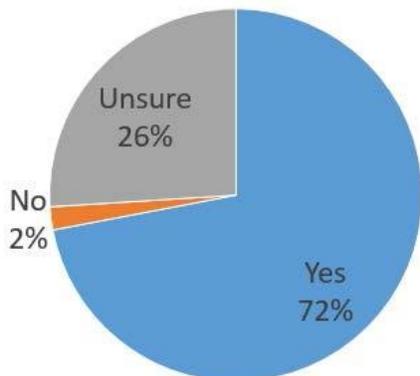
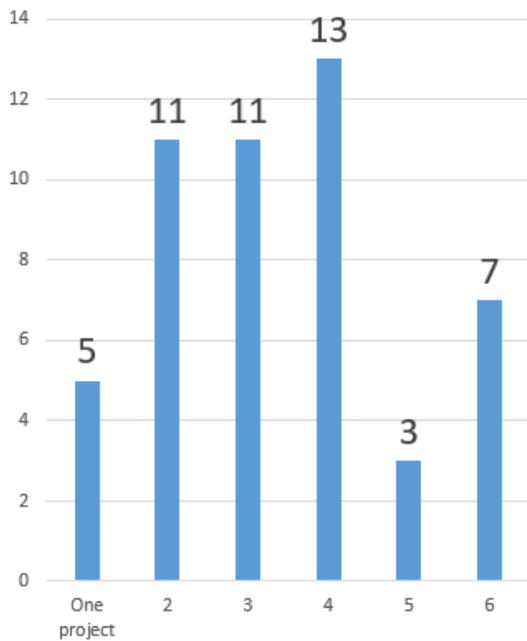


Table 11: Assessment Respondent's Submitting RFP

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

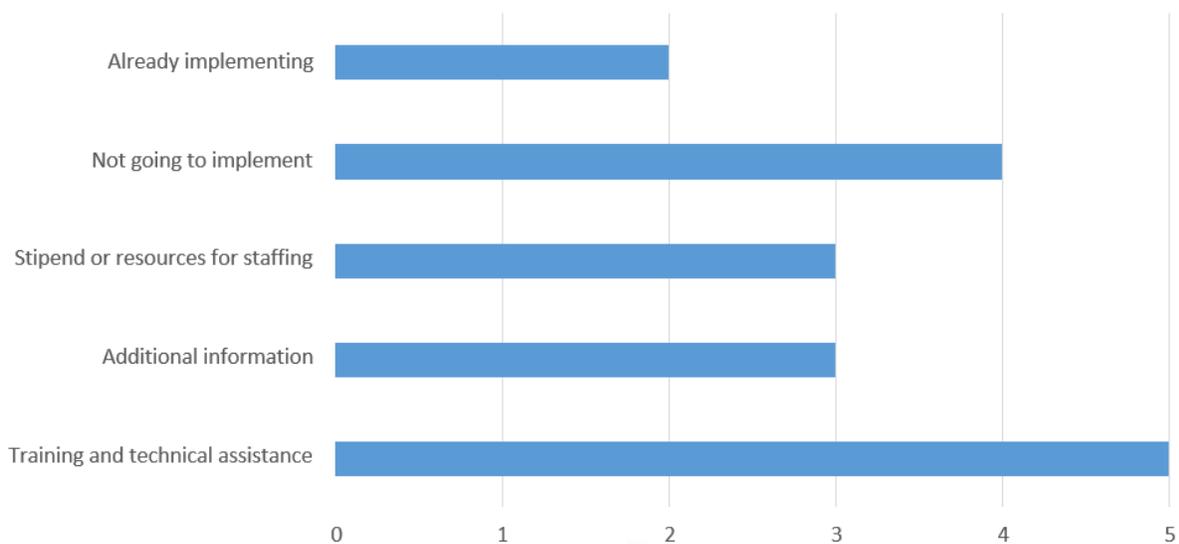
ACH Response:

One of CPAA priorities is improving linkages between community-based organizations (CBOs) and clinical organizations. CPAA continues to advocate for CBOs to be involved with the MTP. We recognize that health is more than health care, and improving health starts outside the clinic walls and is critical to an innovative transformation. CPAA dedicated several areas in the assessment to CBOs and social services organizations including community paramedicine, syringe exchange, and public health departments.

Home visiting programs are existing community assets identified by CPAA that directly support health equity. There are multiple home visiting programs in our region including Nurse Family Partnership, Parents as Teachers, and Family Spirit. CPAA will continue to provide support for home visiting programs without duplicating services by providing technical assistance and resources as requested (Table 12).

Table 12: Home Visiting, Nurse Family Partnership

Q133. What kind of support is needed to enhance Nurse Family Partnership? (10)



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

ACH Response:

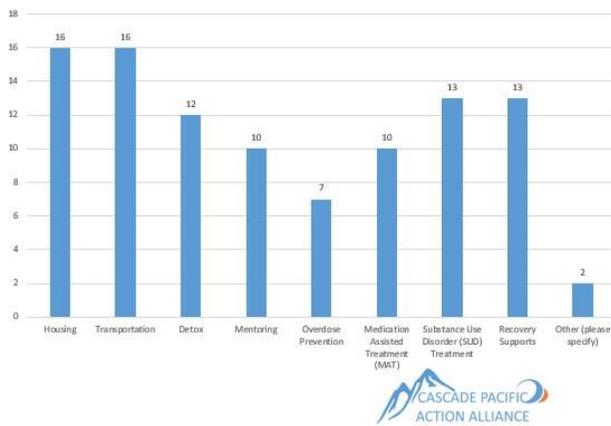
CPAA and potential partnering providers are keenly aware that health is much more than medical health care, and improving overall health in our region will depend on addressing health equity and the social determinants of health that drive adverse health outcomes to a large extent. CPAA’s Current State Capacity Assessment addressed partnering providers’ knowledge of social determinants of health by asking them to identify barriers and resources needed to improve their patients’ health outcomes and increase health equity. Data was collected in each care setting by asking respondents to not only identify the patients’ greatest need/s, but also what barriers the provider routinely assesses for. (Table 13 – Table 16). The fact that many of our partners already routinely assess for these needs, barriers, and services demonstrates that they are very aware of the importance of foundational community supports and better communication and care coordination between providers, CBOs, and social service organizations. Nevertheless, going forward, CPAA intends to regionally scale up both assessing for social support needs and linkages and referrals to the CBOs and social service organizations that address social determinants of health; the availability of viable solutions and community-based supports will encourage more clinical providers to assess for social support needs in their most vulnerable patients.

Most recently, the CPAA’s Clinical Provider Advisory Committee had a detailed discussion about the use of screening tools to assess social determinants of health in provider settings. During the discussion, a number of screening tools were identified that providers in the region either use already or that are generally available. The committee agreed to catalog these tools and make the tools available to implementation partners. While CPAA will not require the use of a particular assessment tool, all partnering providers will be expected to use an assessment tool of their choosing going forward. The committee plans to review the different tools and identify a few key questions that all providers should include in their social determinants of health screening based on available community resources to which providers can refer their clients and patients.

In the Current State Assessment, a common theme emerged across care settings: access to housing and transportation are the biggest barriers to care, confirming what CPAA had already learned from its Consumer Advisory Committee and other community engagements. CPAA will use this data to target CBOs that provide housing and transportation services in the region for participation in the MTP.

Table 13: Primary Care Response to Social Determinants of Health

Q44. Related to social determinants of health, which of the following services do your patients or clients need most? (Please check all that apply.) [2141]



Others: None Apply to Us, Medicaid patients with substance use disorder can have a wide range of needs. Some are highly functional and could use help primarily with vocational skills and job availability. At the other end are a few patients without a steady place of residence. Many have transportation problems due to cars breaking down and living away from bus lines. Most of our Medicaid patients do not have substance use disorder but could use all kinds of help - home nursing, diabetes education, nutrition education and mentoring, etc.

Table 14: Primary Care Responses Addressing Social Determinants of Health

Q54. Does your practice routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors? (19)

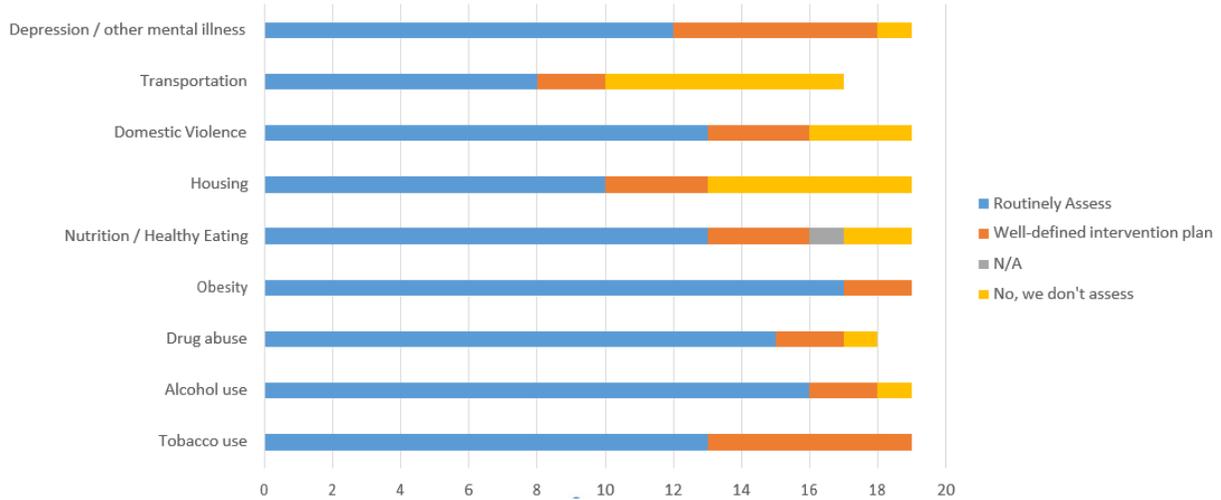


Table 15: Behavioral Health Responses Addressing Social Determinants of Health

Q86. Related to social determinants of health, which of the following services do your patients or clients need most? (25)

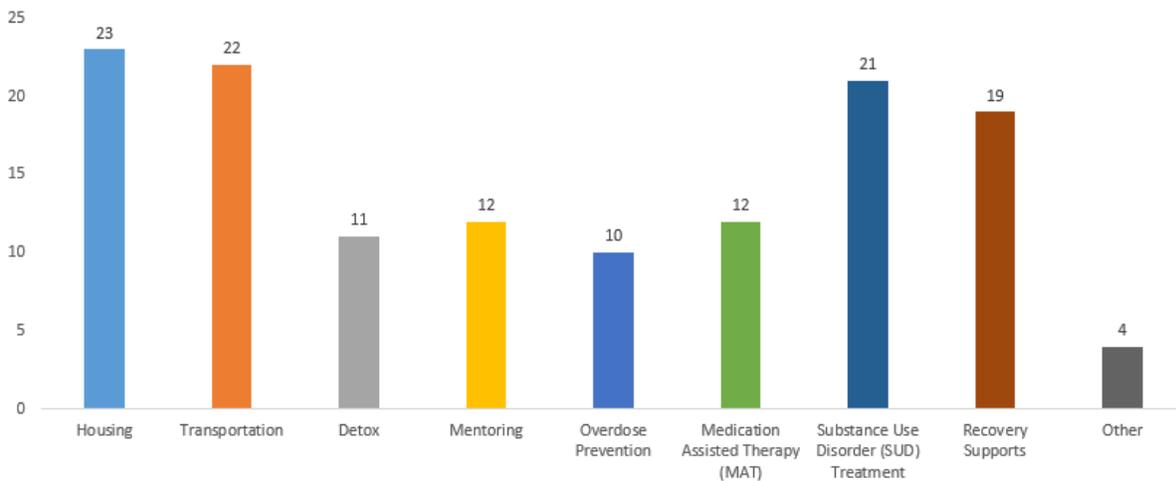
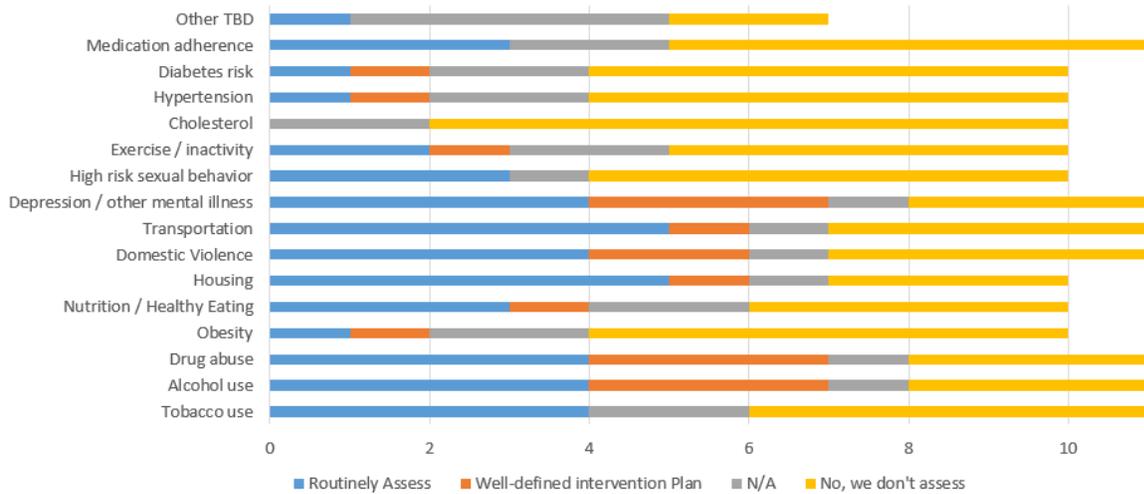


Table 16: Community-Based Organizations Responses Addressing Social Determinants of Health

Q141. Does your organization routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors? (11)



The Care Coordination Environmental Scan uncovered a gap in the workforce of employees with the same lived experiences as the clients they serve, such as Community Health Workers or Peer Counselors. This gap represents an opportunity for the Care Coordination project to address equity. In addition to improving the health of patients participating in the Pathways program, implementing the Pathways model in the CPAA region will create new job opportunities for individuals living in poverty and experiencing health disparities.

CPAA will continue to meet monthly with the Consumer Advisory Committee, which includes Medicaid beneficiaries, to receive feedback about health equity and social determinants of health directly from Medicaid beneficiaries receiving services in the region. Furthermore, CPAA is committed to continue convening community-based and social services organizations with clinical providers to increase awareness of health disparities among partnering providers, improve communication, and address barriers to care. CPAA recognizes that without linkages between different provider types, improved health equity and whole-person care are unlikely to be achieved.

Additionally, CPAA incentivizes improvements in health equity through partner engagement, providing additional resources to those organizations that potentially have the greatest impact on improving health equity in the region. CPAA allocated nine percent of DY1 provider engagement funding, or \$352,786, for a health equity bonus pool and seven percent, or \$246,938, for a rural bonus pool. Zip code data provided by selected partners in the RFP will be used to determine overall bonus payments for those organizations that qualify.

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

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

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

Yes	No
X	

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

ACH Response:

Not Applicable

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

ACH Response:

During this reporting period, CPAA has begun to identify Domain 1 strategies to support the six selected project areas. CPAA explored partner needs pertaining to Domain 1 focus areas through cross-sector stakeholder engagement. Domain 1 needs were discussed in multiple settings including work groups, council meetings, and advisory committees.

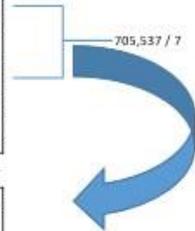
CPAA’s Year 1 (YR1) Funds Flow Model was developed over several months by the Finance Committee, with technical assistance provided from Health Management Association (HMA) and input from council members and stakeholders. The YR1 funds flow was initially approved by the CPAA Board on May 10, 2018, and modified on May 30, 2018, to provide a multi-project incentive funding pool (Table 17). CPAA is dedicating 28 percent of YR1 funding, or \$3,285,272, to Domain 1 investments in the region.

Table 17: Approved YR1 Funds Flow

First-Year Funds Flow: APPROVED – May 30, 2018

Use Category	Action	%	\$
Project Management/Administration	Hold	10%	1,175,894
Reserve/Contingency	Hold	5%	587,947
Regional Wellness Fund	Hold	8%	940,715
Capacity Development Fund	Disburse	3%	335,179
Sub-Total		26%	3,039,736
Health Systems & Comm. Cap. Bldg (D1)	Invest Centrally	28%	3,285,272
Health Systems & Comm. Cap. Bldg (Tribes)	Disburse	3%	352,768
Sub-Total		31%	3,638,040
Provider Engagement	Disburse	32%	3,787,683
Provider Engagement (Tribes)	Disburse	3%	352,768
Provider Performance (Implementation Plan)	Disburse	8%	940,715
Sub-Total		43%	5,081,166
Grand Total		100%	11,758,942

NON-TRIBAL PROVIDER ENGAGEMENT			\$
A. Basic Engagement		93%	3,787,683
A. Basic Engagement			3,518,530
<i>Base Payments</i>			
Assessment Survey	Pre RFP	5%	176,384
Standard Agreement	Post RFP	5%	176,384
Project Participation	Post RFP	33%	\$1,234,689
<i>Bonus Payments</i>			
Attribution (Medicaid Lives Served)	Post RFP	17%	\$634,983
Equity	Post RFP	9%	\$352,768
Rural	Post RFP	7%	\$246,938
Multi-Project (4+ Projects)	Post RFP	14%	\$520,000
Local Community Forums	Post RFP	5%	176,384
B. Centers For Transformation	Hold	7%	\$269,152

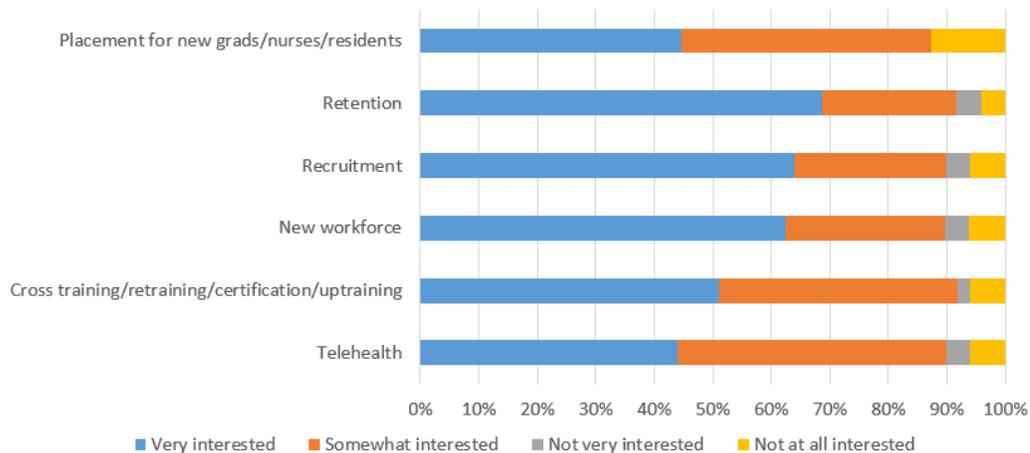


Workforce Investments

Domain 1 needs were further refined during the current state assessment. Table 18 demonstrates our regional partners' interest in Domain 1 workforce investments. Access to services continues to be a major barrier to regional health improvement, and workforce continues to be a priority throughout the region to expand capacity. CCAA is planning to invest some of the first-year Domain 1 funding later this year to support expanding our partnering provider's workforce needs.

Table 18: Domain 1 Workforce Needs

Q155. How interested is your organization in the following investment opportunities



In the assessment, providers identified funding and additional staff as their top two Domain 1 priorities needed for successful implementation of integrated care in Project 2A: Bi-Directional Integration of Care (Table 19). Each provider has specific needs, and Domain 1 requirements will be evaluated on an individual basis. After MTP implementation partners are formally identified through the RFP process in August 2018, CPAA will assess individual organizational needs and determine where to make targeted Domain 1 investments that meet both the individual organizations' needs and those of the larger region.

Table 19: Organizational Needs to Implement Project 2A: Bi-Directional Care Integration

Q12. What does your organization need most to implement an integrated care program? (29)

Some responses:

- Access to mental health resources, Social workers, community care providers who are willing to treat patients in an outpatient setting
- Current funding doesn't typically pay for planning and collaboration time, so some resources to
- Startup funds for placing a behavioral health therapist in a primary care clinic (or clinics), that we could then help to train and support. Startup funds are necessary to be able to reach a point a year or so down the line when billing can support the role.
- Extra funding and appropriate staff
- funding for FTE, education/training and clinic level buy-in
- Infusion of dollars from CPAA to do primary care services onsite from hired WBH staff (RN, NP/FNP-BC, CMA) to perform psychiatrically sensitive primary care onsite in our Long Beach and Raymond locations.
- Funding streams, Minimize bureaucracy, challenges around funding streams, partnership limitations with BHO
- health care exchange, rule and regulatory changes regarding primary care
- Funding, Protocols
- More therapists interested in the primary care behavioral health integration model Financial support
- Increase budget
- FHC is fully integrated
- Staffing resources, community resources, funding

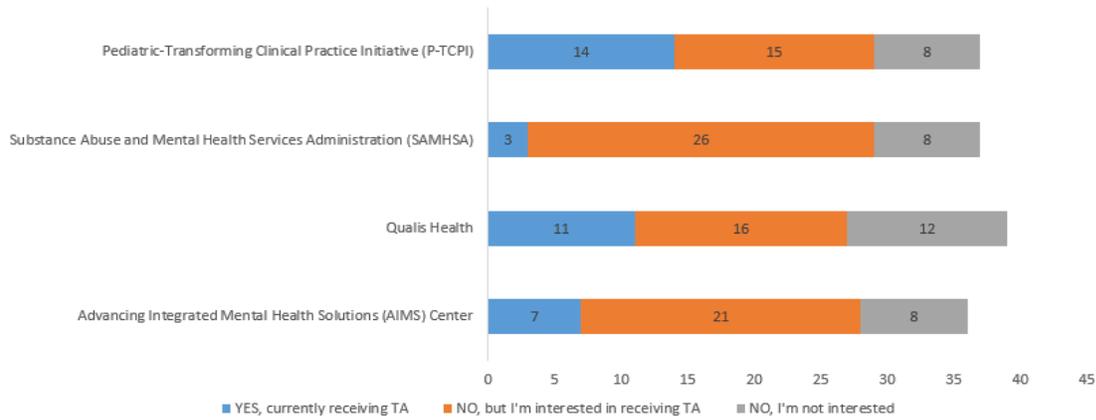


Technical Assistance and Training

One question in the current state assessment highlighted the current utilization and future need of technical assistance (TA) by a variety of vendors (Table 20). In response to the data collected, CPAA finalized a contract with the AIMS Center to offer their Bi-Directional Care Integration training program to partners in the region. We expect the first cohort will begin the training this fall. In preparation for this training program, CPAA co-hosted two informational sessions with the AIMS Center for partners to learn about the training program and submit input into the program's design. Additionally, a summer webinar series on key topics in whole person care has been scheduled for July and August. We are coordinating activities and TA with our colleagues at Qualis Health and the Pediatric Transforming Clinical Practice Initiative to ensure partners are receiving clinic-based TA. We are also in discussions with both organizations to understand how investments in their TA services could further support our implementation partners throughout the MTP.

Table 20: Partner Technical Assistance Overview

Q16. Are you currently receiving technical assistance to implement integrated care from any of the following? (40)



HIT/HIE and Data Analytics

Early development of our Care Coordination project identified specific Domain I needs for successful implementation of this project. The Pathways model of Care Coordination utilizes community health workers (CHW) and similarly skilled employees. The limited CHW workforce in the region indicates a need for CPAA to provide training and other workforce supports in addition to creating new job opportunities through implementation of the Pathways model. The ability to share care plans through Health Information Technology (HIT) is another key component for success of the Pathways model that CPAA must expand through Domain I investments.

CPAA has worked throughout this reporting period to identify suitable Domain 1 resources and acquire them. Initially, we contracted for TA from experts in the Pathways model to help us understand the requirements within the model for workforce supports and HIT. One of our TA partners, Foundation for Healthy Generations, is currently in the process of becoming a certified master trainer in a curriculum specifically designed for the Pathways model. CPAA plans to utilize this resource to provide training, free of charge, to the Care Coordination Agencies partnering with us to implement the Pathways model.

Part of the HIT functionality desired in our region includes the ability to better share client information across providers and to improve the coordination of referrals for services outside of the Pathways program. After careful consideration of several software platforms that would support the Pathways project, CPAA elected to contract with Care Coordination Systems (CCS) for their software designed for Pathways. The CCS platform was purchased in May 2018 for both implementation of the Pathways model and for its capability to add additional HIT functionality desired by our broad set of partners.

Part of CPAA's strategy for Domain 1 investments related to Pathways has been to explore potential partnerships with other ACHs that are implementing this program. CPAA helped to convene initial cross-ACH conference calls on this topic and remains an active participant in these discussions. Albeit still in early development, cross-ACH collaboration has directly resulted in building common ground among ACHs working with Pathways by identifying shared investment strategies. We do anticipate the individual contracts ACHs have or are entering into with CCS will be transitioned into a shared services

agreement during the MTP period, creating economies of scale and savings for our ACH and other participating ACHs around the state.

CPAA also continues to contract with CORE to provide TA and data support during this planning period. CORE recently applied for and was approved as the recipient of one of a few no-cost licenses on behalf of several ACHs, including CPAA, for the new Washington State All-Payer Claims Database (APCD) Analytic Enclave. As the data use cases and data products from the APCD Enclave are developed over coming months, CPAA will continue to look for opportunities to inform Domain 1 strategies, particularly related to understanding the transition to value-based payment (VBP) occurring across the region. CPAA will combine learnings from the APCD data products provided by CORE with information provided in the state’s VBP survey and its own assessment to better understand provider barriers and needs related to VBP.

Table 21: Domain 1 TA and Data Support Timeline

Timeline	Key Activities
May 18	CORE will work to develop a plan for amending contracts with ACHs to reflect appropriate APCD-related data use and security provisions, and understand what agreements are needed between both CORE and the APCD, as well as between CORE and the ACH.
Jun 18	CORE will work with the APCD lead organization to have a Data Use Agreement in place by June
Jul 18	CORE will attend Enclave orientation, begin review of data, and build analytic infrastructure.
Aug-Sep 18	CORE will continue to review data, build analytic infrastructure, develop processes for ACH ad hoc requests, and design data products.
Oct-Dec 18	CORE will generate initial data products (“preliminary reporting”) and vet initial products with ACHs and partners (as applicable).
Jan 19 - Forward	CORE will produce regular reports, as well as provide ad hoc analytic support for ACHs.

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

ACH Response:

No changes have been made to the overarching Domain 1 strategies outlined in CPAA’s Project Plan. Partnering providers will be selected through the RFP process in August 2018. At that time, CPAA will refine the Domain 1 strategy based on the needs of individual providers to ensure their success in the

Transformation. Table 22 demonstrates potential Domain 1 strategies and their direct relationship to projects.

Table 22: Domain 1 Development Ideas

CPAA Domain I Development Ideas

Topic	Development Ideas	Cross-project examples	Project specific elements
Data & Analytics	<ul style="list-style-type: none"> ➤ Purchase/develop software platform(s) that increase interoperability between organizations and sectors ➤ Partner with Public Health to develop "chief health strategist" capability and workflows ➤ Partner with Providence CORE to increase research and evaluation capabilities ➤ Develop or customize data dashboards that integrate multiple data sets 	<ul style="list-style-type: none"> • Patient risk stratification • Coordination of services • EMR linkage to other systems • Population health surveillance • Data analysis • Evaluation & research 	<ul style="list-style-type: none"> • Patient registries which includes measures to track specific conditions and SDOH • Pathways software • EDIE & Pre-manage • HMIS • One Health Port • Population Health data • Claims data • Evaluation of projects • ROI calculation
Learning Communities	<ul style="list-style-type: none"> ➤ Develop specific training and/or coaching that CPAA staff will offer ➤ Contract with trainers to make various trainings available to partners ➤ Develop an online learning portal ➤ Develop specific communities of practice that support partners learning from each other 	<ul style="list-style-type: none"> • Clinical practice transformation • Trauma informed • Cross-sector integration • Skill building (training & coaching) 	<ul style="list-style-type: none"> • Specific models (e.g. coleman, chronic care, etc.) • Grouping of partners (e.g. geographic, provider type, population served, etc.)
Planning & Policy	<ul style="list-style-type: none"> ➤ Make the RHIP a living document that partners integrate into own planning processes ➤ Identify regional needs, barriers, or gaps that require legislative advocacy ➤ Support the planning work initiated by multiple partners working as a collaborative ➤ Provide data & analysis products to inform the planning of others 	<ul style="list-style-type: none"> • RHIP • Gap analysis • Change management • Legislative agenda • Regional policy agenda 	<ul style="list-style-type: none"> • Project implementation • Program policies & procedures
Administrative Services	<ul style="list-style-type: none"> ➤ Create a suite of back-office support services that increases the ability of smaller organizations and non-traditional Medicaid partners to participate in MTD 	<ul style="list-style-type: none"> • ACH Staffing • Contracting • Back-office support 	<ul style="list-style-type: none"> • Project management • Braided funding • Shared services

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

ACH Response:

CPAA worked in collaboration with some of the other ACHs on a combined table of additional supports and resources needed from Washington State and other state agencies for the MTP (Appendix H).

CPAA is keenly aware of the need for interoperability between electronic health records (EHRs), not only within our region but across the state, to successfully implement the MTP project areas. However, ACHs do not have the expertise or funding needed to bring about this statewide change. ACHs, in collaboration with Health Care Authority, are working to identify potential funding sources that could be used for the 10% state match under HITECH and MMIS funding.

HCA and ACHs, in collaboration with stakeholders and partners including the Washington State Association of Public Hospital Districts, the Washington Hospital Association, and Systems for Population Health Management will identify topics for an on-going Educational/TA series on HIT/HIE. HCA currently hosts a monthly Health IT Operational Plan meeting to develop and expand health information

technology and health information sharing. During this monthly meeting, CPAA is able to share concerns and ask for additional assistance with Domain 1 resources related to HIT/HIE.

Additionally, workforce shortages continue to be a concern for CPAA. Multiple organizations have current openings they are unable to fill due to a lack of qualified applicants. CPAA anticipates this problem will not only persist but continue to grow as all nine ACHs across the state seek to expand the often specialized workforce necessary to implement MTP programs. Regional workforce shortages are compounded by the fact that Medicaid traditionally reimburses at a lower rate than commercial health plans or Medicare. Because of this, fewer providers, in a region already suffering from provider shortages, are accepting Medicaid patients compared to commercial plans. Being on Medicaid is, in itself, a barrier to care and a health equity concern. Providers are uncertain on how to best engage this population while moving forward with value-based care, knowing Medicaid beneficiaries are most vulnerable, have some of the worst health outcomes, and will be difficult to engage in preventative care. Advocating for increased Medicaid reimbursement rates and providing adequate financial incentives for quality of care, not quantity, is key to supporting sustainability of the MTP.

One solution to regional workforce shortages and the resulting lack of access to care is support at the state level for expanding the scope of practice for current providers and allowing for reimbursement on additional codes. This would allow providers to increase capacity immediately, without relying on additional hires, which may not be available. For example, approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings. In addition, it would be helpful to streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, dental health aide therapists, community health workers, Peers, and behavioral health care coordination, to lessen the costs of hiring. Support at the state level for stronger recruitment and tuition support would also help address the workforce shortages.

CPAA continues to look to Health Care Authority for guidance on the ACHs' role in moving towards whole-person care and value-based payment, especially regarding guidance for rural health providers. CPAA has sought guidance from providers, BHOs, MCOs, and HCA on how we can best support this transition. CPAA can act as a convener to enhance the collaboration of cross-sector agencies to reach the region's VBP goals. As an ACH, CPAA would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.

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

For this milestone, the ACH should either:

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

Or,

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

1. Medicaid Transformation Approaches and Strategies

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

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

- a. A description of the ACH’s evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals, and requirements.
- b. A list of transformation activities ACH partnering providers will implement in support of project objectives. Transformation activities may include entire evidence-based approaches or promising practices, sub-components of evidence-based approaches or promising practices, or other activities and/or approaches derived from the goals and requirements of a project area.
- c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area, and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

2. Target Populations

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

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

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

under the project are expected to reach which identified target populations.

3. Expansion or Scaling of Transformation Strategies and Approaches

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

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Project 2A: Bi-directional Integration of Physical and Behavioral Health

1. Transformation Strategies and Approaches

CPAA selected the Collaborative Care Model (CoCM) and Bree Collaborative Behavioral Health Integration Recommendations as the two evidence-based approaches for behavioral health integration. Due to similarities between both approaches, we are stressing the importance of implementing core principles of collaborative care rather than solely adhering to one model. The Milbank Report, titled "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness," is being used as guidance, along with the core principles of collaborative care, to integrate primary care into behavioral health settings. Each organization is starting from a different readiness level with varying capacities to develop or improve an integrated care program. CPAA understands a degree of flexibility must be built into implementation planning. Following the core principles of collaborative care will allow CPAA and partners to achieve whole person care, strengthen meaningful partnerships between primary care and behavioral health, and ensure our most vulnerable populations have access to primary care and behavioral health services.

The following list does not encompass the full range of transformation activities that partners will implement but rather lists example activities under each of the core principles of collaborative care. Please note that final MTP activities are dependent on the selection of partnering providers and will be specified in CPAA's Implementation Plan submitted to the Health Care Authority by October 1, 2018.

- Patient-centered team care
 - Establish integrated care teams and/or enhanced collaboration between primary care and behavioral health.
 - Establish effective information and data sharing between primary care and behavioral health.
 - Clinics provide access to psychiatric services either through direct in-person and/or virtual care or via case consultation to primary care physicians.
 - Each team member has clearly defined roles and responsibilities.
 - Patient's goals are incorporated into a shared treatment plan.
 - Develop an effective system for communication and care coordination for the care team.
- Population-based care
 - A structured workflow is in place to identify patients needing integrated care services.
 - A defined patient population is tracked in a registry.
 - Develop workflows to review registry and undertake active follow-up based on valid outcome measures.
- Measurement-based treatment to target

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<ul style="list-style-type: none"> ○ Use patient registry to follow patients’ treatment targets, clinical outcomes, and dates of contact. ○ Change and adjust treatments if treatment targets are not met. ○ Systematically implement behavioral or physical health symptom rating scales to determine whether patients are improving. • Evidence-based care <ul style="list-style-type: none"> ○ Provide evidence-based counseling and psychotherapy in the primary care setting. Provide routine preventative care and track physical health measures such as body mass index, HbA1C, and blood pressure in the behavioral health setting. ○ Evidence-based care is age-appropriate. • Accountable care <ul style="list-style-type: none"> ○ Develop a quality improvement process that includes reviewing clinical outcomes, quality of care, and patient satisfaction. ○ Administrative and clinical support are available to support integrated care team and program.
<p>2. Target Populations</p>	<p>Integrated care programs following the Bree Collaborative Standards and Collaborative Care Model will reach the target populations listed below. Due to variations of patient population needs at different organizations, partners will determine from this list which populations will be served. Please note that final MTP target populations will be dependent on the selection of partnering providers and will be specified in CPAA’s Implementation Plan submitted to the Health Care Authority by October 1, 2018.</p> <ul style="list-style-type: none"> • All Medicaid beneficiaries, both adults and children, particularly those with behavioral health conditions <ol style="list-style-type: none"> a. Patients w/ depression, anxiety, PTSD, and/or low mental health needs b. Patients w/ substance use disorder: alcohol use disorder, opioid use disorder, and/or tobacco use disorder c. Patients w/ bi-polar disease, schizophrenia, and/or other serious mental illness d. Co-occurring chronic illnesses: obesity, diabetes, cardiovascular disease, asthma e. Individuals who are homeless or unstably housed f. Individuals without an assigned primary care provider g. Young parents ages 18-24 h. Individuals with reoccurring, potentially avoidable, ED use

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

CPAA expects integrated care programs will take up to two years for some partners to fully implement. During implementation DSRIP years, CPAA is encouraging partnering providers to focus on collaborative care principles and best practices to create a customized integrated care program best suited to their clinics. In this way, organizations can take a graduated approach to improving or developing programs based on their specific capabilities and development needs. CPAA will provide technical support and act as a convener of resources to support the expansion of target populations and evidence-based practices to ensure that gaps in care are addressed.

Some partners will be able to move faster than others, resulting in expanding the scope of their programs more quickly. For example, an initial integrated care program may only be suitable for patients with a PHQ-9 score >10 seen in primary care, but may be expanded to include patients with anxiety and/or co-occurring chronic diseases. Expanding the number of co-occurring conditions increases the complexity of care and may result in a decreased number of patients seen.

One additional way partners may expand services is by hiring additional staff to increase the patient capacity for collaborative care. In behavioral health settings, expansion in later years will likely focus on increasing the number of physical health metrics tracked and/or hiring onsite primary care providers.

The workforces trained, workflows established, infrastructure built, financing mechanisms put into place, and overall synergies harnessed will serve as a catalyst for health care transformation that extends beyond Medicaid populations to benefit the CPAA region as a whole.

Project 2B: Care Coordination

1. Transformation Strategies and Approaches

The Pathways Community HUB model of care coordination is being implemented in the CPAA region to meet the Care Coordination MTP Toolkit goals and objectives. The HUB model establishes a whole system for care coordination that standardizes services and focuses on continuous quality improvement. The model uses a population health approach to identify specific populations with critical needs for care coordination support, and the model incorporates a robust Health Information Technology (HIT) element that generates data that is useful both for quality improvement and population health strategy development.

Partnering providers will participate in this project in multiple ways including:

- Care Coordinating Agencies (CCAs) partner with the Pathways Community HUB, administered by CHOICE Regional Health Network, to deliver care coordination services using the Pathways model.
- Providers refer clients to Pathways services, as well as delivering services, which help clients complete their

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<p>selected Pathways outcome goals.</p> <ul style="list-style-type: none"> Providers will work to link their own Health Information Technology with the Pathways HIT Platform, creating more accessibility of client data to inform care planning. <p>CPAA as a whole will utilize Pathways aggregated data to better understand the needs of clients in the region and where gaps in services or resources are creating barriers to reaching positive outcomes.</p>
<p>2. Target Populations</p>	<p>Care coordination produces value by increasing the engagement of patients in their own care and by reducing barriers that prevent people from accessing care. Because the Health Homes model of care coordination is already extensively implemented across the state and focuses on the highest-cost Medicaid clients, the CPAA region has focused on targeting individuals with rising risk. We also reviewed the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. The following definition was developed by the Care Coordination Work Group:</p> <p>Behavioral health issue, such as mental health condition or substance use disorder diagnosis, ... and a chronic disease or high risk pregnancy, ... and one or more risk factors set by the HUB (e.g. homeless, frequent EMS use, reside in high mortality census tract, etc.)</p>
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Initial implementation of the Pathways model will begin in 2018, with up to six initial CCAs serving up to 400 clients. The number of CCAs and their caseload capacity will be scaled rapidly with the goal of reaching 4,000 clients by the end of the MTP. Program data will be regularly evaluated during the MTP to monitor impact and to identify any need to make adjustments to the target population.</p>
<p>Project 2C: Transitional Care</p>	
<p>1. Transformation Strategies and Approaches</p>	<p>CPAA selected the Transitional Care Model, BRIDGE, and Care Interventions as the three evidence-based approaches for transitional care transformation. CPAA is encouraging partnering providers to adopt the subcomponents of these evidence-based approaches to create a customized MTP implementation plan for each partner organization (Change Plan). This strategy will leverage the existing skillsets and transformative practices, prevent duplication of efforts, and ensure a degree of flexibility is built into each provider's change plan.</p>

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

The following is a list of MTP activities partnering providers could participate in that were included in the RFP. Please note that final MTP activities will be dependent on the selection of partnering providers and will be specified in CPAA's Implementation Plan submitted to the Health Care Authority by October 1, 2018.

- Increase access to care
 - a. In a collaborative effort between hospitals, clinical providers, and community-based organizations, establish linkages to primary care providers/behavioral health providers who have open access scheduling or extended hours. This should include a process for connectivity and follow-up.
 - b. Utilize a patient navigator to assist patients presenting with avoidable ED utilization to make immediate appointments with a primary care provider with whom they can establish a care relationship. The navigator may also assist patients in accessing community-based resources.
 - c. In a collaborative effort with primary care physicians, emergency departments, non-emergency medical transport (NEMT), and first responders, an established workflow is in place for patients with requests for non-emergency services to be transported to receive services or home visits.
 - d. Development of a collocated primary care service in EDs with case management protocol for triage and referral.
 - e. Establish linkages to community-based services to provide information about how and where to access health services and the role of primary care/urgent care and ED services. This should include information about community resources available, including contact information.
 - f. Establish linkages between services that provide housing and non-emergency medical transport to ED services and maintain a fixed ratio of openings for ED referral.
 - g. Establish linkages between organizations that provide services that address social determinants of health (e.g. food insecurity and health literacy) to ED services and maintain a fixed ratio of openings for ED referral.
- Population-based care
 - a. Track patients in registry, which includes measures to track unstable housing and transportation. Use registry to follow patients' treatment targets, clinical outcomes, and dates of contact.
 - b. Develop workflow for providers to review registry and do active follow-up.
 - c. Develop a process for connectivity between the assigned PCP and the case manager as applicable. This should include real time notifications.
- Measures to decrease readmission
 - a. Utilize an evidence-based care transition intervention at time of admission (Transitional Care Model, BRIDGE, or Care Transition Interventions) with high-risk populations to prevent readmissions.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<ul style="list-style-type: none"> b. A Care Transition Model can also be utilized, which should include pre-discharge patient education, care record transition to the primary care provider, and one-on-one transitional support for a 30 day transition period, which includes establishing access to relevant community resources. c. Establish workflow that notifies and allows supportive housing to meet with patients at the hospital and assist with transition. • Accountable care <ul style="list-style-type: none"> a. Examine clinical outcomes, quality of care, patient satisfaction, and use of QI. b. Be responsible for quality of care by reporting on health metrics. c. Develop process for quality improvement based around a transitional care tool.
<p>2. Target Populations</p>	<p>The following is a list of proposed MTP target populations partnering providers could impact that were included in the RFP. We also reviewed the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. Please note that final MTP target populations will be dependent on the selection of partnering providers and will be specified in CPAA’s Implementation Plan submitted to the Health Care Authority by October 1, 2018.</p> <ul style="list-style-type: none"> • Medicaid beneficiaries who are admitted into the emergency department who are homeless or unstably housed • Medicaid beneficiaries who have used the ED in the last 12 months who do not have reliable transportation • Medicaid beneficiaries exiting in-patient psychiatric services • Medicaid beneficiaries who have used the ED in the last 12 months who have not seen their primary care physician in the last 12 months or do not have one assigned • Medicaid beneficiaries who have had 5 instances of an “avoidable ED visit” in the last 6 months • Medicaid beneficiaries who have 1 or more chronic illnesses and 4 or more ED visits in the last 6 months • Medicaid beneficiaries who are discharged from a short stay, acute care, or critical access hospital who have: 2 or more chronic illnesses, 1 or more chronic illnesses with SUD /MH or cognitive impairments, or have 6 or more medications prescribed
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>The Transitional Care strategies will support expansion and sustainability of health system transformation for the selected target population/s by adopting a multi-agency care team approach that is patient-centered and focuses on coordinating activities between different care providers around a shared care plan.</p> <p>CPAA expects transitional care transformation and evidence-based practice adoption will take several years for some partners to fully implement and will require initial investments in infrastructure. To establish the requisite infrastructure</p>

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

for expansion, CPAA aims to make targeted investments in (1) bi-directional communication pathways for our partnering providers to exchange relevant care information in a timely manner; (2) changes in partnering providers’ workflows, business practices, and staffing patterns to support team-based care; (3) the capacity to build strong working relationships among the multi-agency care team; and (4) payment mechanisms that support care coordination in DSRIP year two and three.

During implementation DSRIP years, CPAA is encouraging partnering providers to focus on individual transitional care principles and best practices to create a customized MTP implementation plan (Change Plan) specific to their organization. In this way, organizations can take a graduated approach to improving or developing programs based on their specific capabilities and development needs. Some partners will be able to move more quickly than others, resulting in expansion of the scope of MTP work more quickly. CPAA will provide technical support and act as a convener of resources to support the expansion of scale and target populations for evidence-based practices and ensure that gaps in care are addressed. For example, initially a small, rural hospital may only be able to implement the BRIDGE model with a single high-risk population, but they may be able to expand to include a workflow for triage and the establishment of a collocated primary care clinic to target several high-risk populations in later DSRIP years.

Expanding the scope of populations, number of partnerships, and geographic areas that evidence-based practices target will increase early intervention, decrease preventable adverse health outcomes, and, we expect, will significantly decrease avoidable emergency department utilization and hospital readmission over time. Furthermore, the workforce trained, workflows established, infrastructure built, financing mechanisms put into place, and overall synergies harnessed will serve as a catalyst for health care transformation that extends beyond Medicaid populations to benefit the CPAA region as a whole.

Project 3A: Addressing the Opioid Use Public Health Crisis

1. Transformation Strategies and Approaches

CPAA selected Harm Reduction, medication assisted treatment (MAT), trauma-informed care, and recovery supports as the evidence-based approaches for Opioid Response. CPAA is encouraging partnering providers to adopt the subcomponents of these evidence-based approaches to create a customized MTP plan for each organization (Change Plan). This strategy will leverage the existing skill sets and transformative practices, prevent duplication of efforts, and ensure a degree of flexibility is built into each provider's change plan.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

The following is a list of MTP activities partnering providers could participate in that were included in the RFP. Please note that final MTP activities will be dependent on the selection of partnering providers and will be specified in CPAA's Implementation Plan submitted to the Health Care Authority by October 1, 2018.

- Harm Reduction
 - a. Syringe exchange programming
 - i. Initiate programs in areas where there are currently none.
 - ii. Expand services at existing programs.
 - iii. Increase collaboration and communication in service delivery and access to care between co-located services.
 - b. Naloxone distribution to people at risk of an opioid overdose
 - i. Increase access to naloxone by diversifying partnerships to effectively distribute naloxone to target populations.
 - ii. Increase overdose prevention education.
 - iii. Provide TA to develop policies and standard operating procedures for new naloxone distributors.
 - c. Low barrier access to MAT
 - i. Develop protocols for implementation of a low barrier clinic.
 - ii. Increase collaboration with low barrier clinics around the state.
 - iii. Form interdisciplinary team to create regional clinic.
 - iv. Support legislative advocacy to modify existing rules to increase access in rural settings.
- MAT
 - a. Expand access to buprenorphine treatment by creating a network of providers similar to a hub and spoke model.
 - b. Support the network in applications for funding to enhance MTP efforts.
 - c. Support legislative advocacy to modify existing rules to increase access in rural settings.
 - d. Provide TA to develop policies and standard operating procedures for MAT providers.
 - e. Collaborate with existing waived providers, recruit new waived providers, and develop a network of support for waived providers.
- Trauma-informed care
 - a. Use Domain 1 investments to increase capacity to train providers in the principles of trauma-informed care in order to bring providers to a base line level of knowledge across disciplines.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<ul style="list-style-type: none"> • Increase the number of evidence-based recovery supports <ul style="list-style-type: none"> a. Work with organizations to increase their capacity to hire state certified Peers. b. Work with organizations to increase their capacity to hire certified recovery coaches. c. Work with housing agencies to understand the housing first model, rather than sober only housing.
<p>2. Target Populations</p>	<p>The target populations below were identified by prioritizing specific geographic areas in our region that require special focus due to oversaturation of opioid prescriptions, lack of services, and high ED utilization related to drug use. We also reviewed the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. We believe by addressing health disparities, health equity will improve in our community. CPAA's cross analysis of assessment data has been used to identify sub-populations and sub-regions as a proxy to identify areas where there are significant health disparities. Additionally, CPAA looked at Medicaid claims data and mortality rates in counties by census tracts to identify specific target populations and sub-regions for this project.</p> <p>The following is a list of proposed MTP target populations partnering providers could impact that were included in the RFP. Every intervention is relevant to all target populations listed, and every evidence-based approach is adaptable to the progression of the individuals in these populations as they progress or regress along the cycle of behavior change. Please note that final MTP target populations will be dependent on the selection of partnering providers and will be specified in CPAA's Implementation Plan submitted to the Health Care Authority by October 1, 2018.</p> <ul style="list-style-type: none"> • Incarcerated populations with OUD • Injection drug users/individuals who utilize needle exchange programs • Individuals with Hepatitis C and OUD • Individuals with HIV/AIDS and OUD • Homeless populations • Pregnant and parenting women with OUD • Individuals with inadequate control of SUD and behavioral health issues (e.g., multiple ED visits and hospital readmissions related to drug use) • Individuals living in rural areas with limited access to OUD treatment

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

The MTP is expanding the capacity of health care and behavioral health care providers to respond to the needs of the communities they serve. While this particular project is focused on responding to the opioid epidemic, the framework and approach will increase capacity to address OUD and SUD in multiple settings with multiple approaches. The infrastructure increase will create capacity to respond to other behavioral health crises before they reach epidemic status. The expansion of MAT, trauma-informed care training, and a recovery-based approach will build resilience in communities, increase early intervention, decrease preventable health outcomes, and empower individuals and providers to treat people in their own community and within their own support network in a framework that will endure beyond the Medicaid Transformation. Furthermore, the workforce trained, workflows established, infrastructure built, financing mechanisms put into place, and overall synergies harnessed will serve as a catalyst for health care transformation that extends beyond Medicaid populations to benefit the CPAA region as a whole.

Project 3B: Reproductive and Maternal/Child Health

1. Transformation Strategies and Approaches

CPAA selected One Key Question, Parents as Teachers, Nurse Family Partnership, Early Head Start Home Based Model, Bright Futures, Enriched Medical Home Intervention Screening, and School Based Health Centers as the evidence-based approaches for reproductive and maternal/child health care transformation. CPAA has also identified a need to train practices, partners, and community organizations in trauma-informed care practices.

CPAA is encouraging partnering providers to adopt the subcomponents of these evidence-based approaches or enhance already existing programs or systems to create a customized transformation plan that is individualized for each organization (Change Plan). This strategy will leverage the existing skillsets and transformative practices, prevent duplication of efforts, and ensure a degree of flexibility is built into each provider's implementation plan.

The following is a list of MTP activities partnering providers could participate in that were included in the RFP. Please note that final MTP activities will be dependent on the selection of partnering providers and will be specified in CPAA's Implementation Plan submitted to the Health Care Authority by October 1, 2018.

- Reproductive health screening
 - a. Integrate pregnancy intention (i.e. One Key Question) or other reproductive health screening (i.e. sexually transmitted infection testing) into primary care, behavioral health, or other health care setting.
 - b. Increase access to long-acting reversible contraception (LARC).
 - c. Establish referral and follow-up workflows based on reproductive health intention.
- Evidence-Based Home Visiting - Nurse Family Partnership, Parents as Teachers, Early Head Start Home Visiting

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<p>Model</p> <ul style="list-style-type: none"> a. Establish program or scale up existing programs b. Establish linkages between programs based on patient eligibility or child age, or with larger health care system based on patient needs • Well-Child Visits <ul style="list-style-type: none"> a. Bright Futures electronic medical records screening and referral system b. Enriched Medical Home Intervention Screening utilizing community health workers • School Based Health Center <ul style="list-style-type: none"> a. Embed or expand medical or behavioral health services into an elementary, middle, or high school setting • Trauma-Informed Care Training <ul style="list-style-type: none"> d. Use Domain 1 investments to increase capacity to train providers in the principles of trauma-informed care
<p>2. Target Populations</p>	<p>The following is a list of proposed MTP target populations partnering providers could impact that were included in the RFP. We also reviewed the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. Please note that final MTP target populations will be dependent on the selection of partnering providers and will be specified in CPAA’s Implementation Plan submitted to the Health Care Authority by October 1, 2018.</p> <ul style="list-style-type: none"> • Men or women of reproductive age • Pregnant women • Mothers of children aged 0-3 • Mothers of children aged 0-17 • Other
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>The reproductive and maternal/child health strategies will support a system of well-timed children's and maternal health care that both reduces the risk of adverse childhood experiences and mitigates the impact of these experiences. CPAA expects reproductive and maternal/child care transformation and evidence-based practice adoption will take several years for some partners to fully implement and will require initial investment in infrastructure. For example, integrating One Key Question into new provider settings will give more women the option to consider what their reproductive intentions are, and full scale-up will ensure that they are connected with appropriate resources to achieve those intentions. Expansion of pre-existing services, such as home visiting programs and Bright Futures, will ensure that</p>

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

high-risk populations such a non-English speaking families, teen parents, and rural families receive the support they need to thrive. Increasing the capacity of these programs will also enable staff to ensure a warm hand-off of patients to other programs to ensure appropriate developmental milestone are achieved.

During implementation DSRIP years, CPAA is encouraging partnering providers to focus on trauma-informed care in a variety of settings such as primary care, behavioral, pediatric, dental, OBGYN, and non-clinical community-based partners. Giving providers additional guidance around reproductive health screenings and well child visits, alongside trauma-informed care training will ensure that care is delivered timely and appropriately.

Furthermore, the workforce trained, workflows established, infrastructure built, financing mechanisms put into place, and overall synergies harnessed will serve as a catalyst for health care transformation that extends beyond Medicaid populations to benefit the CPAA region as a whole.

Project 3D: Chronic Disease Prevention and Control

1. Transformation Strategies and Approaches

CPAA selected the Wagner's Chronic Care Model, Chronic Disease Self-Management Program, Million Hearts Campaign, CDC Diabetes Prevention Program, and Community Paramedicine as the five evidence-based approaches for chronic disease prevention and control transformation. CPAA is encouraging partnering providers to adopt the subcomponents of these evidence-based approaches to create a customized transformation plan that is individualized to each organization (Change Plan). This strategy will leverage the existing skill sets and transformative practices, prevent duplication of efforts, and ensure a degree of flexibility is built into each provider's implementation plan.

The following list is a list of transformational activities partnering providers could participate in that were included in the Request for Proposal. Please note that final Transformation activities will be dependent on the selection of partnering providers and will be specified in the Implementation Plan submitted to the Health Care Authority by October 1, 2018.

- Self-Management Support
 - a. Providers assist patients with self-management goals by using evidence-based self-management tools, using group visits to support self-management, setting and documenting self-management goals collaboratively with patients, and systematically monitoring and following up on those goals.
 - Utilize “Assessment, Advice, Agree, Assist and Arrange” protocol from CCM.
- Decision Support: Provide clinical care that is consistent with scientific evidence and patient preferences

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- a. Embed evidence-based guidelines into daily clinical practice and share these guidelines with patients to increase their knowledge and confidence in self-management of chronic diseases.
- b. Integrate specialty expertise in primary care.
- c. Use “teach back method” to ensure patients understand their care plans.
- Delivery System design
 - a. Use registry to regularly assess disease control, adherence, and ensure follow-up is taking place.
 - b. Use planned interactions to support evidence-based care.
 - c. Standardized referral process to CDSM or community resources to address social determinants of health.
 - d. Provide clinical case management services for complex patients.
- Clinic Information System
 - a. Utilize a registry to:
 - Provide care reminders for providers and identify relevant patient subpopulations for proactive care.
 - Facilitate individual patient care planning.
 - Monitor performance of team.
- Community-Based Resources
 - a. Encourage patients to participate in effective programs.
 - b. Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.
- Health Care Organization
 - a. Develop quality improvement process by reviewing clinical data, quality of care, and patient satisfaction. Incentives can be provided based on quality of care.
 - b. Develop agreements with community-based organizations to facilitate care coordination.
- Implement an Evidence-Based Chronic Disease Management Tool
 - a. Implement Stanford Chronic Disease Self-Management Program.
 - b. Implement Million Hearts Campaign or the similar initiative, Healthy Hearts Northwest.
 - c. Implement CDC National Diabetes Prevention.
- Partner with EMS/Community Paramedicine
 - Provide medical treatment, health education, and resources for patients who utilized 911 dispatch but do not need to be transported to the hospital.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

	<ul style="list-style-type: none"> • Provide short-term post-discharge follow-up for high-risk patients recently discharged from the hospital to decrease readmission and improve health outcomes. • Provide patients with non-emergency medical needs transportation in a non-emergency vehicle to an alternative care site that is appropriate for their needs.
<p>2. Target Populations</p>	<p>The following is a list of proposed MTP target populations partnering providers could impact that were included in the RFP. We also reviewed the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. Please note that final MTP target populations will be dependent on the selection of partnering providers and will be specified in CPAA’s Implementation Plan submitted to the Health Care Authority by October 1, 2018.</p> <ul style="list-style-type: none"> • Medicaid beneficiaries with an asthma diagnosis who do not have an up-to-date Asthma Action Plan <u>Priority Population:</u> Residents of Grays Harbor, Lewis, and Wahkiakum counties • Patients with two or more hospital ED visits in the last 6 months and one (or more) chronic disease • Medicaid beneficiaries with a diabetes diagnosis <u>Priority Population:</u> Residents of Grays Harbor, Mason, and Thurston counties <u>Priority Population:</u> Patients who have not completed an annual eye exam or HbA1c test • Medicaid beneficiaries with heart disease <u>Priority Population:</u> Residents of Lewis, Mason, and Thurston counties • Medicaid beneficiaries in the CPAA region with two or more chronic diseases or with one or more chronic disease and a comorbid behavioral health disorder
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>The chronic disease prevention and control strategies will support expansion and sustainability of health system transformation for the selected target population/s by adopting a multi-agency care team approach that is patient-centered and focuses on coordinating activities between different care providers around a shared care plan.</p> <p>CPAA expects chronic disease prevention and control transformative and evidence-based practice adoption will take several years for some partners to fully implement and will require initial investments in infrastructure. To establish the requisite infrastructure for expansion, CPAA aims to make targeted investments in (1) transformation of the clinical delivery system in all health care settings (primary care and behavioral health); (2) bi-directional coordination with community-based prevention efforts to raise awareness and better self-management of chronic disease; (3) changes in</p>

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

partnering providers' workflows, business practices, and staffing patterns to support team-based care; (4) the capacity to build strong working relationships among the multi-agency care team; and (5) payment mechanisms that support care coordination in DSRIP year two and three.

During implementation DSRIP years, CPAA is encouraging traditional partnering providers to focus on the adoption of Wagner's Chronic Care Model principals and supporting best practices (Million Hearts Campaign, Community Paramedicine, Diabetes Prevention Program, etc.) to create a customized transformation plan (Change Plan). In this way, organizations can take a progressive approach to improving or developing programs based on their specific capabilities and development needs. Some partners will be able to move more quickly than others, resulting in expansion of the scope of the transformative work more rapidly. CPAA will provide technical support and act as a convener of resources to support the expansion of scale and target populations for evidence-based practices and ensure that gaps in care are addressed. For example, initially a rural hospital may only be able to implement the Chronic Care Model with a single high-risk population but may be able to expand to include a workflow for referral to chronic disease education programs and expand to target several high-risk populations in later DSRIP years.

Expanding the scope of populations, number of partnerships, and geographic areas that evidence-based practices target will increase early intervention, decrease preventable health outcomes, and, we expect, will significantly decrease avoidable emergency department utilization and healthcare expenditures related to the prevention and control of chronic diseases. Adoption of the Chronic Care Model further supports the transition to value-based care and provides compounding value that extends past the DSRIP years and CPAA region by reducing the number of admissions and readmissions, improving patient self-management, controlling costs and bringing together MCOs, providers, and community resources to ensure all entities are positioned well for value-based purchasing after the Medicaid Transformation ends in 2021.

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

ACH Response:

CPAA expects to achieve a number of specific outcomes by the end of the Transformation. The following is a summary of key anticipated outcomes by project area:

2A: Bi-Directional Care Integration

This project area is expected to result in a number of positive outcomes that will improve access to care and the quality of care for the target populations. To improve access to primary and behavioral health care, we expect an increased number of organizations will self-identify at a higher level of integration compared to the levels determined through CPAA's initial Current State Capacity Assessment and achieve higher scores on the MeHAF Site Self-Assessment compared to their initial assessment. In primary care settings, behavioral health services will be provided onsite or through enhanced collaboration with a partner organization as evidenced by a memorandum of agreement. In behavioral health settings, primary care services will be provided onsite or through enhanced collaboration with a partner organization as evidenced by a memorandum of agreement (which includes tracking physical health metrics). Additional outcomes include an increase in shared care plans between primary care and behavioral health, using patient registries, and providing evidence-based care as well as adopting a regular quality improvement process. In addition to improving Pay for Performance metrics, these outcomes support regional transformation objectives by contributing to the goal of achieving whole-person care for children and adults by addressing physical and behavioral health needs in integrated systems.

2B: Community-Based Care Coordination

Successful implementation of this project is expected to lead to significant system changes in the region that will drive improved health outcomes, better care for patients, and reduced overall cost. This "care traffic control" system will allow physical and behavioral health providers to better communicate and coordinate care for patients they share. This system will help mobilize and organize our region's response to the opioid epidemic as well as ensure people suffering from SUD can more easily be identified and supported in getting the care they need. This robust system for care coordination will improve successful transitions of care and reduce the burden on the EMS call system. Specific positive outcomes include: creating capacity to provide care coordination services to an annual caseload of 4,000 people in the region; identifying and targeting specific target populations that experience health disparities; target populations will be supported in accessing care and becoming more engaged in the management of their own care; increasingly standardized care coordination services towards best practices; creating over 100 new care coordinator jobs available for people from the target populations; establishing HIT infrastructure that improves secure exchange of client records, reduces duplication of services and data collection, and supports data informed decision making among local planners and policy makers; and establishing sustainable payment mechanisms for care coordination and the HIT infrastructure.

2C: Transitional Care

Within this project area, CPAA seeks to achieve a number of outcomes linked to improving access to care and the quality of care for the target populations. Specifically, to increase access to care, CPAA aims to increase emergency department referrals to primary care physicians, increase the number of physical healthcare providers who offer expanded hours, increase the non-emergency transportation services available to transport patients to care, and decrease avoidable emergency department utilization. To increase the quality of care, CPAA seeks to increase the

number of patients who receive evidence-based transitional care planning, increase the use of registries to follow treatment targets, record dates of contacts, and inform active follow-up, and increase the number of referrals made to connect patients to community-based services that address social determinants of health.

3A: Opioid Response

This project is expected result in a number of positive health outcomes that will improve access to care and the quality of care for the target populations. Positive outcomes include increased access to treatment services, recovery supports, and systems of care that have multiple engagement points to support individuals experiencing OUD in places where people can relevantly engage in care, regardless of where they fall on the continuum of behavioral change. Services will be trauma-informed, recovery-oriented, and supportive without moral judgement of the individuals who experience OUD and SUD. The infrastructure developed through this project will make it possible to address the opioid epidemic in the region and is expected to result in more providers capable of being responsive to patients experiencing SUD.

3B: Reproductive and Maternal/Child Health

This project area is expected to result in a number of positive short and long-term health outcomes for women and children in the region. Potential short-term outcomes include increased access to the following: LARCs, chlamydia screenings, well-child visits, and immunizations as well as decreased unnecessary emergency room visits and pre-term births. Potential long-term outcomes include a reduction of teen pregnancy, chronic school absenteeism, and reported deaths due to neglect. Additional long-term outcomes include an increase in healthy birth weights, high school graduation rates, and kindergarten readiness. These outcomes will help integrate trauma-informed care into a variety of care delivery settings utilized by children and their families.

3D: Chronic Disease Prevention and Control

Within this project area, CPAA seeks to implement a number of strategies to improve health outcomes for the target populations. Anticipated outcomes include: increase in the number of referrals to services that provide self-management support of chronic illness, increase in the number of patients who are receiving care under Wagner's Chronic Care Model, increase in the number of patients who participate in evidence-based chronic disease management tools, and increased access to primary care physicians. CPAA also seeks to increase the use of disease-specific preventative care such as up-to-date asthma action plans, annual eye exams, and HnA1c Tests for diabetics.

By meeting the aforementioned project specific outcomes, we expect to advance a number of mutually supportive broader regional health transformation goals and priorities. Specifically, we anticipate making progress with achieving three overarching regional health transformation goals that CPAA identified through the regional health improvement planning process that preceded the advent of the MTP, namely: improving health equity and health outcomes for all residents, advancing prevention and whole-person care, and reducing per-capita health care costs while improving the quality of care provided. The infrastructure built and the practice transformation brought about by reforming the delivery of

care in the six MTP project areas selected by CPAA will benefit not just Medicaid beneficiaries, but all patients. Thus, the MTP is expected to accelerate the region's broader health system transformation goals. Moreover, the six MTP project areas selected by CPAA for regional health care system transformation align to a high degree with the region's five shared health priority areas: improve health care access, improve care coordination and integration, prevent and manage chronic disease, prevent and mitigate adverse childhood experiences, and enhance economic and educational opportunities.

Milestone 4: Identification of Partnering Providers

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

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

Please see completed item D.1 in CPAA.SAR1 Workbook.7.31.18. There are no additional Partnering Providers to include in Tab D.

Section 2: Standard Reporting Requirements

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

ACH-Level Reporting Requirements

ACH Organizational Updates

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

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

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

ACH Response:

Not Applicable

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

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

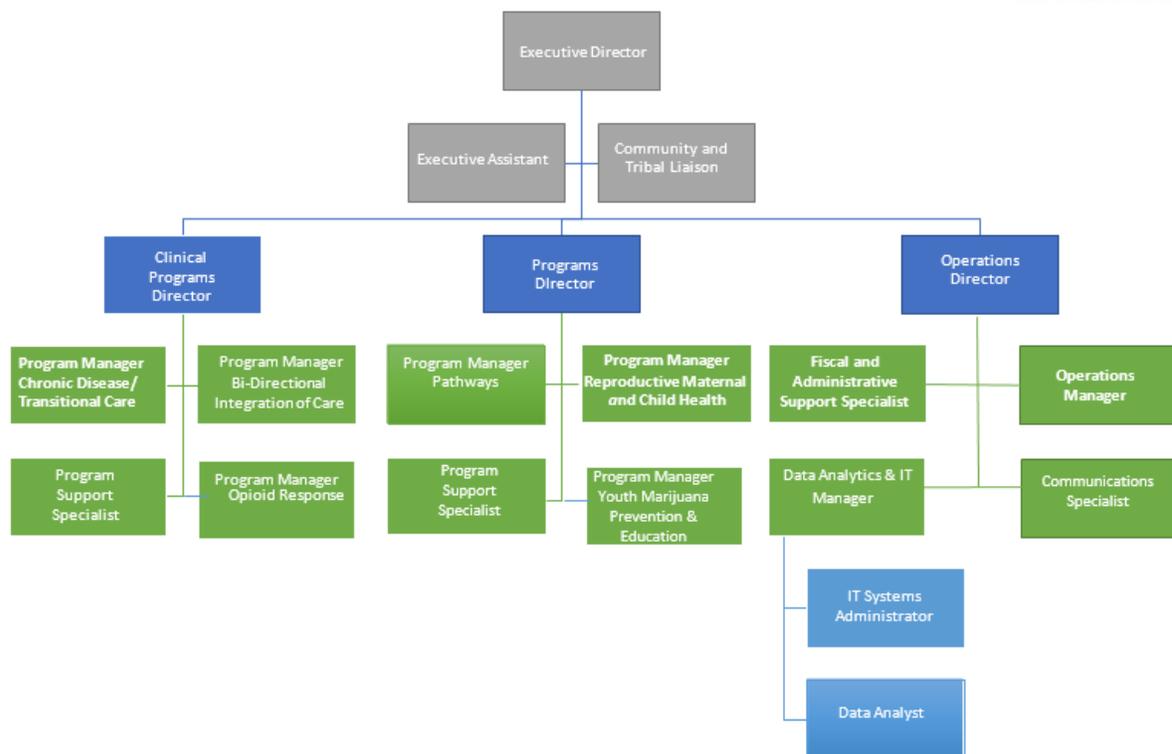
Insert or Include as an Attachment: Organizational Chart

CPAA hired two key staff positions during this reporting period. Alexandra Toney was selected as Program Manager for Chronic Disease and Transitional Care project areas. Caroline Sedano was selected as Program Manager for the Reproductive, Maternal, and Child Health and Oral Health project areas. Justine Wagaman, Community and Tribal Liaison, left CPAA and was replaced by Rene' Hilderbrand. New hires are noted with an asterisk.

At this time, while CPAA is looking for additional support staff, all key positions to support the Medicaid Transformation Project are filled. We will continue to evaluate if additional resources are needed as CPAA moves toward implementation.

Name	Position	Role
Winfried Danke	CEO	Provides strategic direction and oversight of the organization.
Samantha Tatum	Operations Director	Provides oversight of facilities, IT, operations, and finances.
Christina Mitchell	Clinical Programs Director	Provides oversight of the Care Integration, Opioid, Chronic Disease, and Transitional Care programs.
Jennifer Brackeen	Program Director	Provides oversight of Pathways, Reproductive and Maternal/Child Health, and Oral Health programs.
Matthew Shellhart	YMPEP Manager	Manages the Youth Marijuana Prevention and Education program.
*Christine Haywood	Operations Manager	Provides operational support.
Ivan Rodriguez	Data and IT Manager	Provides oversight of data analytics and IT.
Kyle Roesler	Care Integration Manager	Manages the Bi-Directional Care Integration program.
Michael O'Neill	Pathways Hub Manager	Manages the Pathways program.
Malika Lamont	Opioid Response Manager	Manages the Opioid Response program.
*Alexandra Toney	Chronic Disease and Transitional Care Manager	Manages the Chronic Disease and Transitional Care programs.
*Caroline Sedano	Reproductive, Maternal, and Child Health Manager	Manages the Oral Health and Reproductive and Maternal/Child Health programs.
*Megan Moore	Executive Assistant	Provides administrative support for the CEO.
Shannon Linkous	Program Support Specialist	Provides administrative support for the clinical programs and clinical director.
*Vacant	Program Support Specialist	Provides administrative support for the Pathways, Reproductive and Maternal/Child Health, and Oral Health programs and director.
*Vacant	Fiscal and Administrative Support Specialist	Provides fiscal and administrative support.
Randolph Thomas	Data analyst	Provides data analytics.
Evan Clayton	IT Administrator	Provides IT expertise to setup and maintain technology systems within the organization.
*Rene' Hilderbrand	Community and Tribal Liaison	Collaborates with the community and tribes to inform, make recommendations, and gather input.

Name	Position	Role
Carol Palay	Communications Specialist	Provides communications expertise and supports stakeholder, implementation partner, and community engagement.



Tribal Engagement and Collaboration

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

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Tribal Health Partner Meeting	21 Feb 18	Chehalis, Cowlitz, Nisqually, Quinault, Shoalwater Bay, Skokomish, Squaxin	CPAA staff, Chehalis, Cowlitz, Quinault, Shoalwater Bay	CPAA overview, overview of MTP project areas, tribal engagement goals	The four participating Health Directors determined they would like to continue to convene with CPAA every other month. CPAA Directors will scheduled one-on-one meetings with all seven tribes to discuss opportunities and alignment with the MTP. HCA Tribal Liaison will be invited to all future meetings.
Nisqually Health Services MTP Engagement Meeting	4 April 18	Nisqually Health Director	CPAA staff and Nisqually HS Director and staff	Explore opportunities through the MTP and customize Transformation participation strategy.	CPAA recognized the tribe's top 3 priorities of traditional healing, MAT, and integrated health and identified ways CPAA can support.
Squaxin Health Services MTP Engagement Meeting	20 April 18	Squaxin Health Director	CPAA staff, Squaxin HS Director and staff, and Lena Nachand	Introduction and explore opportunities through the MTP to assist meeting tribal health gaps and priorities.	CPAA will send follow-up email, tribe will register in payment portal, tribe will begin to consider which priority areas to work in, and CPAA will schedule next 1-1 tribal meeting.

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Nisqually Health Services MTP Engagement Meeting	17 April 18	Dr. Alison Spencer, Jen Olson, Amber Arndt	CPAA staff	Discuss project plans for behavioral health integration, MAT program, and partnership opportunities	Tribe shared plans for implementing behavioral health integration, starting a MAT program, and how traditional healing services fit into their model of whole person care. This model of care will be supported by a funding strategy that braids tribal ACH funding with CPAA funding. Next steps include coordinating/developing/supporting a tribal regional training event or series on harm reduction and trauma informed care and striving for consistent messaging.
American Indian Health Commission (AIHC) MTP Engagement Meeting	11 April 18	Vicki Lowe	Vicki Lowe and CPAA staff	Discuss tribal engagement strategies, upcoming meetings (group and tribal 1-1), AIHC assessment sharing, issues and concerns	AIHC shared tribal concerns of confusion but believes with a tribal liaison the tribes will be more receptive to partnership, invited to April 27, 2018, Tribal Work Shop, and for those tribe that welcome ACH at 1-1 meetings, they will include tribal liaison.
Skokomish Tribal Health Director 1-1 Meeting	17 April 18	Denese LaClair	CPAA staff, Denese LaClair, and staff	Discuss opportunities for MTP and possible priorities, and how CPAA can best support the tribe.	Tribe will explore Bi-Directional Care Integration and register in payment portal. CPAA will provide next steps to priority selection-What tribes need to submit –

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
					and schedule next Tribal Directors meeting.
HCA Tribal Liaison Meeting	18 April 18	Lena Nachand	Lena Nachand and CPAA staff	Discuss Tribal meetings, engagement, assessment sharing, reporting, portal, and possible ACH tribal liaison calls.	Lena will follow-up to get feedback from other ACH Tribal Liaisons for standing calls and to schedule tribal site visits.
HCA-AIHC Tribal BH-Workshop	27 April 18	All Tribes and ACH Tribal Liaisons	Jesse Dean, Lena Nachand, Vickie Lowe, staff, tribal health directors, ACH tribal liaisons	HCA overview of funding streams, AIHC update, review bi-directional integration process, tribal needs and gaps	Tribes will receive an agreement with HCA and ACHs, tribes will register in portals, tribes will begin thinking about their plans and how they will spend their MTP funding.
Chehalis Tribal Health Director 1-1 Meeting	01 May 18	Denise Walker	Denise Walker, CPAA staff	Discuss May 30, priority presentation, tribal directors meeting, 1-1 meetings, CPAA Council/Board seat, portal, sharing assessment, and Memorandum of Understanding (MOU).	CPAA will schedule Tribal Directors meeting and email MOA Agreement for tribal review and feedback. Tribe will include possible project outcomes and offered to host next Tribal Directors Meeting. Tribe agreed to share assessment and would like a copy of what was submitted to CPAA.
HCA Administrator and Tribal Liaison Meeting	03 May 18	Jesse Dean and Lena Nachand	Jesse Dean, Lena Nachand, CPAA staff	Discuss CPAA road trip to meet Tribes 1-1, ACH Tribal Liaison Calls, and May 24th Meeting – plan and reporting, payment portal.	HCA will add items to agenda for call May 5 and for May 24 ACH Tribal Liaison Meeting. HCA will begin to schedule meetings in July with tribes.

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
HCA/AIHC-ACH Tribal Liaison meeting/call	04 May 18	ACH Tribal Liaisons, Lena Nachand, Vicki Lowe	ACH Tribal Liaisons	<ol style="list-style-type: none"> 1. Intro 2. Purpose 3. What is an Indian Health Care Plan (IHCP) 4. FE Portal 5. May 24th Meeting 	Next call AIHC will provide IHC 101 Training. AIHC will send electronic version of "Assessment" to tribes to forward if they choose.
Shoalwater Bay Tribal Health Director 1-1 Meeting	16 May 18	Kim Zillyett-Harris	Kim Zillyett-Harris, CPAA staff	Discuss what tribe may need to partner, Tribal Directors Meeting Jun 7th, Needs/Gaps, 1-1 monthly, program(s) or proposal for funding, July HCA/AIHC/ACH meeting, MOA/MOU next steps	<ol style="list-style-type: none"> 1. Tribe will try to obtain Tribal Resolution 5-24-18 2. After Resolution, tribe will complete payment portal registration for ACH/CPAA 3. CPAA will send Draft Agreement 4. Tribe will determine best utilization of funding but has currently selected all programs in case of directional changes. Tribe may begin with "Bi-Directional Care Integration" 5. Tribe will submit program outline; needs/gaps; approach/timeline/outcomes/budget; 6. CPAA schedule next Tribal Director Meeting
HCA/AIHC-ACH Tribal Liaison Meeting/call	18 May 18	ACH Tribal Liaisons, Lena Nachand, Vicki Lowe, Jesse Dean	Jesse Dean, Lena Nachand, ACH Tribal Liaisons, CPAA staff	Presentation on Indian Health Care System in Washington State	AIHC provided presentation on Tribal Sovereignty and the Indian, Tribal and Urban Health System to all ACH-Tribal Liaisons.

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Nisqually Tribal Health Director 1-1 Meeting	22 May 18	Samantha Phillips	Samantha Phillips, CPAA staff	Discuss what tribe may need to partner, Tribal Directors Meeting Jun 7th, Needs/Gaps, 1-1 monthly, program(s) or proposal for funding, July HCA/AIHC/ACH meeting, MOA/MOU next steps	<ol style="list-style-type: none"> 1. Tribe will complete registration with payment portal for ACH/CPAA 2. CPAA will send Draft MOU Agreement 3. Tribe will determine best utilization of funding and will send outline of project 4. Tribe will submit program outline; needs/gaps; approach/timeline/outcomes/budget ; 5. CPAA will schedule next Tribal Director Meeting
Quinault Indian Nation Tribal Health Director 1-1 Meeting	23 May 18	Aliza Brown	Aliza Brown, CPAA staff	Discuss what tribe may need to partner, Tribal Directors Meeting Jun 7th, Needs/Gaps, 1-1 monthly, program(s) or proposal for funding, July HCA/AIHC/ACH meeting, MOA/MOU next steps	<ol style="list-style-type: none"> 1. Tribe will complete registration with payment portal for ACH/CPAA 2. CPAA will send Draft MOU Agreement 3. Tribe will determine best utilization of funding and will send outline of project 4. Tribe will submit program outline; needs/gaps; approach/timeline/outcomes/budget; 5. CPAA will schedule next Tribal Director Meeting
ACH Tribal Liaisons Meeting in Person	24 May 18	ACH Tribal Liaisons, Lena Nachand, Vicki Lowe, Jesse Dean	Jesse Dean, Lena Nachand, ACH Tribal Liaisons.	Q&A/overview of MTP funding, ACH updates on status with tribes	On the next call, HCA will develop and share a document containing information from each ACH on funding plan, types of agreement, etc.

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Chehalis Tribal Health Director Meeting	30 May 18	Denise Walker	Denise Walker, CPAA staff	Tribal presentation on MTP	Tribe provided a presentation on their MTP project on Chronic Disease Prevention and Control.
AIHC meeting	4 June 18	Jen Olsen	Jen Olsen, CPAA staff	Discuss possible organization collaboration on Tribal Bi-Directional Work Group	Propose Tribal Bi-Directional Work Group at Tribal Directors Meeting for interest and clarification.
Tribal Directors Meeting	7 June 18	Chehalis, Cowlitz, Nisqually, Quinault, Shoalwater Bay, Skokomish, Squaxin	Chehalis Cowlitz Shoalwater Bay Skokomish Squaxin Island Jessie Dean, Lena Nachand, Jen Olsen, CPAA staff	CPAA Update, CPAA-Tribal MOU, MOU Exhibit B, Payment Portal, CPAA Tribal Seat	Tribes will review and provide feedback on MOU, Tribes will complete Exhibit B, Tribes appointed Denise Walker (Chehalis) as CPAA Board member and Karla Miller (Skokomish) as an alternate
Nisqually Tribal Health Director 1-1 Meeting	11 June 18	Samantha Phillips	Samantha Phillips, CPAA Staff	Provided CPAA Tribal Director meeting updates	Tribes will review and provide feedback on MOU, Tribes will complete Exhibit B, Tribe will host next Tribal Health Directors meeting Aug 23, 2018

Project Reporting Requirements

Project Status Update

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

Examples of activities may include, but are not limited to the following:

- *The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.*
- *Partnering providers have completed training on project interventions.*
- *Partnering providers have adopted and/or are using project tools/protocols.*
- *The ACH has invested in and/or provided technical assistance for partnering providers.*
- *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
- *New services are being offered/provided to Medicaid beneficiaries.*

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Current State Capacity Assessment	All Project Areas	Y	Evaluate outcomes and incorporate into implementation plan and partner selection.
YR1 Funds Flow Approved	All Project Areas	Y	Continue to distribute funds to partners based on meeting key milestones.
Request for Proposal (RFP)	All Project Areas	Y	Independent assessor contracted by CPAA will select partnering providers in August 2018.

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
YR 2-5 Funds Flow Development and Approval	All Project Areas	Y	YR 2-5 funding model will continue to be developed by the Finance Committee and ultimately approved by the CPAA Board.
CPAA completed Tribal MOUs for the seven tribes in the region	All Project Areas	Y	Tribes are currently reviewing a five-year Memorandum of Understanding (MOU) for MTP planning and implementation.
Health Innovation Leadership Network (HILN)	All Project Areas: Health Equity	Y	Winfried Danke, CEO, serves as the co-chair of the Community and Health Equity Committee. The committee is taking an active role in the development of the Healthier Washington Health Equity Conference in October 2018. The HILN will continue to address health equity across the state.
Informational and Design Session with the AIMS Center	2A	Y	Apply information gathered in this event to design the AIMS Center's Bi-Directional Care Integration Training program for the CPAA region.
Webinar with the UW AIMS Center	2A	Y	Use information gathered in this event to design the AIMS Center's Bi-Directional Care Integration Training program for the CPAA region.
Care Coordination Environmental Scan	2B	Y	Use information for selecting Care Coordination Agencies

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
			and project implementation planning.
CPAA contracted for technical assistance from the UW AIMS Center to support planning and implementation for partners developing/strengthening integrated care programs.	2A	Y	Finalize our contract, develop training program commitment letters, and schedule partners to begin training program in fall 2018 or early 2019.
CPAA Contracted for Technical Assistance from Pathways implementation experts to support implementation planning	2B	Y	Utilize regular meetings w/TA providers, templates provided, and other TA received to strengthen project implementation plans.
Partner with other ACHs to explore what shared services purchasing is possible for Pathways HIT, workforce training, and evaluation	2B	Y	Continue conversations with other ACHs and potential vendors of shared services to describe specific opportunities and to move towards formal agreements.
Selection and purchase of HIT for Pathways program implementation	2B	Y	Customize workflows for our regional implementation and enter data about community resources and providers.
Information and design summit with Area Agency on Aging Topic: chronic disease education evidence-based practices and alignment with Chronic Disease Self-Management Program	3D	Y	Apply information gathered in this event to design and coordinate Chronic Disease Self-Management Program efforts in the CPAA region.
Information and design session with the Transformation Hub, Innovaccer, and CipherHealth	All Project Areas	Y	Select a technology platform to coordinate, monitor, and support partners' transformation efforts in the region.

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Develop partner change plans	All Project Areas	Y	Evaluate information received through the current state capacity assessment and RFP process and use to develop partner-specific change plans.

Partnering Provider Engagement

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

ACH Response:

All nine Accountable Communities of Health recognize the importance of collaboration to maximize impact while reducing confusion for partnering providers participating in projects in more than one ACH. ACH Executive Directors and staff communicate on a regular basis not only with each other, but also with Health Care Authority, Department of Health, and other organizations that are critical to the success of the MTP. This includes weekly group phone calls among the ACHs and monthly in-person meetings of the ACH directors.

Health Care Authority, through the State Innovation Model (SIM) Grant, hosted annual learning sessions for all ACHs to discuss opportunities for collaboration and to share best practices and lessons learned from provider engagement. The last ACH Convening was held January 23-24, 2018, in Seattle, WA. ACH Executive Directors, staff, and supporting organizations attended. The two-day agenda was packed with topics to explore key areas for potential collaboration and begin forming work groups and work plans to take action on collaborative initiatives. ACHs explored how best to engage shared partners and overcome challenges and barriers to working collaboratively.

Additionally, ACHs have addressed shared partner engagement through bi-weekly Developmental Council calls hosted by Health Care Authority. These calls allow ACHs to standardize their approach in a multitude of areas while addressing individual needs of their region. In addition, ACHs participated in informal weekly telephonic huddles on Wednesday mornings. This has allowed Executive Directors and staff to collaborate and coordinate efforts across ACHs to achieve collective impact.

Although SIM funding for quarterly Accountable Communities of Health convenings ended in the spring of 2018, ACHs recognize the importance of face-to-face interactions to move toward common goals. ACHs have self-organized a monthly convening, meeting on the second Tuesday of every month. Executive Directors frequently discuss partner engagement, ensuring strategies align to maximize health outcomes. HCA made a portion of remaining SIM funding available to support the ACHs in this effort and CHOICE Regional Health Network, the administrative organization for CPAA, is holding the contract on behalf of all nine ACHs to support these monthly meetings.

CPAA has also reached out to neighboring ACHs to align efforts across ACHs. For instance, we worked with SWACH to identify partnering providers that span both ACHs service areas and have since collaborated on coordinating our ACHs' approaches to these partners.

Additionally, specific to Care Coordination, part of CPAA's strategy for Domain 1 investments related to Pathways has been to explore potential partnerships with other ACHs that are implementing this model. CPAA helped convene initial cross-ACH conference calls on this topic and remains an active participant in these discussions. Cross-ACH collaboration has directly resulted in building common ground among ACHs working on Pathways by identifying shared investment strategies, which are still in early development. We do anticipate the individual contracts ACHs have or are entering into with CCS will be transitioned into shared services during the MTP period, creating economies of scale and savings for CPAA and the other participating ACHs.

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

ACH Response:

CPAA recognizes that the success of the MTP depends heavily on the actions of partnering providers that will be undertaking a multitude of practice transformation activities in their respective organizations to achieve larger region-wide system change goals. As such, the active engagement of partnering providers in the change process is vital. This includes the planning of MTP activities.

During the reporting period, much of CPAA's work involved strategic planning, and CPAA partners were expected to engage – and did engage – in MTP activities at multiple levels. Specifically, this included participating in the Current State Capacity Assessment and Care Coordination Environmental Scan, providing input for the project area logic models, and participating in a Care Coordination Planning Team retreat and informational sessions with the AIMS Center. Additionally, the Opioid Response Work Group has been developing a low-barrier MAT pilot and opioid network for our region. Partners were also expected to submit letters of intent prior to the RFP due date and were invited to participate in two RFP virtual “Town Hall meetings” (webinars) to answer any RFP questions and ensure robust participation in the RFP from throughout the region. Again, they did so, with over 65 letters of intent received and over 80 participants calling in for the first “Town Hall meeting” and over 40 for the second.

When MTP implementation partners are selected through the RFP process in August 2018, CPAA will clarify, and include in contractual agreements, more specific roles and expectations for partnering providers, including developing partner specific change plans, reporting performance goals and metrics, data sharing, and participation in peer learnings and continuous quality improvement.

However, even without formalized contracts or commitments in place, partners in the CPAA region have shown passion, commitment, and dedication and have expended a great amount of time and energy towards improving regional health and transformative action. CPAA fully anticipates continued engagement from a broad range of providers and other partners, including those not formally selected at this time as MTP implementation partners.

CPAA expects providers to remain engaged in council and board meetings, as these meetings are critical to the success of the MTP by serving as a venue to convey, explore, and negotiate interests, priorities, and perspectives of local county-based cross-sector communities in the seven-county region. The council will continue to update the strategic direction for the region while establishing or modifying regional action plans including shared goals, strategies, action, milestones, and metrics. The CPAA Council will help monitor the progress of the MTP and make recommendations for improvement as required.

Local community forums keep providers engaged in MTP activities at the county level. Community forums meet monthly to identify local health priorities and see how they align with MTP activities. CPAA recognizes the importance of these forums and designated \$176,384 of Year 1 funding, or \$25,198 per county, to support each of the seven local community forums.

Work groups continue to be the platform for project specific alignment. Program managers develop strategies in partnership with work group members by gathering and analyzing data, aligning opportunities, and making recommendations to the council. Work groups have played an important role

in the development of transformation projects while simultaneously keeping partners engaged and informed during the planning phase.

A Request for Proposal (RFP) process is currently underway in the region to identify MTP implementation partners. CPAA worked with Oregon Health and Science University (OHSU) to develop the RFP, which was released on May 30, 2018. The RFP will remain open until July 18, 2018. The responses to the RFP will be evaluated and scored by Oregon Health and Science University, an independent assessor contracted by CPAA, and in August 2018, the CPAA network of MTP implementation partners will be formally established.

Additionally, CPAA plans to continue to engage a broad cross-sector of partners in our region who play a critical role in improving community health through innovative and creative solution but do not require funding at the same level as formally selected MTP implementation partners. To support this effort, CPAA allocated \$335,179 for a Health Capacity Building Fund. This money will be used to resource targeted, smaller scale initiatives which are focused on improving health in our region and support the MTP.

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

ACH Response:

CPAA has made a deliberate effort to engage partnering providers who are critical to the success of transformation activities. Critical partners are those who serve a large number of Medicaid lives (attribution), CBOs and social service organizations that provide key foundational community supports (such as transportation and housing), and providers who are impacting region-wide coverage, including both in urban centers and more isolated rural communities. Partners with greater attribution are critical to Pay for Performance (P4P) success, however, providers in rural areas may need the greatest assistance due to their more limited resources and diminished ability to spread financial risk. CPAA continues to engage vital community-based and social service organizations and attempts to increase communication between social service and clinical providers to move toward whole-person care.

CPAA and its administrative support organization, CHOICE Regional Health Network, have worked closely with the community for over 20 years and are familiar with both health care needs and existing services provided in the region. CPAA's governance and advisory structure bring to the table a wide-range of service providers, stakeholders, and organizational leaders in the CPAA region, including the two Behavioral Health Organizations and all five Managed Care Organizations that serve Medicaid beneficiaries. This broad range of partner representation and participation already in place throughout the CPAA region enabled us to closely monitor which organizations had completed the Current State Capacity Assessment. CPAA took advantage of our good working relationships and individually reached out to partners who had not completed the assessment. Through this process, the majority of critical partners completed the assessment. In the few instances when we did not have an existing working relationship, we relied on board members to make introductions and attended community forums and

county-specific work groups to meet new potential partners and talk about MTP program areas. CPAA's outreach proved successful when all provider types from all seven counties completed the assessment.

Similarly, we have used the submissions of letters of interest during the RFP process to ensure that partners critical to the success of the Medicaid Transformation Project are responding to the RFP and we have followed up with key partners to ensure their participation. We anticipate that most, if not all, critical partners will respond to the RFP and become formal implementation partners.

CPAA has identified and is addressing barriers to participation in the Medicaid Transformation Project, which applies to critical partners as well as other stakeholders and partners. The primary barriers identified were uncertainty with funding and long-term sustainability. CPAA was very intentional in developing the DY1 funds flow model to address these concerns to the greatest extent possible. The board, council, and finance committee – all composed of potential partnering providers – were directly involved in the development of the finance model to ensure partners receive sufficient resources to implement MTP transformation activities while engaging the greatest number of providers in the region. CPAA continues to look for additional funding, such as grants, to support MTP implementation and complement available MTP funding for implementation partners. In addition, CPAA is working with payers to support the transition to value-based purchasing, while maintaining communications with the state to adjust contracting with MCOs, who in turn are expected to modify provider payment arrangements accordingly. This should address providers' concerns about long-term financial sustainability of transformation activities.

Another barrier to participation is the vast geography of the CPAA region, with many individuals residing in underserved and difficult to reach rural communities. Responses to the RFP will collect organizational information on Medicaid lives served by partnering providers and also detailed information on zip codes served. Although this information will not affect the overall RFP score, it will be used to determine providers' eligibility for bonus pool payments as part of DY1 funds flow. Bonus payments will be made based on the extent to which providers serve individuals experiencing health disparities (health equity bonus pool), rural residents (rural bonus pool), and Medicaid beneficiaries (attribution bonus pool). CPAA's goal is to ensure all critical providers will be fairly compensated for their work using this funding model.

Health is more than health care, and ensuring foundational community supports are in place to support transformation efforts has been challenging. CPAA devoted considerable thought to developing project-specific program one-pagers (Appendix H) as tools in meetings, quickly showing MTP goals and outcomes and why providers should be involved in this work. This was particularly effective in engaging new partners that are non-clinical CBOs and social service organizations who did not initially see themselves as contributing to MTP outcomes.

CPAA used the RFP and DY1 funds flow model as a vehicle to engage those partners, both clinical and non-clinical, who are critical to transformation activities. CPAA is making a deliberate effort to select both clinical providers and community-based organization in all seven counties as part of its MTP implementation partner network. RFP applicants will be sorted into categories based on services provided and service location to ensure broad sectoral and geographic representation. We recognize non-traditional, community-based, and social service organizations provide crucial resources in transitioning to whole-person care and promoting health equity, but these organizations may not score well through the standardized scoring process. To mitigate this barrier to participation and ensure all organizations can be competitive, regardless of size or scope of practice, CPAA has identified opportunities for up to 11 organizations (out of a total of 35-45 organizations) that provide specialty

services critical to MTP success, such as transportation and housing, to be included in the final implementation partner network even though they may not have scored high enough to be selected otherwise.

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

ACH Response:

Not Applicable

Community Engagement

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

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

Community Engagement Activities for the Reporting Period						
Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Meeting with Molina's Dr. Gough and Vicki Evans to learn about the work they are doing to support the region's Opioid Response project efforts.	1/8/18	Review Molina objectives and alignment with CPAA priorities	MCO	3A Opioid Response	Engaging our MCO partners to better understand/share what work is happening and how to align our efforts where appropriate.	N
Meeting with Law Enforcement Liaison about programming that would fit into Domain I investment for anti-bias training for law enforcement.	1/10/18	Learn about anti-bias framework being used in Eastern Washington	Law Enforcement	3A Opioid Response	Learned about the "Potentially Detective" Sociological Framework.	N
The Aging and Long Term Support Administration (ALTSA) Chronic Disease Self-Management (CDSME) Expansion Project final summit,	5/2/18	Create a learning collaborative highlighting the successful work done throughout the year. Discuss the challenges encountered in the execution of the	A diverse group of clinical and community-based service providers who are currently or considering making referrals to a CDSM program or	3D: Chronic Disease Prevention and Control	Created an environment of collaboration around the current body of CDSM work, inspired others to expand the current capacity for CDSM work, increased awareness of	N

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Bridging Beyond the Grant— Transforming Lives Through Evidence-Based Programs		Washington State CDSME grant in 2016-2018.	administrating a CDSM program.		CDSM programs, and disseminated CPAA’s evidence-based practices and implementation plan.	
Numerous discussions with the AIMS Center regarding a contract for a year-long Bi-Directional Care Integration training program. This includes an in-person informational/ design event and webinar with the AIMS Center and potential partnering providers.	2/27/18 3/14/18 5/1/18 5/31/18 6/5/18	Provide partners with the necessary training/ technical assistance resources to plan, implement, and sustain their model of integrated care.	Partners within the CPAA region and potentially organizations that do not formally become partnering providers through RFP selection.	2A: Bi-Directional Care Integration 3A: Opioid Response	Training program contract, summer webinar series, and connections with regional partners.	TBD for year-long training program
Trauma-Informed Care	4/17/18	Provide community members background information on adverse childhood experiences and principles of trauma-informed care	Rochester School District	Youth Behavioral Health Care Coordination Project	Increased community awareness of ACEs and trauma-informed principles	N
CPAA Consumer Advisory Committee	4/10/18 6/12/18	The committee applies a health equity lens to review and	Medicaid beneficiaries Consumer partners from	MTP	Presentations: Y CPAA Updates	

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Meeting of stakeholders to include former and current Medicaid beneficiaries		provide input on CPAA projects and strategies	all CPAA project work groups		Molina-Social Determinants of Health Dr. David Meyers- Integrating Oral Health with Physical and Mental Health CPAA Consumer web page input and feedback Navigator program overview	
Thurston County Coordinated Council (Forum) meeting- meets monthly to promote and sustain initiatives to improve the health of all Thurston County residents	4/11/18 5/18/18	Listen, provide updates of CPAA- MTP	Partner CBO Business, Health, and Government Council members	MTP Community Engagement	Introduction of CTL role, listened to other presenters, invited presenter to share, and CPAA Consumer Advisory Committee 5/8/18 CPAA Updates RFP for project partners	N
Mason County (Forum) moving Mason forward meeting- meets monthly to promote community awareness	4/19/18 5/21/18 6/21/18	Listen, provide updates of CPAA- MTP	CBO and Partners	MTP Community Engagement	Introduction of N CTL role, listened to other presenters, and announced upcoming RFP CPAA Updates RFP for project partners	

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Grays Harbor County Crises Partners Coalition (Forum) meeting- meets monthly to provide updates, program enhancements, new facilities	4/19/18	Listen, provide updates of CPAA- MTP	Crisis Partners	MTP Community Engagement	Introduction of CTL role, listened to other presenters, and announced upcoming RFP	N
Pacific County Willapa Community Network to enhance the quality of life in North Pacific County	5/1/18 6/6/18	Listen, provide updates of CPAA- MTP	Community Organizations and local health care providers	MTP Community Engagement	Introduction of CTL role, listened to other presenters, and announced upcoming RFP CPAA Updates RFP for project partners	N
Wahkiakum County Health & Human Services Advisory Board	5/17/18 6/21/18	Listen, provide updates of CPAA- MTP	Public Health Social and Health Services, community organizations and local health care providers	MTP and Community Engagement	Introduction of CTL role, listened to other presenters, and announced upcoming RFP CPAA Updates RFP for project partners	N
CPAA Consumer Advisory Committee Meeting of stakeholders to include former and current	5/8/18	The committee applies a health equity lens to review and provide input on CPAA projects and strategies	Medicaid beneficiaries	MTP	Discussed Y Committee Charter, elected chair and co-chair, CPAA Consumer web page content Presentation: Coordinated Human Services Transportation.	

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Medicaid beneficiaries						
Cowlitz Community Charter	5/14/18	Identify next steps Community Charter can take to support organizations acting on their ideas	Reproductive and Maternal/Child Serving Agencies	MTP Community Engagement	Further future discussions on how the Community Charter can help organize and support next steps	N
Pediatric-Transforming Clinical Practice Initiative (P-TCPI) Medical Home Neighborhood Team	5/17/18 and monthly	Coordinate transformation activities and events with state and regional partners	Pediatric clinicians and behavioral health providers	2A: Bi-Directional Care Integration	Engaging additional pediatric clinics in CPAA activities resulting in RFP applications. Also, jointly developing coordinated strategies for value-based payment.	N
Lewis County Community Health Partnership	5/24/18 6/28/18	Listen, provide updates of CPAA- MTP	Public Health Social and Health Services, community organizations and local health care providers	MTP and Community Engagement	Introduction of CTL role, listened to other presenters, and announced RFP information CPAA Updates	N
YMCA of SW Washington: Collaborating for Community and Clinical Linkages	5/23/2018	Learn about integrated health work in the community and coordinate transformation activities and events with state and regional partners	Washington YMCA of Southwest Washington CEO and staffs, local healthcare and community champions, CPAA Chronic Disease Program Manager and the	3D: Chronic Disease Prevention and Control	Engaged and established linkages between Community and Clinical Services in CPAA region to coordinate efforts around chronic disease prevention and control.	N

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
			Washington State Alliance of YMCAs' staff			
AIMS Center Pre-Engagement Event	5/30/18		Partners within the CPAA region and potentially organizations that do not formally become partnering providers through RFP selection.	2A: Bi-Directional Care Integration 3A: Opioid Response	Identified a number of training and technical assistance topics based on the AIMS Center Readiness checklist. Identified key topics for a summer webinar series. Identified when organization will commit to starting the programs.	N
CPAA Consumer Advisory Committee Meeting of stakeholders to include former and current Medicaid beneficiaries	6/12/18	The committee applies a health equity lens to review and provide input on CPAA projects and strategies	Medicaid beneficiaries	MTP	Discussion: health equity Presentation: Consumer web page content Navigator Health Insurance In-Person Assistance	Y
Trauma Informed Care in Early Learning: ACEs, Resiliency, and the Science of Hope	6/15/18	Training for the Early Learning Regional Coalition on NEAR sciences	Early Learning Coalition members from CPAA region	MTP 3B: Reproductive and Maternal/Child Health	Provided insights Y into new research on ACES, early childhood development, and trauma informed care.	

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Tribal Substance Abuse Prevention Gathering	6/19/18	Tribes and DSHS provided training and networking opportunities	State Partners, Tribal Prevention Staff, Tribal Leadership, BHO Partners, CBO's, UIHO's	MTP 3A: Opioid Response	Tribe and DSHS provided training, networking opportunities and culturally aligned prevention strategies as protective factors for substance abuse in Tribal communities.	N
Connections, a center for healthy families	6/20/18	Meeting with an organization that serves underrepresented population to discuss MTP and health equity	Clinical Director and Staff	MTP	Discussed Health Equity and what it means to the Director and the population they serve	

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

ACH Response:

As shown in Table 23, the CPAA region has a relatively small number of populations with limited proficiency in English.

Table 23 – CCAA Language Proficiency

LANGUAGE SPOKEN AT HOME BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OVER - Universe: Population 5 years and over

Geography	Washington	Cowlitz	Grays Harbor	Lewis	Mason	Pacific	Thurston	Wahkiakum	CCAA
Total	6,539,661	96,126	67,322	71,023	57,500	19,688	246,948	3,936	562,543
Speak only English	5,303,472	89,494	61,269	65,010	52,837	17,643	218,908	3,772	508,933
Spanish or Spanish Creole	546,327	4,463	4,449	4,707	3,600	1,485	10,763	56	29,523
Vietnamese	61,610	190	136	19	49	0	3,178	0	3,572
German	30,115	186	247	202	155	76	1,935	42	2,843
Korean	48,425	58	193	27	185	6	2,299	8	2,776
Tagalog	56,497	123	126	135	171	50	1,658	9	2,272
Chinese	89,549	175	41	438	89	48	949	0	1,740
Other Pacific Island languages	29,876	176	86	35	52	15	1,192	22	1,578
Mon-Khmer, Cambodian	17,752	204	171	10	0	116	1,008	0	1,509
French (incl. Patois, Cajun)	23,906	65	93	151	68	17	798	0	1,192
Japanese	25,198	94	19	0	62	31	816	0	1,022
Russian	57,230	354	30	50	14	1	211	0	660
Other Languages	249,704	544	462	239	218	200	3,233	27	4,923

Nevertheless, in the context of improving access to care for vulnerable populations and improving health equity, both important goals of CCAA, reaching out to populations with limited proficiency in English is important. Many providers in the region offer translation services for non-English speakers. This is especially true for larger healthcare providers and providers that target their services at populations with limited proficiency in English. CCAA is seeking to establish a baseline of providers’ outreach strategies to identify potential gaps and barriers to non-English speakers accessing services. To this end, we included a question on the RFP that asks potential partners to discuss what they are doing to successfully engage with populations with limited proficiency in English in a culturally and linguistically appropriate way.

Table 24: RFP Question about Populations with Limited Proficiency in English

Describe how you have reached out to populations with limited proficiency in English or offered culturally and linguistically appropriate services. [273] * ?

The Area Agency on Aging and Disabilities of Southwest Washington (AAADSW) is located in Longview, WA, and serves Cowlitz and Wahkiakum counties. Their approach to engaging limited English proficiency and culturally diverse individuals is twofold. First, AAADSW partners with community-based organizations already serving diverse populations. AAADSW has found working with trusted partners with established relationships is key to successful outreach. One such partner is Lutheran Community Services, an organization whose client base includes a number of Russian speakers. Secondly, AAADSW conducts direct outreach and engages in annual events such as the Cowlitz Tribe Pow-Wow. AAADSW has also hired bilingual staff proficient in English and Slavic languages and has contracts with several interpreter agencies.

Another example is Willapa Behavioral Health (WBH) Clinic, located in Long Beach, WA, which serves Pacific County. WBH recently hired a bi-lingual (English/Spanish speaking) receptionist to reach the Latino communities the agency serves and contracts for interpretive services for individuals with limited English proficiency. WBH has historically offered culturally and linguistically appropriate services through annual cultural competency trainings through rigorous examination and adherence to CARF accredited quality management practices.

When the RFP process has closed and the MTP implementation partners for our region have been selected, CPAA will have a better understanding of the potential language and culture gaps and barriers in the region, not just from medical providers, but also from CBOs and social service organizations, which we can then begin to mitigate.

Moreover, when the selection of partnering providers has been finalized and implementation begins, CPAA intends to initiate a direct-outreach campaign to community members, including those for whom English is a second language. We also plan to translate the Consumer page on CPAA's website into Spanish. We have a native Spanish speaker on staff, which will ensure that our translations are culturally and linguistically appropriate.

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

ACH Response:

There are a number of community groups that may be underrepresented in Transformation efforts. Broadly speaking, they fall into two categories: tribes and Medicaid beneficiaries, who are consumers of healthcare services (consumers).

Tribes

The seven federally recognized tribes in the CPAA region have a long history of generational trauma and have suffered grievances from both the state and federal government, which has resulted in a general mistrust when working with non-tribal organizations. CPAA is committed to working with tribes in a humble and culturally respectful way to help meet their and the larger region's health care goals and priorities.

CPAA understands that building trust with seven different sovereign nations, each with their own priorities, takes time. To support this process, CPAA hired a full-time Community and Tribal Liaison who has been meeting one-on-one with each tribe in addition to supporting a quarterly meeting of the tribal health directors with CPAA. This allows for strategizing with each tribe how to best support the MTP goals while meeting the tribes' health improvement goals, as well as finding alignment among the seven tribes. Recently, CPAA was able to fill the Tribal Government Services seat on its board when Denise Walker, Health Director for the Confederated Tribes of the Chehalis, agreed to serve in this capacity.

Consumers

Medicaid beneficiaries (consumers) are historically difficult to engage due to quickly outdated contact information resulting from unstable housing, substantial socioeconomic challenges, and a long history of inequities, stigma, mistrust, trauma, and language barriers. Additionally, as a region that covers a large geographic area, engaging consumers from all seven counties, when many Medicaid beneficiaries struggle with transportation, is a challenge. Similarly, the complex, abstract nature of the MTP work to date has been a barrier to consumer engagement as well.

To begin to address these challenges, CPAA formed a Consumer Advisor Committee. Members of the committee include representatives from groups often underrepresented in health system transformation, including Medicaid beneficiaries, ethnic and racial minorities, and members of the LBGTQ community. CPAA is continuing to actively solicit additional committee members to ensure representation from all counties in the region with a broad range of lived experiences of health disparities, including individuals experiencing substance use disorder and homelessness.

Many members of the committee have a history of trauma and mistrust of those in positions of authority. As was pointed out by a committee member in a discussion about health equity, the health care system is, by design, inequitable: Medicaid reimburses at a lower rate than other insurance, and Medicaid beneficiaries have fewer choices regarding providers and treatment and often struggle with long wait-lists and other barriers to accessing care. Being poor and having poor health outcomes is a stigma difficult, and many times impossible, to overcome. Medicaid beneficiaries are accustomed to feeling judged as less worthy. There is both explicit and implicit racism and bias against ethnic and racial minorities and members of the LBGTQ community, including from health care providers. Statistically, ethnic and racial minorities suffer worse health outcomes than their white counterparts and are more likely to suffer prosecution for drug-related offenses.

Acknowledging the harm done to CPAA Consumer Advisory Committee members, both personally and to those whom they represent, by a difficult to navigate and inequitable system, is one way CPAA is trying to create a more inclusive health care delivery system. Again, CPAA understands building trust with consumers is a long-term commitment and will take time.

One strategy CPAA has employed to remove barriers to engagement for consumers is the payment of a modest monthly stipend, mileage reimbursement, and provision of a complimentary lunch for all Consumer Advisory Committee meetings. The meetings are currently held at a central location, but there is discussion of rotating the meetings within the region to make travelling more equitable for all committee members.

The committee members are eager to have their opinions heard, and they recognize that they speak for many people in an important, meaningful way. The Community and Tribal Liaison has ensured that the consumers feel safe and confident in their committee and that they have defined their group for themselves. This includes transitioning committee members into leadership roles as co-chairs. Additionally, CPAA is committed to empowering committee members to advocate for themselves by organizing advocacy training through the Justice Project.

The challenge of conveying the complex, abstract nature of the Transformation work is being addressed by developing "plain talk" translations of program work, including "translations" of key materials such as one-page program summaries (Appendix I). Additionally, CPAA Program Managers, partnering providers, and experts present at Consumer Advisor Committee meetings, allowing time for questions and

concerns in a setting more intimate and less intimidating than large CPAA Council meetings. The Community and Tribal Liaison meets with the Consumer Board Representative prior to each CPAA Council and Board meeting to go over the agenda and address any issues in advance, again in a setting more intimate than a large public meeting, to ensure the consumer board member feels confident representing her sector.

In addition to the efforts CPAA is making to include community members and groups that are historically underrepresented in health systems change, partnering providers in the region are also addressing this issue. For example, CPAA has partnered with the Healthy Living Collaborative (HLC) of Southwest Washington, participating in their quarterly meetings and as a funded partner for their 1422 grant. The HLC supports neighborhood-based Community Health Workers from three target communities in Southwest Washington, including South Kelso residents and teens in Cathlamet. These CHWs attend quarterly meetings and other convenings the HLC hosts. They provide valuable perspective on the lived experience of community members who are often missing from the planning and policy work the HLC and its partners engage in. CHWs are full members of the HLC Leadership and Policy committees.

Another example is Valley View Health Centers in Thurston County. They have a dedicated quality improvement (QI) committee that focuses on improving patient care, clinical practices, and the overall patient experience. One QI project involved increasing and improving access to care for their LGBTQ patients, and more specifically, for their transgender patients. Valley View's QI work resulted in modified patient forms to include gender affirming language and shifting the organizational culture to be more gender affirming. By shifting the culture and language used throughout their organization, they have begun to address common barriers to care that LGBTQ patients often experience when accessing medical care.

Health Equity Activities

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

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

ACH Response:

CPAA's commitment to improving health equity resulted in targeted resources set aside in the board approved DY1 funds flow model to improve health equity and address the social determinants of health. Specifically, CPAA created a Capacity Development Fund, a Regional Wellness Fund, and bonus pools for payments for implementation partners based on attribution, equity, and services provided in rural communities (Table 25).

- The Capacity Development fund will support community-based and clinical organizations with innovative ideas and specialty services on a smaller scale that would not have otherwise been chosen as MTP implementation partners.
- The Regional Wellness Fund is a pool of funds available to support investments that address social determinants of health. These funds will be used to make targeted upstream investments in community-clinical linkages such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods that complement MTP goals and investments. The target population for this fund is the most economically disadvantaged and vulnerable residents who experience the greatest health disparities.
- MTP implementation partners will receive bonus payments based on attribution, or the number of Medicaid lives served. The equity bonus payments are being calculated based on the community needs index and zip code for population served. The rural bonus is earned by serving Medicaid lives using the rural designation based on the National Center for Statistics.

Table 25: DY1 Funds Model

First-Year Funds Flow: APPROVED – May 30, 2018

Use Category	Action	%	\$
Project Management/Administration	Hold	10%	1,175,894
Reserve/Contingency	Hold	5%	587,947
Regional Wellness Fund	Hold	8%	940,715
Capacity Development Fund	Disburse	3%	335,179
Sub-Total		26%	3,039,736
Health Systems & Comm. Cap. Bldg (DY)	Invest Contractly	20%	2,285,272
Health Systems & Comm. Cap. Bldg (Tribes)	Disburse	3%	352,768
Sub-Total		31%	3,638,040
Provider Engagement	Disburse	32%	3,787,683
Provider Engagement (Tribes)	Disburse	3%	352,768
Provider Performance (Implementation Plan)	Disburse	8%	940,715
Sub-Total		43%	5,081,166
Grand Total		100%	11,758,942

NON-TRIBAL PROVIDER ENGAGEMENT			
A. Basic Engagement		93%	3,787,683
A. Basic Engagement			3,518,530
Base Payments			
Assessment Survey	Pre RFP	5%	176,384
Standard Agreement	Post RFP	5%	176,384
Project Participation	Post RFP	33%	\$1,234,683
Bonus Payments			
Attribution (Medicaid Lives Served)	Post RFP	17%	\$634,983
Equity	Post RFP	9%	\$352,768
Rural	Post RFP	7%	\$246,938
Multi-Project (4+ Projects)	Post RFP	14%	\$520,000
Local Community Forums	Post RFP	5%	176,384
B. Centers For Transformation	Hold	7%	769,152

705,537 / 7



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

ACH Response:

CPAA recognizes addressing health equity and improving foundational community supports is critical to improving overall health in the region. As a first step, CPAA used the Current State Capacity Assessment to identify barriers and resources needed to improve health outcomes and increase health equity in the region. Data was collected in each care setting by asking providers to not only identify the patients' greatest need/s, but also what barriers the provider routinely assesses for through screening questions. A common theme emerged across care settings: housing and transportation are the biggest barriers to whole-person care, confirming what the Consumer Advisory Committee and other interactions with the community had demonstrated.

Having identified these partnering providers are critical to the success of transformation activities and improving health across the region, CPAA is targeting community-based and social service organizations that provide housing and transportation services across the region. For instance, as explained above, CPAA is using the RFP and DY1 funds flow model as a vehicle to engage partners addressing health equity and social determinants of health. Thus, MTP implementation partners are being selected, in part, based on their efforts to address health equity and social determinants of health. In DY3, when providers are scaling up, CPAA will facilitate a scale-up that specifically addresses gaps in care and impacts on the target populations.

Going forward, the Consumer Advisory Committee will play a key role in ensuring that health equity continues to be assessed and prioritized by CPAA and its partnering providers. The committee will be asked to help develop a regional "health equity dashboard" with key indicators of health equity in the

region. The committee will periodically review the progress made on our region's journey to improved health and health equity using this dashboard. Findings will be shared not only with the CPAA Council and Board, but also with the network of partnering providers. In fact, partnering providers will be asked to track progress for their organization on a set of key health equity indicators that make up the larger region's dashboard. To this end, partnering providers will establish baselines for key health equity indicators this fall.

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

ACH Response:

Improving health equity is one of CPAA's foundational values. As such, the region has had a number of conversations about how best to reduce health disparities. The CPAA Council, work groups and, most recently, the Clinical Advisory Committee, have all discussed different health equity tools. Although consensus has not yet been reached on the utility of the various tools and consequently no specific tool or tools have been adopted as standard evaluation tools for the region, the discussions have been robust, and providing partners are committed to continuing exploration of available options.

The Clinical Advisory Committee has agreed to catalog potential screening tools to assess social determinants of health in provider settings and make the tools available to implementation partners. Once the committee has completed this review, all partnering providers will be required to use an assessment tool going forward, though they will be given the option to choose from a list of assessment tools. Implementation partners will be required to report on the use of their chosen assessment tool, and they will also be required to report regularly on progress made on certain key health equity indicators that make up a regional health equity dashboard.

To support the committee, CPAA in general, and our providers in the selection of appropriate health equity tools, CPAA staff participated in the West Coast Payer and Provider Summit to address social determinants of health for complex situation June 4-5, 2018, in Scottsdale, Arizona. Strategies to implement a population health approach to intervene with high-risk patients were discussed, including tools and resources available to identify and track health outcomes. CPAA will continue to invest in these types of professional development opportunities to make sure our region and partnering providers have the right tools to assess for and monitor health equity.

In an effort to share learning, CPAA also plans to confer with other ACHs in the state to learn what health equity tools they are either considering or have adopted, and we plan to take advantage of other shared learning opportunities, such as the upcoming Healthier Washington health equity summit later this year, to learn about potential tools.

Budget and Funds Flow

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

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

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

Yes	No
X	

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

ACH Response:

Please see CPAA.SAR1.Attachment1.7.31.18 for CPAA’s audited financial report. For the fiscal year 2016-2017 audit, there were no findings which required resolution. CHOICE Regional Health Network, the administrative support organization for CPAA, and CPAA ACH received an unmodified audit opinion. Because the audit includes both CHOICE and CPAA financials, the audit is available on request.

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

ACH Response:

Not Applicable

2. Design Funds

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

3. DY 1 Earned Incentives

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

4. Integration Incentives

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

- a. Describe how the ACH has prioritized, or will prioritize, integration incentives to assist Medicaid behavioral health providers transitioning to fully integrated managed care. Include details on how Medicaid behavioral health providers and county

government(s) have or will participate in discussions on the prioritization of these incentives.

ACH Response:

Not Applicable.

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

ACH Response:

Not Applicable.

5. Total Medicaid Transformation Incentives

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

CPAA SAR1 Appendixes

From: [Laura Spoor](#)
Subject: Instructions: CPAA State Capacity Assessment
Date: Wednesday, February 28, 2018 11:38:17 AM

February 28, 2018

Dear CPAA Partner,

Healthier Washington's Medicaid Transformation Project (MTP) is an unprecedented opportunity for our region to earn funds for investments in six interrelated project areas: health care integration, care coordination, care transitions, opioid response, reproductive and maternal/child health, and chronic disease prevention and control.

Recently, Cascade Pacific Action Alliance (CPAA), our region's Accountable Community of Health, was awarded top marks for its Project Plan, receiving 100 percent of total possible points and earning \$9.3 million in start-up funding for our partnering organizations.

CPAA is developing a strategic and coordinated approach to health improvement across all six project areas in collaboration with our partners, ensuring the most effective use of MTP resources. Investments made in the six project areas are intended to improve the care delivery system and transform the way health care is provided in the region, benefitting everyone in our communities, including Medicaid beneficiaries.

CPAA will be conducting an **assessment of current capacity and available services** in the region related to the six improvement areas to identify issues affecting access to care and MTP implementation. This assessment will be in the form of an **online survey** through Survey Monkey, **emailed March 5, 2018**, to stakeholders and partners. The survey will also be available online at cpaawa.org.

Your participation in the survey is vital to ensure a data-driven approach to health improvement investments in the region. **CPAA will use survey responses to identify gaps and assets in existing services and inform decisions about selecting partnering providers and investment areas.**

Participation in the assessment may qualify your organization for a stipend to participate in implementation planning and receive planning related performance-based payments. Additionally, CPAA intends to use the survey results to structure a forthcoming Request for Proposals process, which will result in the selection of partnering providers and the opportunity to earn additional project funds.

CPAA's assessment survey is best completed by a group of 2-3 staff members with in-depth knowledge of clinical practices, financing, and care delivery oversight. We strongly encourage you to complete the survey as a group or gather input from your team to inform your answers. A PDF version of the survey questions will be available for review at cpaawa.org and will be emailed to your organization before the survey period opens. The survey will include skip-logic, so you are not required to answer all the questions, although we encourage complete responses. The survey will take you about 30 - 40 minutes to complete. CPAA will contact you to follow-up if additional information is required.

To the greatest extent possible, CPAA will report assessment findings in aggregate and will make

every effort to preserve the confidentiality of you and your organization.

Please forward the assessment to organizations in the region that might be interested in participating in the MTP.

Please contact **Christina Mitchell, CPAA Clinical Programs Director**, if you have any questions or need assistance responding to the assessment: mitchellc@crhn.org or 360-539-7576 ext. 131.

Health is more than health care: It is the total well-being of individuals, families, and communities. Therefore, we hope the survey will be completed not only by traditional health care providers, but also by social service agencies and other organizations providing community supports. **Please be advised that CPAA has set aside MTP funds specifically to support non-traditional health care partners.**

Thank you for supporting building safer, healthier communities in the region by taking the time to share your expertise through the forthcoming survey.

Sincerely,

Winfried Danke
Chief Executive Officer
Cascade Pacific Action Alliance

danke@crhn.org | www.crhn.org | www.cpaawa.org



CONFIDENTIALITY NOTICE: This e-mail (including any documents accompanying it) may contain confidential information belonging to the sender. The information is intended only for the use of individuals or entities named above. If you are not an intended recipient, you are prohibited from disclosing, copying, or distributing this information or taking any action in reliance on the contents. If you have received this email in error, please immediately notify me by telephone.

From: [Laura Spoor](#)
To: [Christina Mitchell](#)
Subject: CPAA State Capacity Assessment
Date: Monday, March 5, 2018 2:17:04 PM
Attachments: [CPAAStateAssessment.pdf](#)

Dear CPAA Partner,

As referenced in the email sent last week, the CPAA State Capacity Assessment Survey is now online:
https://www.surveymonkey.com/r/CPAA_Assessment

The survey can also be found on our [website](#).

A PDF version of the survey questions is attached for your review prior to starting the assessment. The survey incorporates skip-logic, so you may not be required to answer all the questions.

Please complete the assessment by March 26, 2018.

Feel free to contact CPAA Clinical Programs Director, Christina Mitchell, if you have any questions or need assistance responding to the assessment: mitchellc@crhn.org

Sincerely,
Winfried Danke
Chief Executive Officer
Cascade Pacific Action Alliance

Assessment Introduction & Instructions:

Thank you for taking part in Cascade Pacific Action Alliance's state capacity assessment. CPAA will use survey responses to identify gaps and assets in existing services, inform implementation planning, and assist with selecting partnering providers. Your participation in the survey is vital to ensure a data-driven approach to Medicaid Transformation Project (MTP) health improvement investments in the region.

CPAA's assessment survey is best completed by a group of 2-3 staff members with in-depth knowledge of organizational practices, financing, and programmatic services and/or care delivery oversight. We strongly encourage you to complete the survey as a group or gather input from your team to inform your answers. [Click here for a PDF version of the survey questions](#) to review prior to starting the assessment. The survey incorporates skip-logic, so you may not be required to answer all the questions. A prepared respondent can expect the survey to take about 30 - 60 minutes to complete, depending on your organization type.

We encourage complete responses and ask that you please read full survey questions before answering. Please note, respondents can change their answers on any survey page until they complete the survey; if respondents exit the survey and go back to it, it records a new response — it doesn't update their existing response. Recognizing your time constraints and busy schedules, CPAA intentionally designed the assessment so organizations providing different types of services only have to complete it once.

You may have been asked to complete a previous survey for Care Coordination (Pathways). This is an independent assessment that includes additional Transformation Project Areas.

Please complete the assessment by March 26, 2018.

Contact Christina Mitchell, CPAA Clinical Programs Director, if you have any questions or need assistance responding to the assessment: mitchellc@crhn.org or 360-539-7576 ext. 131.

Demographics

1. Respondent Information

Your Name

Organization

Email Address

Phone Number

2. Counties your organization serves (Please check all that apply.)

Cowlitz

Grays Harbor

Lewis

Mason

Pacific

Thurston

Wahkiakum

3. About how many Medicaid beneficiaries do you serve?

4. In what year was your organization founded?

5. About how many employees work at your organization?

6. Which of these categories best matches your organization? (Please check all that apply.)

- Medical Provider (Primary Care, Specialty, Hospital, or Emergency Department)
- Behavioral Health Provider (Substance Use Treatment and Mental Health Treatment)
- Tribal Health Clinic
- Tribal Behavioral Health
- Fire & Rescue / EMS
- Law Enforcement
- Education Organization
- Payer (Managed Care or Behavioral Health Organization)
- Community Action Agency/Program
- Public Health
- Area Agency on Aging
- County Human Services
- State Agency or Association (DSHS, DOH, HCA, WSHA, WSMA, etc...)
- Syringe Exchange Services
- Other Social Service Agencies (not otherwise described)
- Other Community-Based Organization (otherwise not described)

7. If your organization would like to be eligible to potentially receive a stipend for completing this assessment survey, please provide the following information:

*Transformation funds are being structured through a Financial Executor portal. The Financial Executor verifies provider names and EINs before inviting you to register with the portal. It is important you provide your organization name exactly as it appears in your Form W9.

**This is not a contract. Registering with the Financial Executor portal is a prerequisite for receiving Transformation funding; however, registration does not guarantee funding. This is the name of the individual who will serve as the administrator for your organization's account in the portal.

Organization Legal Name*

Employer Identification Number (EIN)

Contract Manager First Name**

Contract Manager Last Name

Contract Manager Phone Number

Contract Manager Email

8. Does your organization provide clinical services?

YE

S

NO

All Clinical Providers

9. Which level of integration best describes your practice/clinic/organization? [2101]

- Level 1 – Minimal Collaboration: Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.
- Level 2 – Basic Collaboration at a Distance: Providers have separate systems at separate sites but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.
- Level 3 – Basic Collaboration Onsite: Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular.
- Level 4 – Close Collaboration in a Partly Integrated System: Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other's roles and cultures.
- Level 5 – Close Collaboration in a Fully Integrated System: Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise.

10. Please list partners you routinely collaborate with around integrated care or other health care services. Enter N/A if none. [2102]

11. Please list partners or types of partners that would be most helpful for developing an integrated care program. Enter N/A if none. [2103]

12. What does your organization need most to implement an integrated care program? [2104]

13. Please check all of the following aspects of integrated care that you are interested in exploring: [2105]

- Integrated care teams
- Data sharing agreements between physical and behavioral health
- Colocation of physical and behavioral health providers in the same facility
- Opioid use disorder treatment
- Substance use disorder treatment (other than opioid use disorder)
- Care team meetings or case staffing (when staff from different organizations meet around a shared patient or client)
- Telehealth
- Telepsychiatry
- Enhanced collaboration (contractual agreements between physical and behavioral health providers around service delivery)
- Shared workforce (such as primary care providers or behavioral health providers)
- Not interested or does not apply
- Other (please specify)

14. What are the most important needs in your patient population that could be addressed with integrated care? [2106]

15. What are your biggest challenges to implementing an integrated care program? (Please check all that apply.) [2107]

- Start-up cost is too high
- Long-term, sustainable funding
- Lack of support from administrative leaders
- Lack of support from clinical staff
- Workforce shortages
- Unsure where to start
- Other (please specify)

16. Are you currently receiving technical assistance to implement integrated care from any of the following? (Please check all that apply.) [2108]

	YES, currently receiving TA	NO, but I'm interested in receiving TA	NO, I'm not interested
Advancing Integrated Mental Health Solutions (AIMS) Center	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Qualis Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse and Mental Health Services Administration (SAMHSA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pediatric-Transforming Clinical Practice Initiative (P-TCPI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (Please specify if you are currently receiving technical assistance to implement integrated care or are interested.)

17. How do you see CPAA supporting your efforts to develop or further implement an integrated care program? (Please check all that apply.) [2110]

- Programmatic funding
- Establishing a patient registry
- Assisting with health information technology
- Funding for workforce
- Organizing trainings for providers and staff
- Providing direct technical assistance
- Provider recruitment
- Loan repayment funding
- Developing a learning collaborative
- Not interested or does not apply
- Other (please specify)

18. Does your organization offer primary care?

- YES
- NO

Primary Care

19. Is there involvement and support from key senior leadership and clinic leadership to implement an integrated care program? [2111]

- Yes
- No
- Somewhat

20. Does your practice have a plan in place for integrating behavioral health? [2112]

- Yes
- No
- Somewhat
- No, but we are interested in developing a plan

21. Do providers screen for behavioral health conditions using valid instruments? (Please check all that apply.) [2113]

- PHQ-9 - Patient Health Questionnaire
- GAD-7 - Generalized Anxiety Disorder 7-item
- SBIRT - Screening, Brief Intervention, and Referral to Treatment AUDIT-
- C - Alcohol Use Disorders Identification Test
- DAST-10 - Drug Abuse Screening Test
- Other (please specify)

22. Do providers in your practice prescribe opioids to treat patients for chronic pain? [2114]

- Yes
- No
- Unsure

23. Do providers in your practice use an assessment tool (e.g. Pain, Enjoyment of Life, General Activity Scale, or Graded Chronic Pain Scale) to assess pain before prescribing opioids to patients? [2115]

- Yes, we use an assessment tool
- Yes, but we use some other form of assessment
- No
- Unsure

24. Do providers in your practice use a patient screening tool (e.g. OpioidRiskTool or CAGE-AID Questionnaire) for opioid addiction or substance abuse before prescribing opioids? [2116]

- Yes, we use a screening tool
- Yes, but we use some other form of screening
- No
- Unsure

25. Do you currently have a behavioral health provider(s) who works in your primary care setting? [2117]

- Yes (please explain below)
- No

Yes (please explain)

26. Please answer the following about providers: [2118]

	Yes	No	Unsure
Do providers in your practice discuss other methods of treatment for chronic pain (e.g., non-opioid medication, physical therapy, injections, behavioral treatment) before prescribing opioids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have providers in your practice been trained in the past 3 years on how to treat acute pain for patients with opioid use disorder (OUD)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice use Centers for Disease Control (CDC) guidance for Hepatitis C and HIV testing of injection drug users?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice test patients in the 1945-1965 birth cohort for Hepatitis C?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Which evidence-based brief interventions and psychotherapies are offered to your patients by a behavioral health provider in your practice? (Please check all that apply.) [2122]

- Problem Solving Treatment
- Cognitive Behavioral Therapy
- Behavioral Activation
- Other (please specify below)
- None
- Please specify if Other

28. Do any providers in your practice prescribe medication assisted treatment (MAT)? (Please check all that apply.) [2123]

- Yes, buprenorphine
- Yes, methadone
- Yes, naltrexone
- Yes, some other form
- No
- Unsure

29. Would new buprenorphine prescribers find a support program for new prescribers to engage with helpful? [2124]



Yes

No



Unsure N/A

30. Which opioid prescribing guidelines does your practice follow? (Please check all that apply.) [2125]

- The Bree Collaborative
- CDC - Center for Disease Control and Prevention
- AMDG - Agency Medical Directors' Group
- SUDP - Substance Use During Pregnancy
- None
- Other (please specify)

31. Are any of the following used in your practice to implement opioid prescribing guidelines and/or ensure safe opioid prescribing practices? (Please check all that apply.) [2126]

- Train providers on prescribing guidelines
- Build guidelines into the electronic health record (EHR)
- Use written patient/provider agreements
- Include documentation in patient records
- Participate in the WA's Prescription Monitoring Program
- Provide patient education
- Other (please specify)

32. Do providers monitor treatment response at each contact with a valid outcome measure such as the Patient Health Questionnaire (PHQ-9)? "Provider" is a general term for a member of the primary care team. [2127]

- Yes
-
- Somewhat
- No

Other (please specify)

33. Does your practice use a population-based registry to systematically track patients? [2128]

If yes, which registry tool is used?

If yes, which behavioral health metrics are tracked?

If no, are you interested in using a registry?

34. Does your practice track referrals to any of the following? (Please check all that apply.) [2129]

Behavioral health

Specialty care

Social services

Community-based resources

No (please describe)

35. Are psychiatric services available onsite, with a partner organization, or via telepsychiatry and coordinated with primary care? [2130]

Yes, onsite

Yes, with a partner

organization Yes, via telepsychiatry

No

36. Does your practice conduct regular (e.g. weekly) psychiatric caseload review on patients who are not improving? [2131]

Yes

No (please describe)

37. Are psychiatric assessments conducted for patients with high behavioral health needs in-person or via telemedicine? [2132]

Ye

s

No

38. Is the practice open to learning more about facilitating low barrier buprenorphine treatment? (Low barrier: prescribed unobserved induction exclusively, saw patients no more than weekly, and did not require additional psychosocial treatment.) [2133]

- Yes
- No
- Unsure

39. Do you routinely (e.g. monthly) examine provider and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement? [2134]

Yes (please describe your quality improvement process):

No (please describe):

40. Do providers at your practice do any of the following when they prescribe opioids for chronic pain? (Please check all that apply.) [2135]

- Discuss using the lowest effective dose
- Discuss signs of overmedication/overdose
- Discuss potential for addiction
- Discuss safe storage of medication
- Other (please specify)

41. Please answer the following about providers: [2136]

	Yes	No	Unsure
Do providers assess appropriateness for take-home naloxone? (Note Agency Medical Directors' Group - AMDG - criteria: mental health disorder per Diagnostic and Statistical Manual of Mental Disorders Fifth Edition - DSM 5, family or personal history of substance use disorder, medical condition that could increase sensitivity to opioid-related side effects, current use of benzodiazepines, tobacco use)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice prescribe naloxone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice ask all patients if they have used injection drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

42. Does your program or practice discontinue care for patients with opioid use disorder or substance use disorder when they relapse? [2139]

Yes

No

43. If you are implementing a specific integrated care model, which model or aspects of a model are you implementing? [2140]

44. Related to social determinants of health, which of the following services do your patients or clients need most? (Please check all that apply.) [2141]

Housing

Transportation

Detox

Mentoring

Overdose Prevention

Medication Assisted Treatment (MAT)

Substance Use Disorder (SUD) Treatment

Recovery Supports

Other (please specify)

45. Does your practice receive notification when one of your patients... [2306]

	Yes, via shared EHR	Yes, via HIE	Yes, via fax	Yes, other	No
is admitted to the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
is discharged from the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your practice follow up / provide feedback to the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Yes, Other (please specify)

46. What is your average wait time for a scheduled follow-up appointment after hospital or in-patient discharge? [2308]

- 0-7 days
- 7-14 days
- 14-21 days
- 21 or more

47. For patients who have been discharged from the hospital, which of the following elements has your practice adopted? (Please check all that apply.) [2310]

- Clinical case management for high risk, complex patients
- Medication reconciliation
- Patient and caregiver education using the "teach back" method
- Follow-up visit with primary care provider within 7 days of patient discharge
- Follow-up visit with primary care provider within 30 days of patient discharge
- Patient and family engagement in treatment plan
- Other (please specify)

48. What do you need to implement OneKeyQuestion? (Please check all that apply.) [3201]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

49. What do you need to provide long-acting reversible contraceptives? (Please check all that apply.)

[3202]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

50. What do you need to increase chlamydia screenings in women ages 16-24? (Please check all that apply.) [3203]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

51. What do you need to implement BrightFutures or EnrichedMedicalHomeIntervention? (Please check all that apply.) [3204]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

52. What do you need to increase immunization rates in children? (Please check all that apply.) [3205]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

53. What do you need to become a trauma-informed care practice? (Please check all that apply.) [3206]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

54. Does your practice routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors?

Routinely assess means there is documentation in the patient record of screening questions being asked. Well-defined intervention plan means there is documentation in the patient record of screening questions being asked AND a documented work process for intervening for positive risk factors. Resources used for intervention can be located either within the practice (e.g. diet and exercise counseling) or by referral to an outside source (e.g. substance abuse counselor or clinic). [3401]

	Routinely Assess	Well-defined intervention plan	N/A	No, we don't assess
Tobacco use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nutrition / Healthy Eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression / other mental illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High risk sexual behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise / inactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication adherence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other TBD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

55. Does your practice maintain a chronic disease registry or registries? [3402]

- Yes, electronic (part of the Electronic Health Record - EHR)
- Yes, electronic (separate software)
- Yes, electronic (Excel or access file)
- Yes, paper file
- No

If no, do you plan to establish a registry, and if so, when / for what condition? (please specify)

56. Stanford Chronic Disease Self-Management Program (CDSMP):

Please select the response option that best describes your practice. [3403]

- Our practice currently offers the Stanford Chronic Disease Self-Management Program (CDSMP) on-site.
- Our practice does not offer or refer to CDSMP.
- Our practice does not currently offer the Stanford Chronic Disease Self-Management Program (CDSMP) on-site, but refers patients to a local / community-based organization that offers CDSMP.
Who do you refer to?

57. National Diabetes Prevention Program (NDPP):

Please select the response option that best describes your practice. [3404]

- Our practice currently offers the National Diabetes Prevention Program (NDPP) on-site.
- Our practice does not offer or refer to NDPP.
- Our practice does not currently offer the National Diabetes Prevention Program (NDPP) on-site, but refers patients to a local / community-based organization that offers NDPP.
Who do you refer to?

58. Our practice currently offers the following: (Please check all that apply) [3405]

- Asthma education (on-site)
- Referrals to asthma education (off-site / community-based)
- Home visits for asthma services
- COPD - Chronic Obstructive Pulmonary Disease education (on site)
- Referrals to COPD - Chronic Obstructive Pulmonary Disease - education (off-site / community-based)
- Home visits for COPD - Chronic Obstructive Pulmonary Disease - services
- Hypertension education (on-site)
- Referrals to hypertension education (off-site / community-based)
- Home visits for hypertension
- Support for home-based blood pressure monitoring
- Diabetes education (on-site)
- Referrals to diabetes education (off-site / community-based)

59. Does your organization offer behavioral health services (mental health and/or substance use disorder)?



- YES
- NO

Behavioral Health or Substance Use Disorder

60. Is there involvement and support from key senior leadership and clinic leadership to implement an integrated care program? [2142]

- Yes
- Somewhat
- No

61. Does your practice have a plan for integrating primary care? [2143]

- Yes
- Somewhat
- No
- No, but we are interested in developing a plan

62. Do you record any of the following physical health indicators in a patient's record? (Please check all that apply.) [2144]

- Body Mass Index (BMI)
- Blood pressure
- Smoking status
- Lab results (glucose, lipid values, etc.)

63. Do providers in your practice prescribe opioids to treat patients for chronic pain? [2145]

- Yes
- No
- Unsure

64. Do providers in your practice use an assessment tool (e.g. Pain, Enjoyment of Life, General Activity Scale, or Graded Chronic Pain Scale) to assess pain before prescribing opioids to patients? [2146]

- Yes, we use an assessment tool
- Yes, but we use some other form of assessment
- No
- Unsure

65. Do providers in your practice use a patient screening tool (e.g. OpioidRiskTool or CAGE-AID Questionnaire) for opioid addiction or substance abuse before prescribing opioids? [2147]

- Yes, we use a screening tool
- Yes, but we use some other form of screening
- No
- Unsure

66. Are physical health diagnoses made in your practice? [2148]

- Yes
- No

If yes, please specify which diagnoses:

67. Do providers ask about any of the following routine preventative care? (Please check all that apply.) [2149]

- Mammograms
- Immunizations
- Annual checkups
- No
- Other

If No, please describe.

If Other, please specify.

68. Please answer the following about providers: [2150]

	Yes	No	Unsure
Do providers in your practice discuss other methods of treatment for chronic pain (e.g., non-opioid medication, physical therapy, injections, behavioral treatment) before prescribing opioids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have providers in your practice been trained in the past 3 years on how to treat acute pain for patients with opioid use disorder (OUD)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice use Centers for Disease Control (CDC) guidance for Hepatitis C and HIV testing of injection drug users?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice test patients in the 1945-1965 birth cohort for Hepatitis C?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

69. Do providers prescribe and manage chronic disease medications as clinically indicated? [2154]

Yes

No

If yes, for which conditions?

70. Do any providers in your practice prescribe medication assisted treatment (MAT)? (Please check all that apply.) [2155]

	Yes	No	Unsure
Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Naltrexone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Some other form	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

71. Would new buprenorphine prescribers find a support program for new prescribers to engage with helpful? [2156]

Yes

No

Unsure

N/A

72. Which opioid prescribing guidelines does your practice follow? (Please check all that apply.) [2157]

Bree - The Bree Collaborative

CDC - Centers for Disease Control and Prevention

AMDG - Agency Medical Directors' Group

SUDP - Substance Use During Pregnancy

None

Other (please specify)

73. Are any of the following used in your practice to implement opioid prescribing guidelines and/or ensure safe opioid prescribing practices? (Please check all that apply.) [2158]

- Train providers on prescribing guidelines
- Build guidelines into the electronic health record (EHR)
- Use written patient/provider agreements
- Include documentation in patient records
- Participate in the WA's Prescription Monitoring Program
- Provide patient education
- None
- Other (please specify)

74. Is your practice using a population-based registry to systematically track any of the following physical health metrics? (Please check all that apply.) [2159]

- BMI - Body Mass Index
- BP - Blood Pressure
- HbA1C - Hemoglobin A1c
- No, but I am interested in using a registry
- No, I am not interested in using a registry
- Other (please specify)

75. Does the integrated care team proactively reach out to patients who do not attend follow-up appointments in primary care or specialty medical care? [2160]

- Yes
- Yes, some of the
- time No (please

describe)

76. Do providers track referrals to any of the following? (Please check all that apply.) [2161]

- Primary care
- Specialty care
- Social services
- Community-based resources
- No (please specify)

77. Are care managers and/or coordinators in place to support an integrated care program? [2162]

Yes

No

If Yes, what position types do you have?

If No, please describe.

78. Do you have effective communication mechanisms for care coordination and to promote effective communication with primary care providers? [2163]

Yes

No

If yes, explain

79. Is a primary care practitioner or consultant hired or under contract for consultation and/or direct patient care? [2164]

Yes

No

If yes, explain

80. Do you routinely (e.g. monthly) examine provider and program-level outcomes (e.g. clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement? [2165]

Yes

No

If Yes, please describe your quality improvement process.

If No, please describe.

81. Is the practice open to learning more about facilitating low barrier buprenorphine treatment? (Low barrier: prescribed unobserved induction exclusively, saw patients no more than weekly, and did not require additional psychosocial treatment.) [2165]

Yes

No

Unsure

82. Do providers at your practice do any of the following when they prescribe opioids for chronic pain? (Please check all that apply.) [2167]

Discuss using the lowest effective dose

Discuss signs of overmedication/overdose

Discuss potential for addiction

Discuss safe storage of medication

Other (please specify)

83. Do any providers in your practice: [2168]

	Yes	No	Unsure
Do providers assess appropriateness for take-home naloxone? (Note Agency Medical Directors' Group - AMDG - criteria: mental health disorder per Diagnostic and Statistical Manual of Mental Disorders Fifth Edition - DSM 5, family or personal history of substance use disorder, medical condition that could increase sensitivity to opioid-related side effects, current use of benzodiazepines, tobacco use)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice prescribe naloxone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do providers in your practice ask all patients if they have used injection drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

84. Does your program or practice discontinue care for patients with opioid use disorder or substance use disorder when they relapse? [2171]

Yes

No

85. If you are implementing a specific integrated care model, which model or aspects of a model are you implementing? [2172]

86. Related to social determinants of health, which of the following services do your patients or clients need most? (Please check all that apply.) [2173]

Housing

Transportation

Detox

Mentoring

Overdose Prevention

Medication Assisted Therapy (MAT)

Substance Use Disorder (SUD) Treatment

Recovery Supports

Other (please specify)

87. Are you a skilled nursing or long term care facility?

YE

S

NO

Skilled Nursing or Long Term Care Facility

88. Does your organization routinely receive referrals from patients being discharged from in-patient services? (Please check all that apply.) [2311]

- Yes, via shared EHR - Electronic Health Record
- Yes, via HIE - Health Information Exchange
- Yes, via fax
- Yes, via telephone
- No, we only provide services at patient request, not by referral
- Yes, Other (please specify)

89. Do you receive a discharge summary or treatment plan? [2312]

- Yes, directly from the discharging facility
- Yes, the patient provides a copy
- No
- Yes, Other (please specify)

90. How do you receive reimbursement for your services? (Please check all that apply.) [2313]

- Via Medicaid reimbursement
- Via a grant
- Via state funding
- Via donated funds
- Other (please specify)

91. Do you contact the discharging hospital or primary care doctor with any discharge concerns? (Please check all that apply.) [2314]

- Yes, we regularly exchange information
- Yes, but communication varies based on the provider
- Yes, but we seldom get feedback in return
- No, we do not regularly communicate with medical providers
- Other (please specify)

92. Do you provide in-patient services?



- YES
- S
- NO

Questions for Hospital Partners

93. Does your organization have any of the following: (Please check all that apply.) [2301]

- Written procedures for transitional care planning
- Transitional care planning applied to all behavioral health patients
- Transitional care planning applied to all in-patient medical patients
- No, we do not have transitional care planning
- Other: Transitional care planning is applied to:

94. Does your organization use an evidence-based method for screening patients for transitional care planning needs? [2301-1]

- No
- Yes, please list the evidence-based method(s) used

95. Does your organization: (Please check all that apply.) [2301-2]

- Provide a transitional care planning evaluation upon request by the patient, patient's family/caregiver(s), or patient's physician?
- Engage the patient and the patient's caregiver(s) in creating the discharge plan?
- Know the capabilities of post-acute and community providers, including support services?
- Not just refer – but arrange for – follow up appointments?
- Not just refer – but arrange for – durable medical equipment to be secured?
- Not just refer – but arrange for – post-hospital services and supports?
- Do you communicate – allowing for questions and clarifications – with receiving providers?
- Routinely reassess patients for their transitional care needs?
- Teach patients and their families self-care skills using the teach-back technique?
- Analyze and trend readmission data and look for root causes?
- Other (please specify)

96. Does your organization teach patients and their families self-care skills using the teach-back technique: (Please check all that apply.) [2301-2]

- Yes, the education and training provided to the patient or patient's caregiver(s) is tailored to the patient
- Yes, teach-back is used to confirm understanding of medication, appointments, self-management tasks, and other follow-up activities
- No, the teach-back technique is not used, but we would like to implement
- No, we do not use the teach-back technique

97. Does your organization analyze and trend readmission data and look for root causes to...: (Please check all that apply.) [2301-3]

- Reassess the effectiveness of your discharge planning process on an ongoing basis
- Track readmissions to your own hospital on an ongoing basis (at least quarterly)
- Track Emergency Department utilization to identify patterns of reoccurring avoidable hospital utilization
- No, we don't analyze readmission data

98. Does your organization currently conduct a systematic screening to determine the risk of hospital readmission for admitted patients? [2203]

- Yes, for all patients
- Yes, for some patients
- Yes, for patients seen in the ED
- No, but we would like to implement screening
- No, we do not screen to determine readmission risk

99. If Yes to the question above, which screening tool(s) do you use? [2303-1]

- LACE Tool
- HOSPITAL score
- BOOST/8Ps
- Other (please specify)

100. If only screening some patients, which patients receive screening? (Please check all that apply.) [2303-2]

- Patients over age 65
- Patients over age 70
- Multiple diagnosis and co-morbidities
- Greater than 5 complex medications
- Impaired mobility
- Impaired self-care skills
- Poor cognitive status
- Catastrophic injury or illness
- Homeless
- Poor social supports
- Chronic illness
- Anticipated long term health care needs (e.g. new diabetic)
- Substance abuse
- History of multiple hospital admissions
- History of multiple ED visits
- Other (please specify)

101. Does your organization notify primary care providers (and other involved services such as in-home and skilled nursing facilities) of their patient's emergency department visit and/or hospital admission? [2304]

- Yes, via shared electronic health record (EHR)
- Yes, via health information exchange (HIE)
- Yes, via
- fax No
- Yes, Other (please specify)

102. What barriers do you face when coordinating transitional care? (Please checkall that apply.) [2305]

- Access to transitional facilities (long term care, skilled nursing, etc.)
- Access to follow-up appointments (primary care physician, physical therapy)
- Transportation
- Stable housing
- Poor communication with family or caregiver
- Other (please specify)

103. Does your organization want to implement or expand transitional care evidence-based methods?
[2202]

Yes

No

If Yes, which model? How can CPAA assist?

104. Do you provide syringe exchange services?

YES

NO

Syringe Exchange Services

105. How many providers work at your practice? Include MD, DO, PA, ARNP in your count. [2204]

Physicians (MDs and DOs)

Advanced Registered Nurse Practitioners (ARNPs)

Physician's Assistants (PAs)

Other

TOTAL

106. How many syringes did your program distribute in calendar year 2017? [2205]

107. How many syringes were returned/collected in calendar year 2017? [2209]

108. Are your services co-located with another agency? [2206]

Yes

No

If Yes: Are syringe exchange services and the co-located agency's services integrated?

109. How many participants received syringe exchange services in calendar year 2017? (Please enter a whole number) [2207]

110. What percentage of these syringes do you estimate were distributed via secondary exchange and/or peer delivery services? (Please enter a whole number between 0 and 100) [2208]

0 100

111. Do you use some kind of unique identifier (e.g., assign each individual a number or code)? [2213]

- Yes
 No
 Unsure

112. How many unique (unduplicated) individuals do you estimate received syringe exchange services in calendar year 2017? (Please include direct contact participants and those served via secondary exchange and/or peer delivery services.) [2218]

113. Did your program distribute naloxone at any point in 2017? [2210]

If Yes, please specify how many kits distributed.

If Yes, please specify how many reported reversals.

If No, please describe.

114. Where is your program located? (If you have multiple or mobile sites, please use the location of main site.) [2211a]

- Rural
 Suburban
 Urban
 On a reservation

115. If you have multiple or mobile sites, where are your other sites located? (Please check all that apply.) [2212]

- Rural
- Suburban
- Urban
- On a reservation
- Does not apply

116. In 2017, how much (\$ amount) of your program's syringe exchange budget came from city government, county government, etc.? Please be sure to include ALL funding sources. (Please enter a whole number per row) [2214]

City government \$

County government \$

State government \$

Private foundations \$

Donations from individuals/fundraising \$

Out-of-pocket (staff donations) \$

NASEN - North American Syringe Exchange Network \$

Donations from Community-Based Organizations \$

Corporate donations \$

Other \$

117. About your program [2216]

	Yes	No	Unsure
Did your program have 501c3 status (tax-exempt status) in 2017?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In 2017, was your program operated by a public health department?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

118. What percentage of your participants are female, male, or transgendered? (Please enter 0 if none. Please estimate if no records are kept.)

Female %

Male %

Transgendered %

119. What percentage of your participants are in the following age categories? (Please enter 0 if none. Please estimate if no records are kept.) [2220]

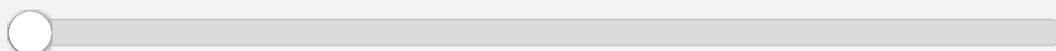
Under age 30 (%)

Age 30 - 49 (%)

Age 50 and up (%)

120. What percentage of your participants are of Hispanic, Latino, or Spanish origin? (Please enter 0 if none. Please estimate if no records are kept.) [2221]

0	100	<input type="text"/>
---	-----	----------------------



121. What percentage of your participants are [African American, Asian/Pacific Islander, ...]? (please enter a whole number between 0 and 100, Please estimate if no records are kept.) [2221-1]

American Indian/Alaska Native

Asian

Black or African American

Native Hawaiian/Other Pacific Islander

White/Caucasian

Biracial/Mixed

Other

122. Does your program collect information on health insurance coverage of participants? [2218]

Yes

No

123. What percentage of syringe exchange participants have health insurance? Please estimate if no records kept or records are not easily available. (Enter 0 if none). [2223]

% participants with Medicaid

% participants with Medicare

% participants with other health insurance

% participants with no health insurance

124. What percentage of your participants inject the following substances or substance combinations? Percentages do not need to add to 100%. Please estimate if no records are kept or records are not easily available. [2224]

Heroin by itself %

Meth by itself %

Heroin and Meth %

Heroin mixed w/ another drug NOT Meth %

Cocaine by itself (including crack) %

Cocaine mixed w/another drug NOT heroin %

Other amphetamine (uppers/Dexedrine) %

Other opiates (OxyContin, Percodan, etc) %

Steroids %

HIV medications and/or insulin %

Downers (benzodiazepines, tranquilizers) %

Silicone %

Hormones %

Methadone %

Buprenorphine/Suboxone %

Fentanyl by itself or mixed w/other drug(s) %

Any other substance(s) %

125. If you reported "any other substance(s)" in the previous question, please specify: [2224-1]

126. What are the reported drugs of choice for your participants? [2225]

127. What services do participants in your program most need? (Please check all that apply.) [2226]

- Housing
- Transportation
- Detox
- Mentoring
- MAT - Medication Assisted Treatment
- Overdose Prevention
- SUD - Substance Use Disorder Treatment
- Recovery Supports
- Other (please specify)

128. Do you plan to provide community paramedicine services?



YE

S

NO

Community Paramedicine Questions

129. Do you have access to an electronic medical record or other electronic documentation of patient / client contacts with the community paramedicine program plan? [3406]

- Yes, we currently have a plan to fully integrate with electronic medical records
- No, but we are developing a plan
- There is no plan at this time to access to electronic medical records
- Other (please specify)

130. What are the priority of patients you plan to focus on with the community paramedicine program? (Please check all that apply.) [3407]

- High utilizers of emergency medical services - EMS
- Chronic Conditions
- Homeless
- Mental Health Conditions
- Patients recently discharged from in-patients services
- High utilizers of the Emergency Department
- Specific facilities (homeless shelters, etc)
- Other (please specify)

131. Which clinical and community partners do you routinely work with? [3408]

CBO Logic 2

132. Are you a Community Based Organization (including Public Health Department) or Social Service Organization?

YES

NO

Community Based Organizations

133. What kind of support is needed to enhance NurseFamilyPartnership? (Please check all that apply.) [3207]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

134. What kind of support is needed to enhance ParentsasTeachers? (Please check all that apply.) [3208]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

135. What kind of support is needed to enhance FamilySpirit? (Please check all that apply.) [3209]

- Training and technical assistance
- Additional information
- Stipend or resources for staffing
- Not going to implement
- Already implementing
- Other (please specify)

136. Related to social determinants of health, which of the following services do your patients or clients need most? (Please check all that apply.) [2173]

- Housing
- Transportation
- Detox
- Mentoring
- Overdose Prevention
- Medication Assisted Therapy (MAT)
- Substance Use Disorder (SUD) Treatment
- Recovery Supports
- Other (please specify)

137. Does your organization routinely receive referrals from patients being discharged from in-patient services? (Please check all that apply.) [2311]

- Yes, via shared EHR - Electronic Health Record
- Yes, via HIE - Health Information Exchange
- Yes, via fax
- Yes, via telephone
- No, we only provide services at patient request, not by referral
- Yes, Other (please specify)

138. Do you receive a discharge summary or treatment plan? [2312]

- Yes, directly from the discharging facility
- Yes, the patient provides a copy
- No
- Yes, Other (please specify)

139. How do you receive reimbursement for your services? (Please check all that apply.) [2313]

Via Medicaid reimbursement

Via a grant

Via state funding

Via donated funds

Other (please specify)

140. Do you contact the discharging hospital or primary care physician with any discharge concerns? (Please check all that apply.) [2314]

Yes, we regularly exchange information

Yes, but communication varies based on the provider

Yes, but we seldom get feedback in return

No, we do not regularly communicate with medical providers

Other (please specify)

141. Does your organization routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors?

Routinely assess means there is documentation in the patient record of screening questions being asked. Well-defined intervention plan means there is documentation in the patient record of screening questions being asked AND a documented work process for intervening for positive risk factors. Resources used for intervention can be located either within the practice (e.g. diet and exercise counseling) or by referral to an outside source (e.g. substance abuse counselor or clinic). [3401]

	Routinely Assess	Well-defined intervention plan	N/A	No, we don't assess
Tobacco use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nutrition / Healthy Eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression / other mental illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High risk sexual behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise / inactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication adherence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other TBD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

142. Do you offer chronic disease self-management or educational classes? [3409]

	YES	NO
Stanford Chronic Disease Self-Management Program (CDSMP) on-site.	<input type="radio"/>	<input type="radio"/>
National Diabetes Prevention Program (NDPP) on-site.	<input type="radio"/>	<input type="radio"/>

We are interested in licensing and training for:

143. Our organization currently offers the following: (Please check all that apply) [3410]

- Asthma education
- Home visits for asthma services
- COPD - Chronic Obstructive Pulmonary Disease - education
- Home visits for COPD - Chronic Obstructive Pulmonary Disease - services
- Hypertension education
- Home visits for hypertension
- Support for home-based blood pressure monitoring
- Diabetes education

144. Does your organization maintain a chronic disease registry or registries? [3411]

- Yes, electronic (part of the electronic health record - EHR)
- Yes, electronic (separate software)
- Yes, electronic (Excel or access
- file) Yes, paper file
- No

If no, do you plan to establish a registry, and if so, when / for what condition? (please specify)

145. Do you have access to patient's treatment or care plans? [3412]

- Yes, electronic (electronic health record - EHR)
- Yes, sent via mail, email, or fax
- Yes, and I send regular reports to the patient's providers
- No
- Other (please specify)

146. Which clinical and community partners do you routinely work with? [3413]

147. Do you routinely receive referrals from medical or behavioral health providers? [3414]

- Yes, via HIE - Health Information Exchange
- Yes, via mail, email, or fax
- No, I receive referrals from other CBOs - Community-Based Organization
- No, all are patients are self-referral

Care Infrastructure

148. How interested is your organization in the following investment opportunities? [9001]

	Not at all interested	Somewhat interested	Very interested	N/A
Advocating for scope of practice changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Disease self-management support (DPP, CDSM, WHAM)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication assisted treatment (MAT) for waived primary care providers and substance use disorder outpatient treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shared recruitment and retention tools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Placing nursing students and residents from local community colleges in internships and practicums	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shared workforce (e.g., specialists)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mobile workforce (e.g., mobile dental van)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Virtual team-based care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trauma-informed care training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription drug monitoring program (PDMP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opioid Misuse and Abuse Prevention: Clinical redesign for safer opioid prescribing practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Population health management: training in how to make a referral, use a registry, etc...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
AIMS Center Bi-directional Integration Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
AIMS Center Problem-Solving Treatment Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
AIMS Center Patient Activation Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please specify any additional infrastructure investment opportunities your organization is interested in.

149. Please answer the following regarding population health management: [9003]

	Yes	No	Maybe	N/A
Are you interested in a shared population health management strategy? (For example, an interactive electronic data-sharing platform that facilitates referrals and supports coordination of care.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you interested in investing in compatible EHR (electronic health record)/EBR (electronic behavioral health record) platforms to support health information exchange?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

150. Does your organization currently operate one or more registries? [9005]

Yes

No

Maybe

N/A

If you answered "yes" above, please describe your registry or registries.

151. What is your current EHR (electronic health record)/EBR (electronic behavioral health record)? (If none, please leave blank.)

152. Would you like to change or upgrade this system? [9008]

Yes

Maybe

No

Please tell us about it.

153. Do you currently have a population health management system? [9009]

Yes, I2I

Yes, HealthyPlanet

Yes,

Other No

If Yes, Other please specify

If No, which one(s) are you exploring?

154. Please indicate your willingness to perform the following: [9011]

	Not at all willing	Not very willing	Somewhat willing	Very willing	N/A
Reproductive Health: contraceptive education	<input type="radio"/>				
Reproductive Health: sexually transmitted infection - STI - screening	<input type="radio"/>				
Reproductive Health: screen for and treat opioid use disorder in pregnant women and neonatal abstinence syndrome in newborns	<input type="radio"/>				
Oral Health into Primary Care: Oral screening, assessment, intervention, and referral	<input type="radio"/>				
Mental Health Care (lite): depression and anxiety screening	<input type="radio"/>				
Mental Health Care (lite): depression medication management	<input type="radio"/>				
Maternal and Child Health: immunizations	<input type="radio"/>				
Opioid Misuse and Abuse Prevention: clinical redesign for safer opioid prescribing practices	<input type="radio"/>				
Opioid Use Disorder Treatment: increase the number of providers waived to prescribe/provide medication assisted treatment	<input type="radio"/>				
Prevention of fatal opioid overdose: co-prescribing naloxone with safe opioid prescribing practices	<input type="radio"/>				
Chronic Disease Prevention and Control: medication management and education	<input type="radio"/>				

155. How interested is your organization in the following investment opportunities? [9012]

	Not at all interested	Not very interested	Somewhat interested	Very interested
Telehealth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cross training/retraining/certification/uptraining	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
New workforce	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recruitment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Retention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Placement for new grads/nurses/residents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

156. Do you currently have value-based purchasing (VBP) contracts of any kind? [9013]

- Yes
- No

157. If you are receiving VBP from a health insurance company, please describe your overall experience with VBP: [9014]

Very positive

Somewhat

positive Neutral

Somewhat

negative Very

negative

N/A

Other (please specify)

158. If you are receiving VBP from any payer, what has enabled your participation in VBP? (Please check all that apply.) [9015]

Interoperable data systems

Access to comprehensive data on patient populations (e.g., demographics, morbidity data)

Availability of timely patient/population cost data to assist with financial management

Ability to understand and analyze payment models

Sufficient patient volume by payer to take on clinical risk

Consumer engagement

Development of medical home culture with engaged providers

Common clinical protocols and/or guidelines associated with training for providers

Regulatory changes (e.g., State legislation promoting behavioral health integration, Federal regulations regarding antitrust/safe harbors)

Aligned incentives and/or contract requirements

Aligned quality measurements and definitions

Trusted partnerships and collaboration with payers

Trusted partnerships and collaboration with providers outside your organization

State-based initiatives (e.g., State Innovation Model grant, Healthier Washington; Medicaid Transformation Demonstration)

N/A

Other (please specify)

159. What are the greatest barriers for engaging in value-based purchasing? (Please check all that apply.) [9016]

- Lack of interoperable data systems
- Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data)
- Lack of availability of timely patient/population cost data to assist with financial management
- Inability to adequately understand and analyze payment models
- Insufficient patient volume by payer to take on clinical risk
- Lack of consumer engagement
- Lack of or difficulty developing medical home culture with engaged providers
- Differing clinical protocols and/or guidelines associated with training for providers
- Regulation or policies (federal, State, other)
- Misaligned incentives and/or contract requirements
- Misaligned quality measurements and definitions
- Lack of trusted partnerships and collaboration with payers
- Lack of trusted partnerships and collaboration with providers outside your organization
- Other (please specify)

160. Realistically, how do you expect your participation in value-based purchasing (VBP) to change over the next 12 months? [9017]

- Increase by more than 50%
- Increase by 25-50%
- Increase by 10-24%
- Increase by up to 10%
- Stay the same
- Decrease by up to 10%
- Decrease by 10-24%
- Decrease by 25-50%
- Decrease by more than 50%
- N/A

161. Is your organization currently reporting through a portal for grants, contracts, or initiatives? [9018]

Yes

No

Maybe

162. Is there a portal or platform that you like? (Please describe, name, link) [9019]

163. Do you anticipate submitting a response to CPAA's Request for Proposals (RFP)?

Yes

No

Unsure

164. Which projectareas are you interested in participating in? (Please check all that apply.)

2A - Bi-Directional Care Integration

2B - Care Coordination (Pathways)

2C - Transitional Care

3A - Opioid Response

3B - Reproductive, Maternal & Child Health

3D - Chronic Disease Prevention and Control

Final Comments

165. Please provide any additional comments or feedback:

166. Would you like to set up a meeting with CPAA staff to discuss the Medicaid Transformation Project? If so, please provide the best contact information to schedule this meeting.

Your Name

Email Address

Phone Number

Thank you for your participation in the CPAA State Capacity Assessment Survey.

Cascade Pacific Action Alliance's State Capacity Assessment.

CPAA used the following survey responses to identify gaps and assets in existing services, inform implementation planning, and assist with selecting partnering providers.

May, 2018

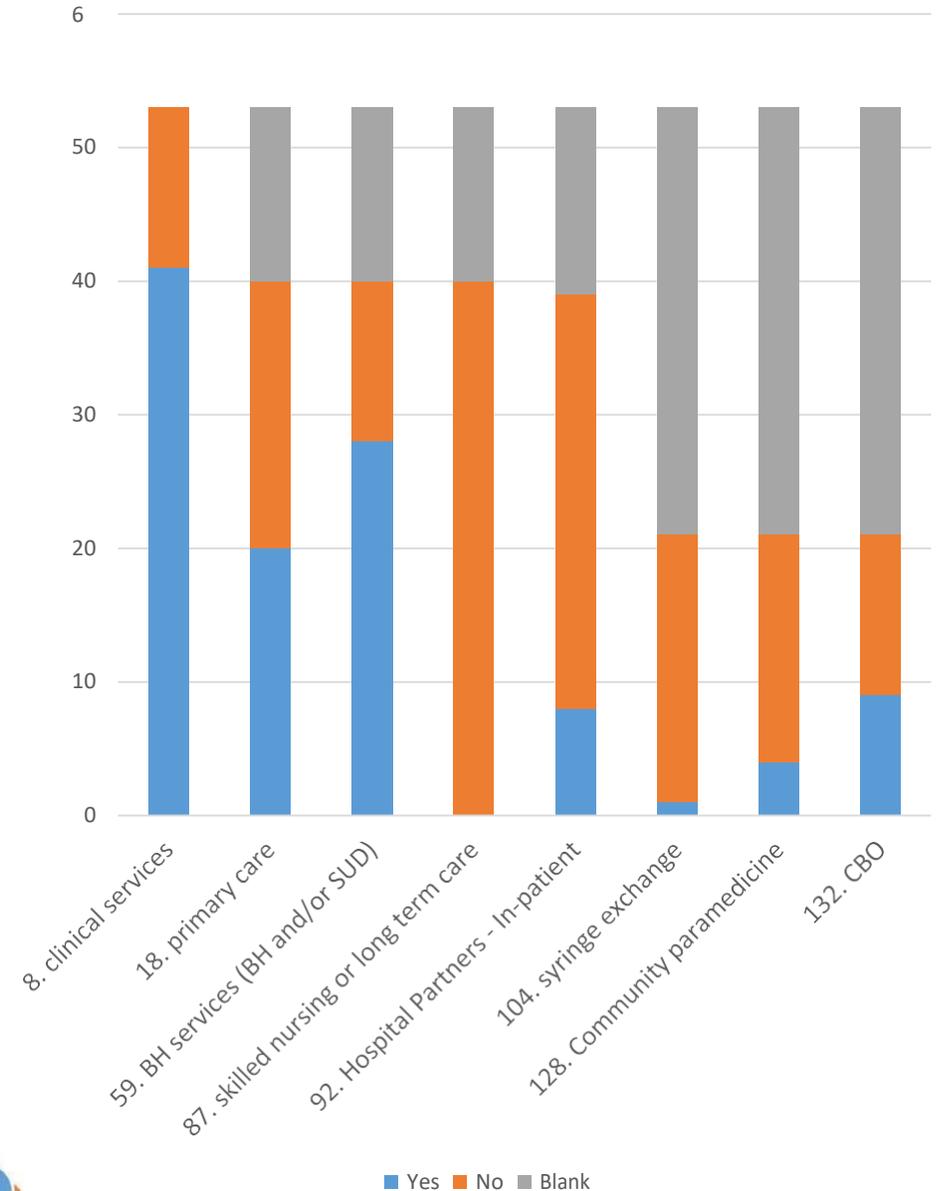


Assessment segments

- Demographics (Question 1 – Q8)
- All Clinical Providers (Q9 – Q18)
- Primary Care (Q19 – Q59)
- Behavioral Health or Substance Use Disorder (Q60 – Q87)
- Skilled Nursing or Long Term Care Facility (Q88 – Q92)
- Hospital Partners - In-patient (Q93-Q103)
- Syringe Exchange Services (Q105-Q128)
- Community Paramedicine Questions (Q129-Q131)
- Community Based Organizations (Q133-Q147)
- Care Infrastructure (Q148 – Q164)

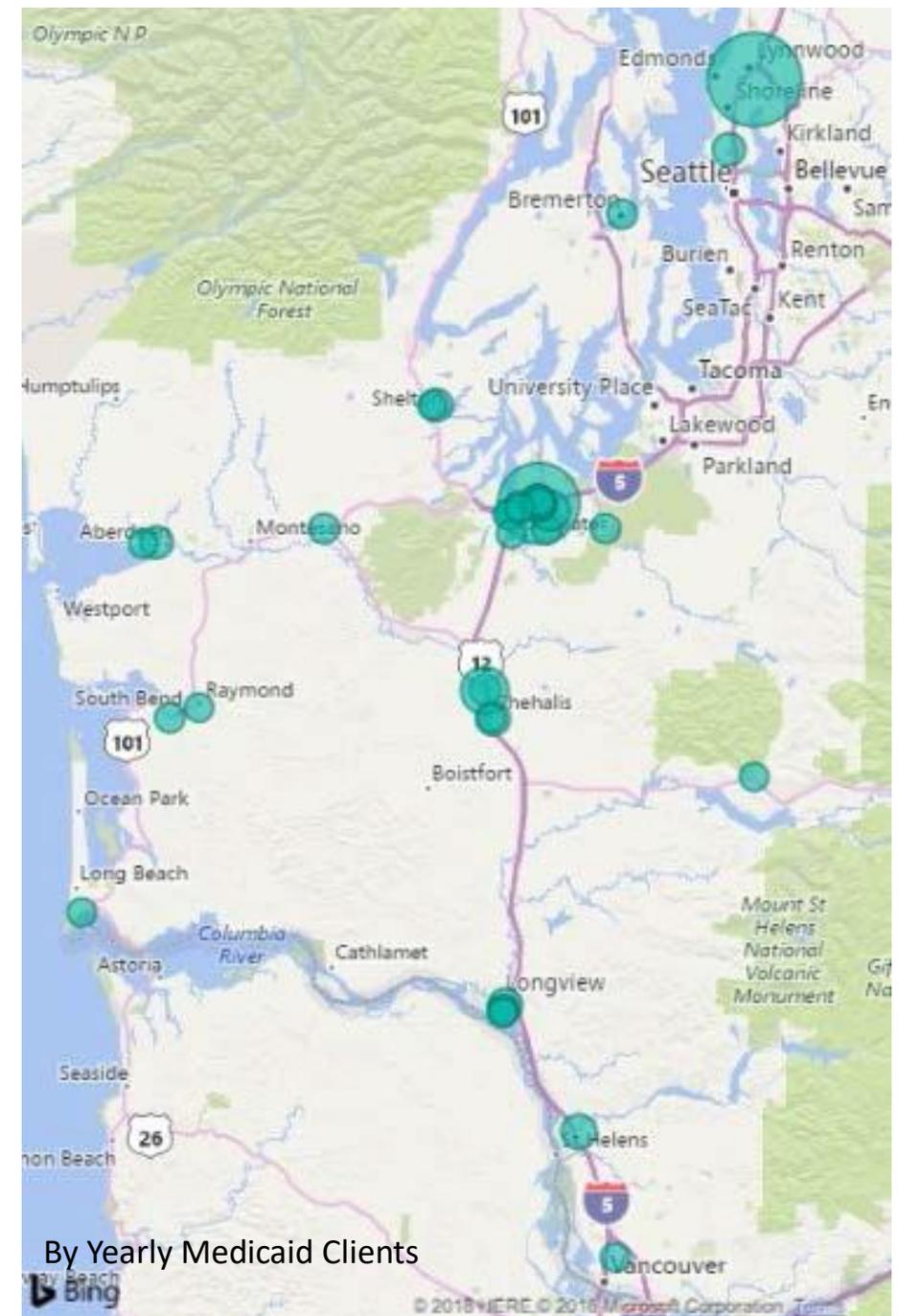
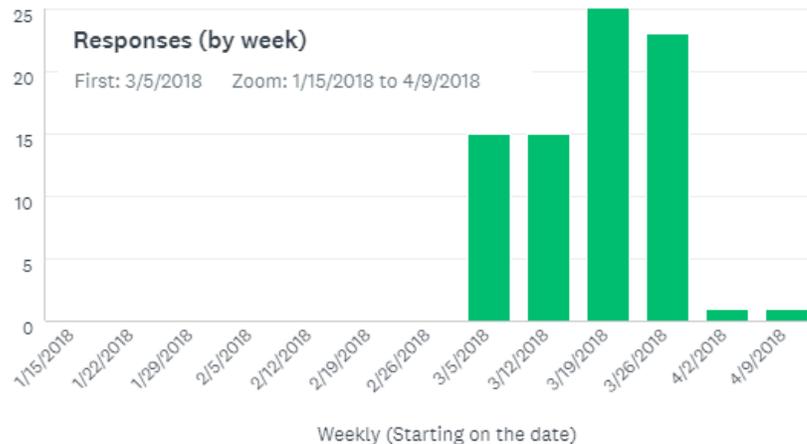
By segment

Question	Yes	No	Blank
8. Does your organization provide clinical services?	41	12	0
18. Does your organization offer primary care?	20	20	13
59. Does your organization offer behavioral health services (mental health and/or substance use disorder)?	28	12	13
87. Are you a skilled nursing or long term care facility?	0	40	13
92. Hospital Partners - In-patient	8	31	14
104. Do you provide syringe exchange services?	1	20	32
128. Do you plan to provide community paramedicine services?	4	17	32
132. Are you a Community Based Organization (including Public Health Department) or Social Service Organization?	9	12	32



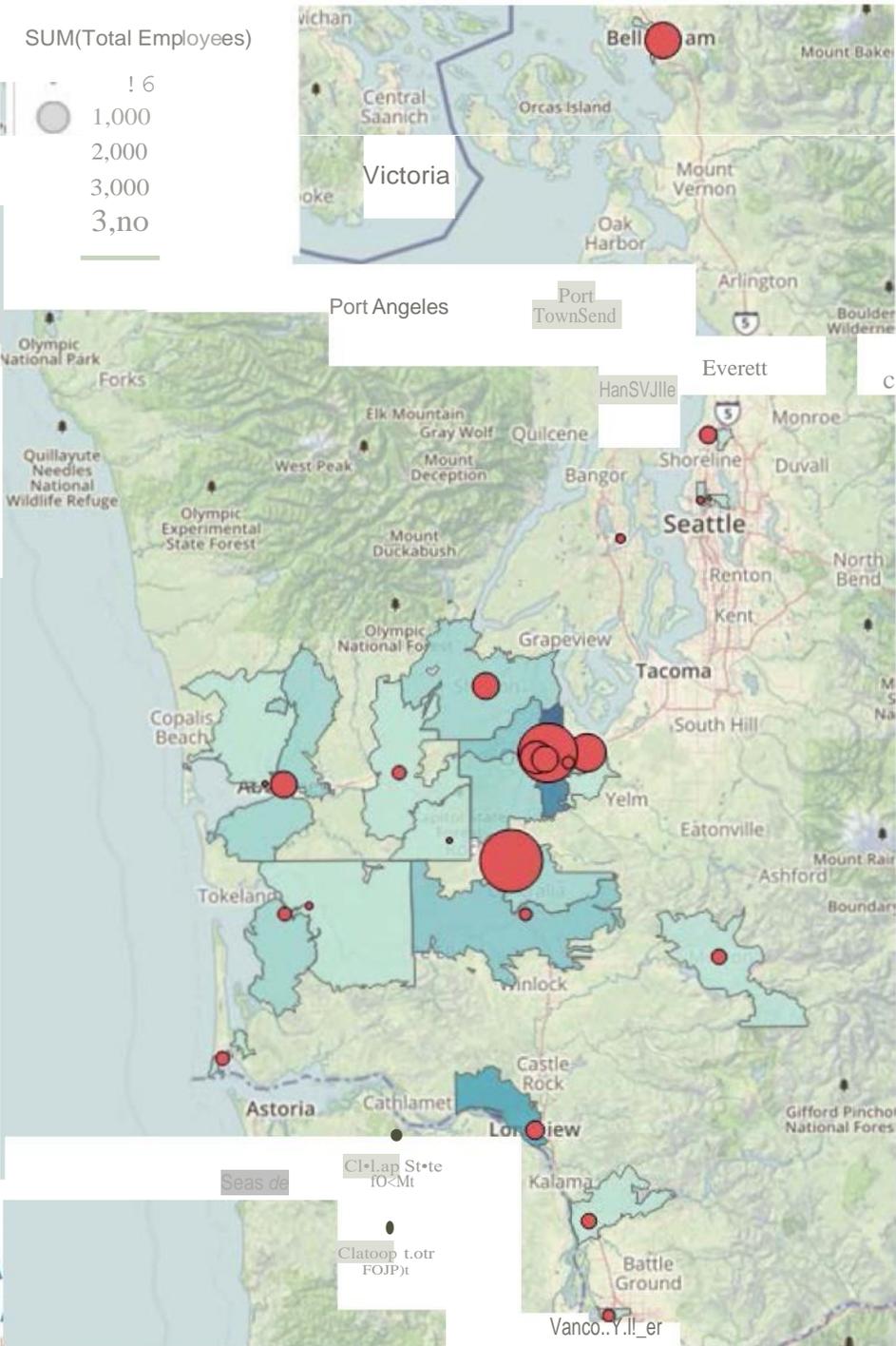
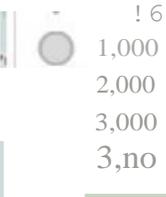
Total respondents: 54

- 54 unduplicated organizations
- 81 duplicated respondents
- 167 questions
(678 different tabulations)

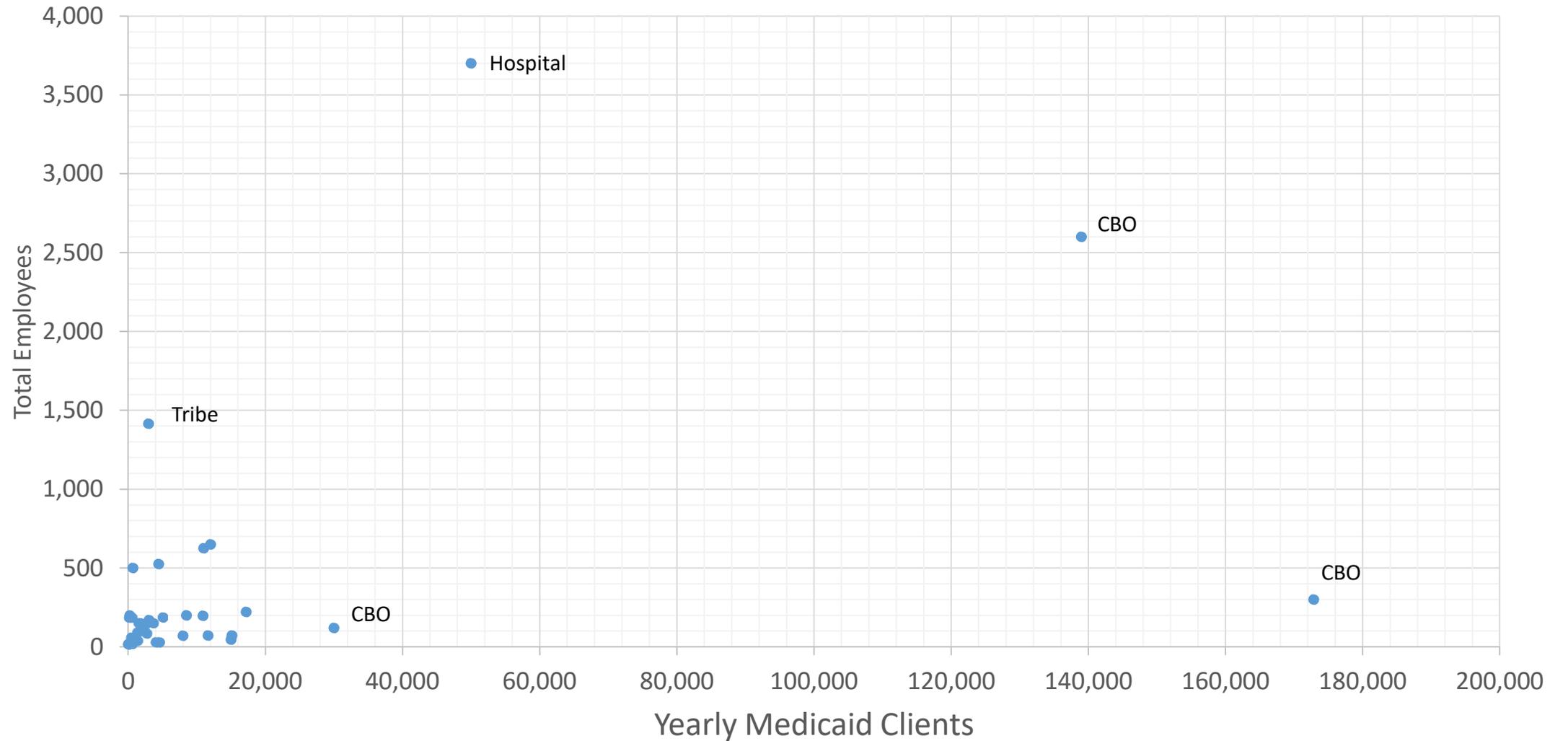


Organizations by total Employees

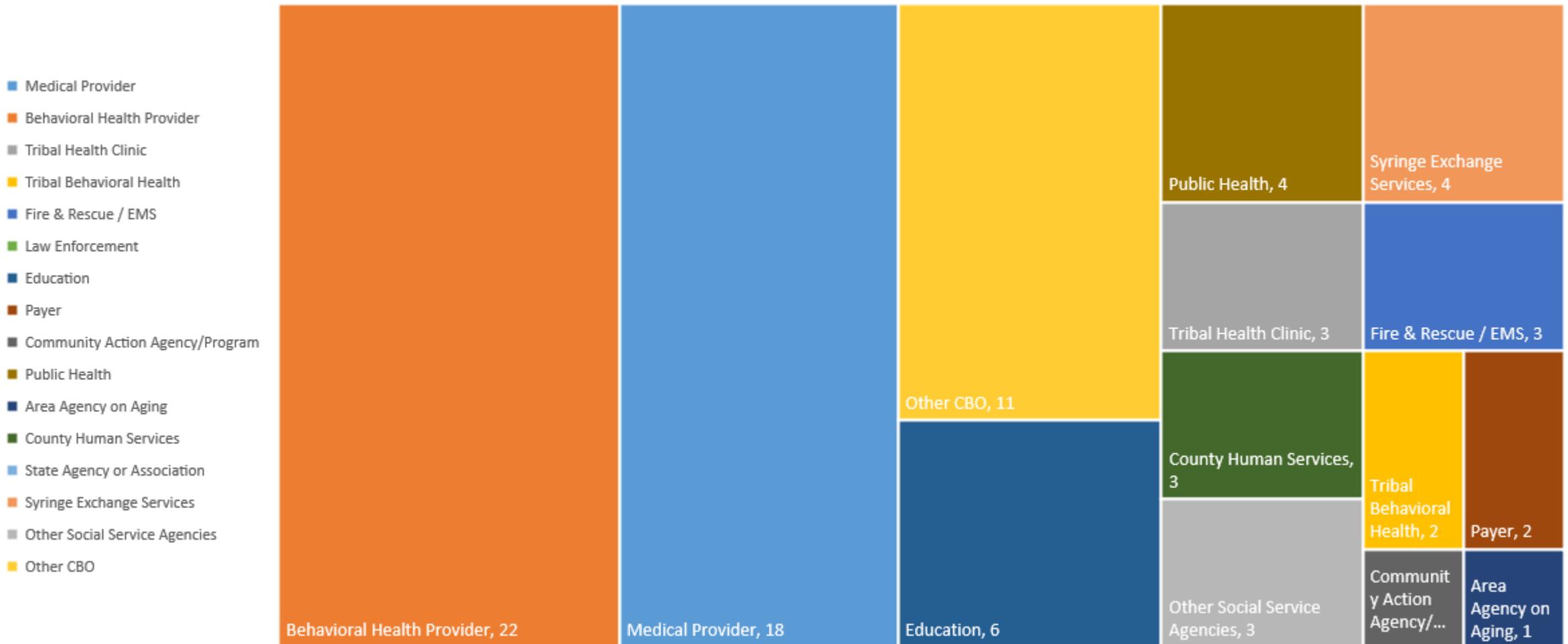
SUM(Total Employees)



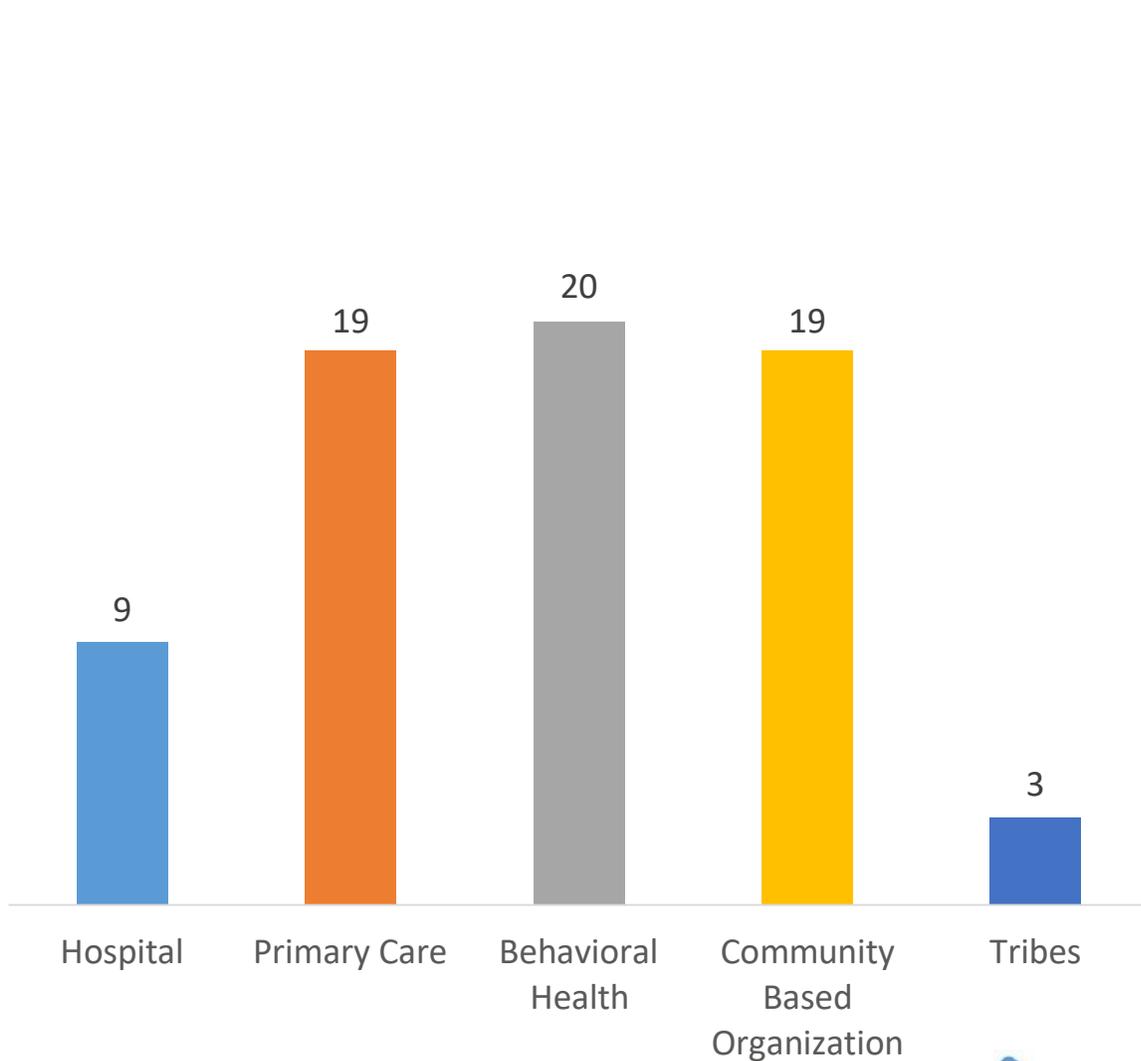
Organizations: Total Employees by Medicaid clients



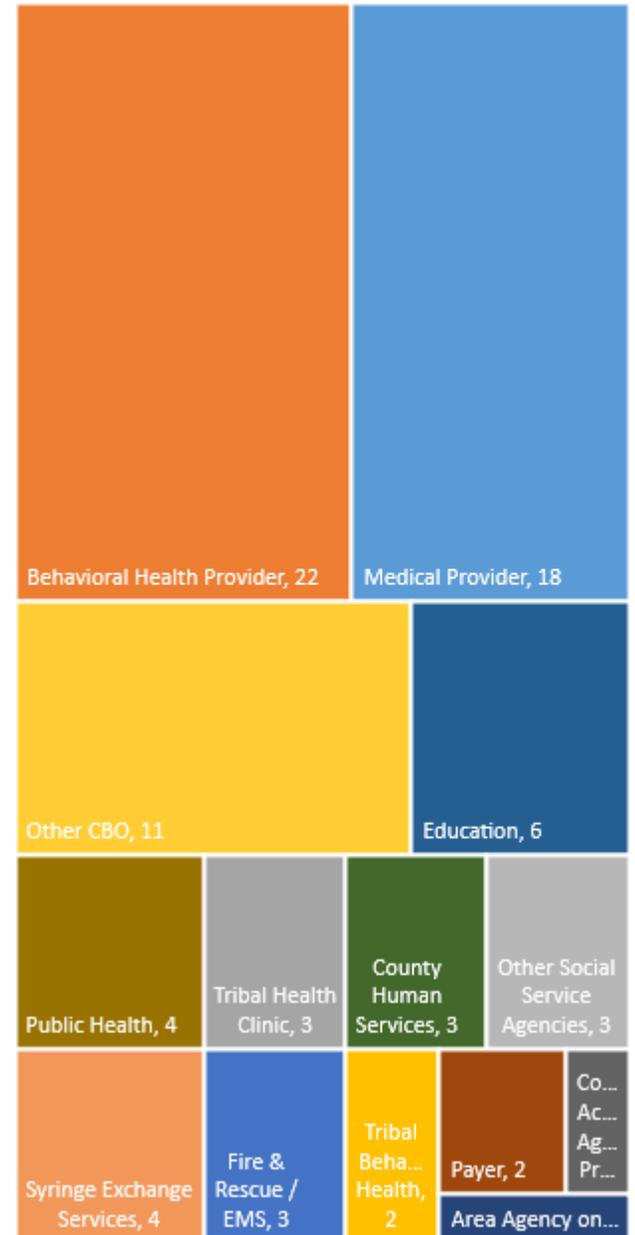
Q6. Which of these categories best matches your organization? (53)



Q6. By Category (53)

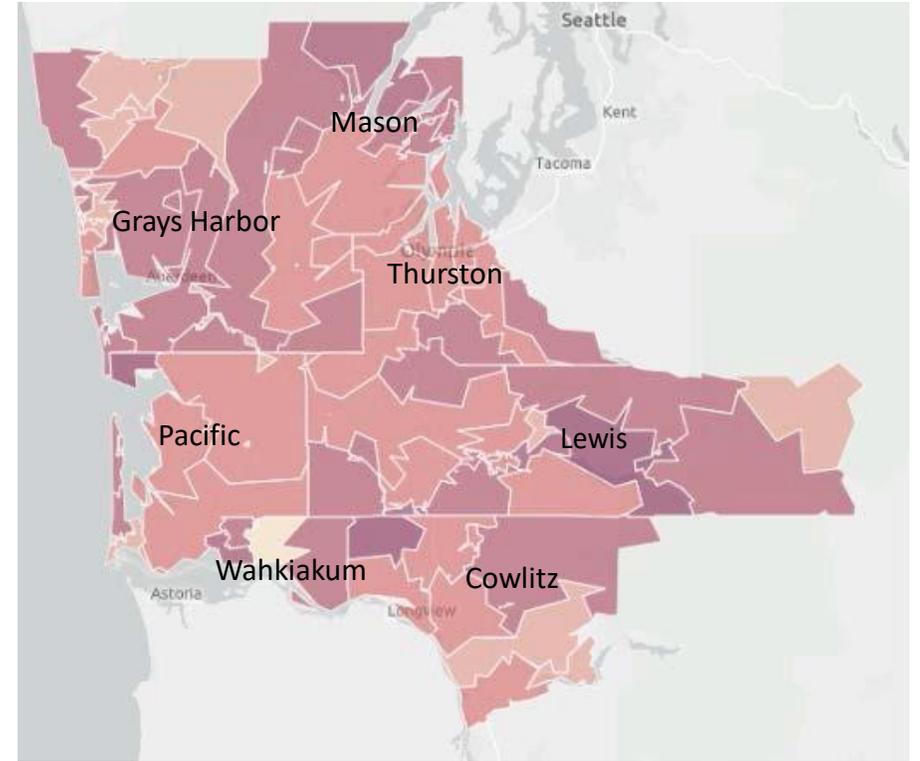
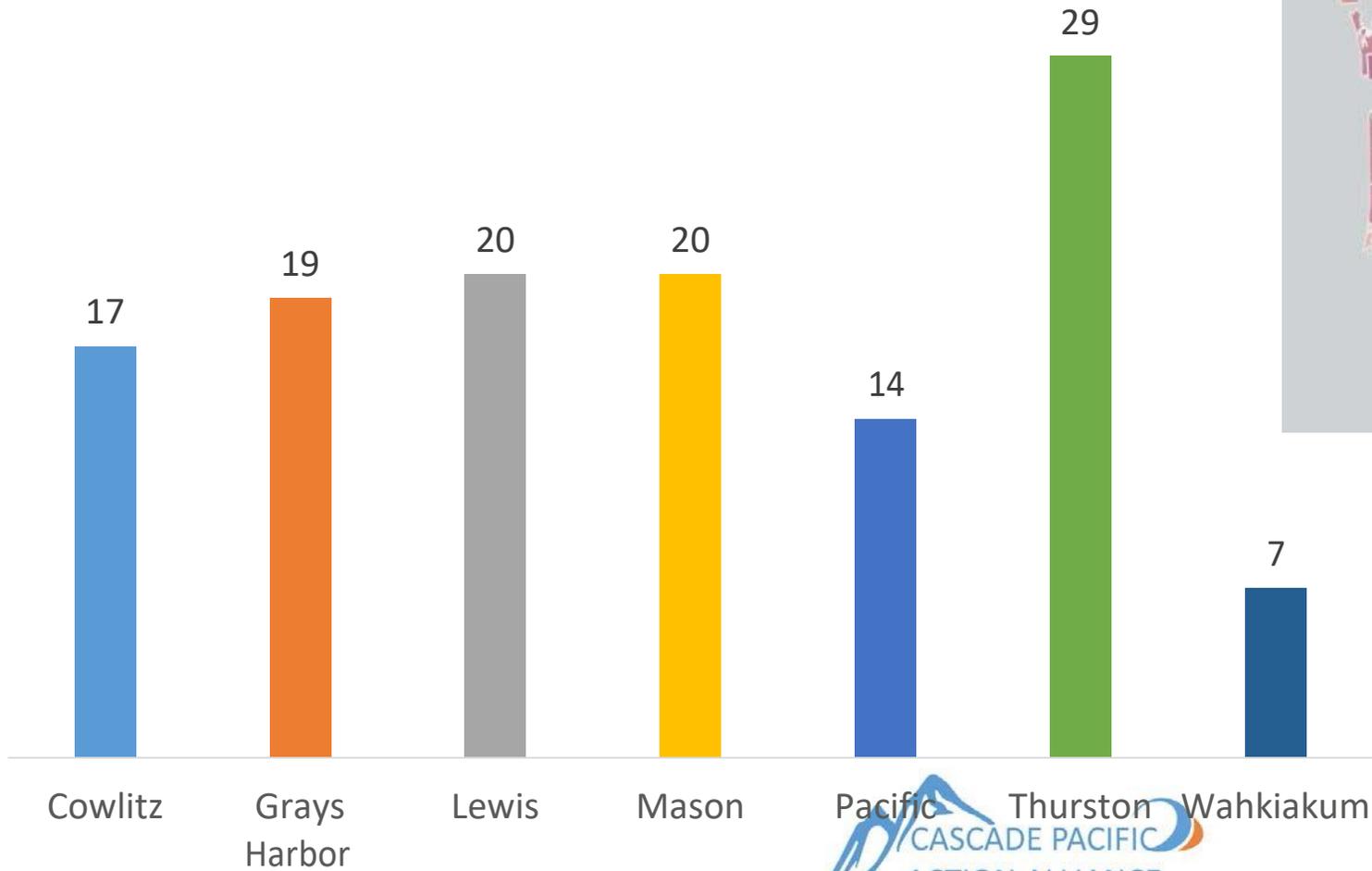


- Medical Provider
- Behavioral Health Provider
- Tribal Health Clinic
- Tribal Behavioral Health
- Fire & Rescue / EMS
- Law Enforcement
- Education
- Payer
- Community Action Agency/Program
- Public Health
- Area Agency on Aging
- County Human Services
- State Agency or Association
- Syringe Exchange Services
- Other Social Service Agencies
- Other CBO



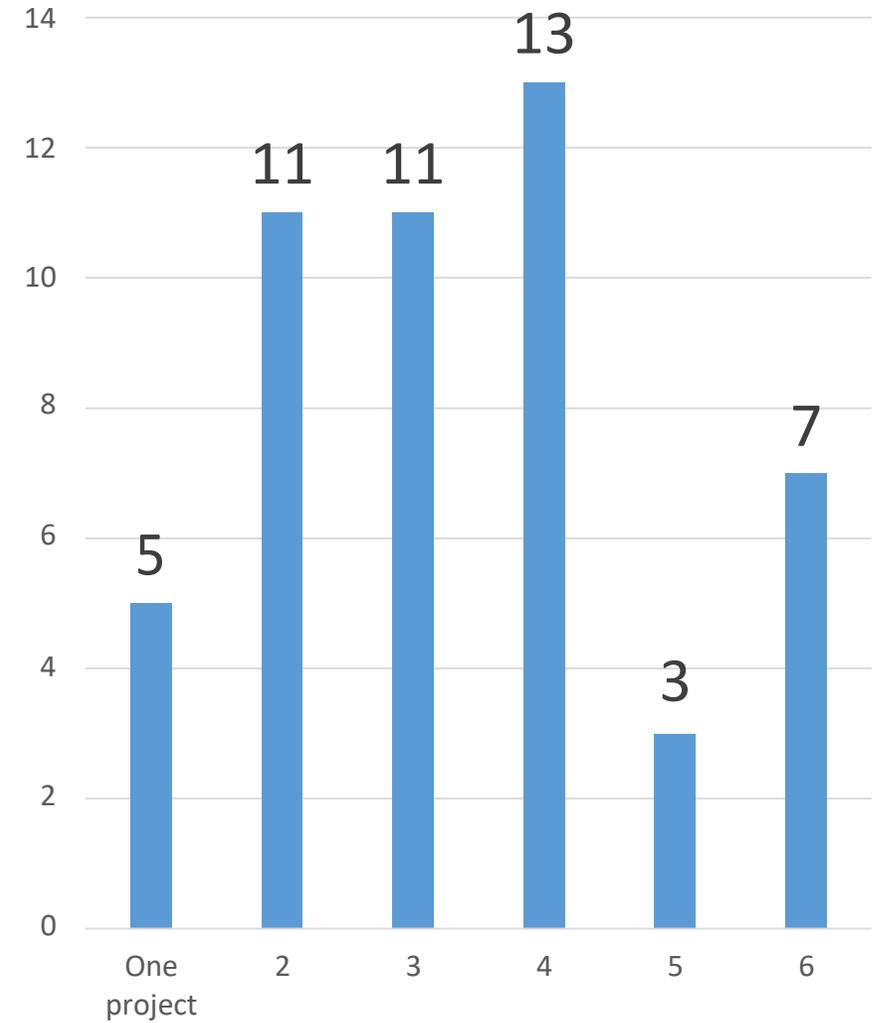
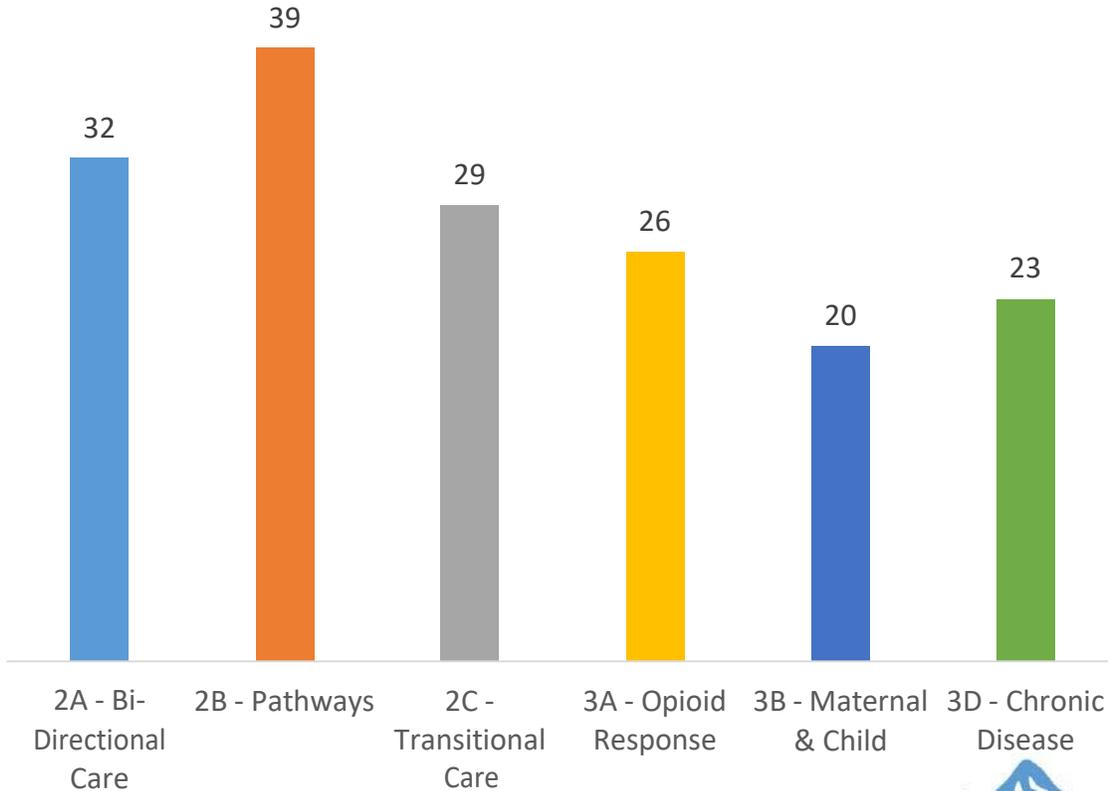
By County (52)

Q2. Counties your organization serves



Q164. By Project Area (50)

Which project areas are you interested in participating in?



All Clinical Providers

Q8. Does your organization provide clinical services? (54)

Yes: 41, No: 13

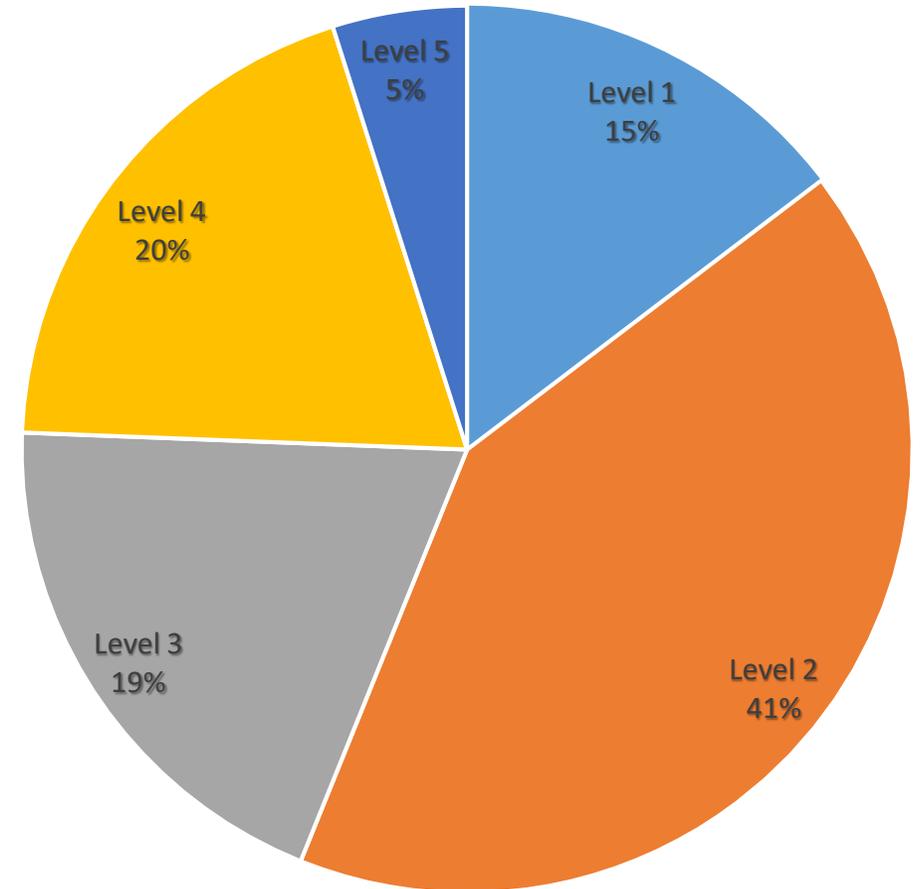




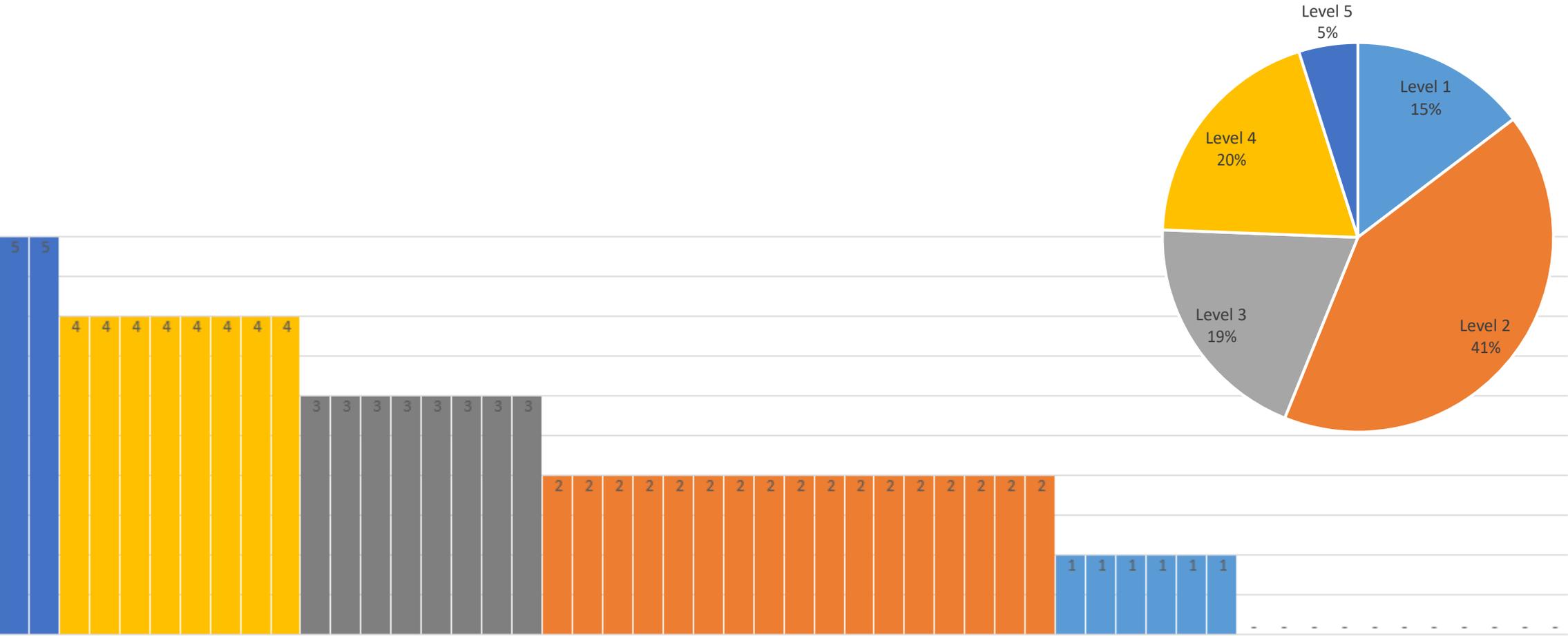
Q9. Which level of integration best describes your practice/clinic/organization? (41)

More than 40%(17) of the respondents have a basic collaboration at distance, providers with separate systems at separate sites

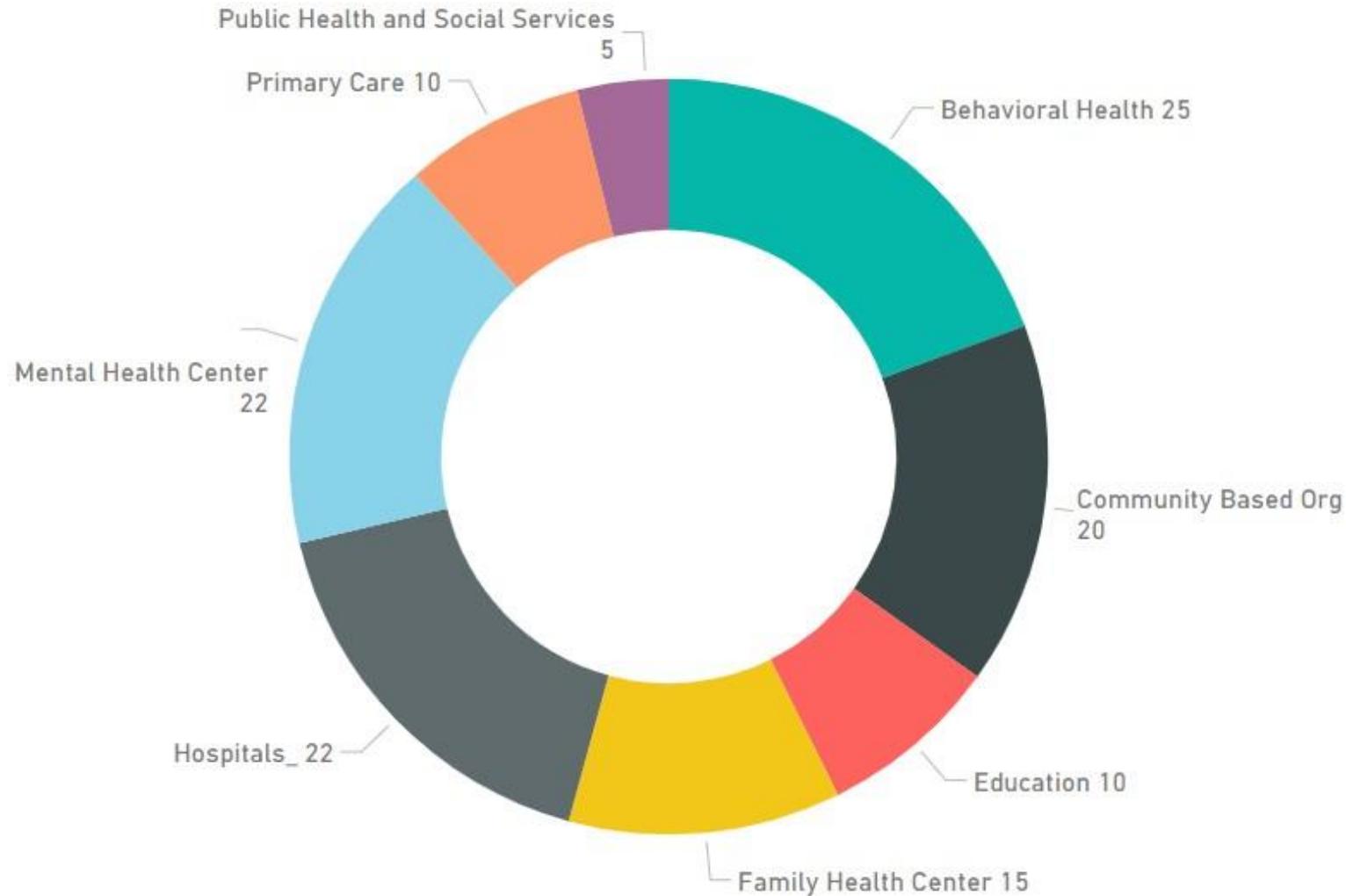
- Level 1 – Minimal Collaboration
- Level 2 – Basic Collaboration at a Distance
- Level 3 – Basic Collaboration Onsite
- Level 4 – Close Collaboration in a Partly Integrated System
- Level 5 – Close Collaboration in a Fully Integrated System



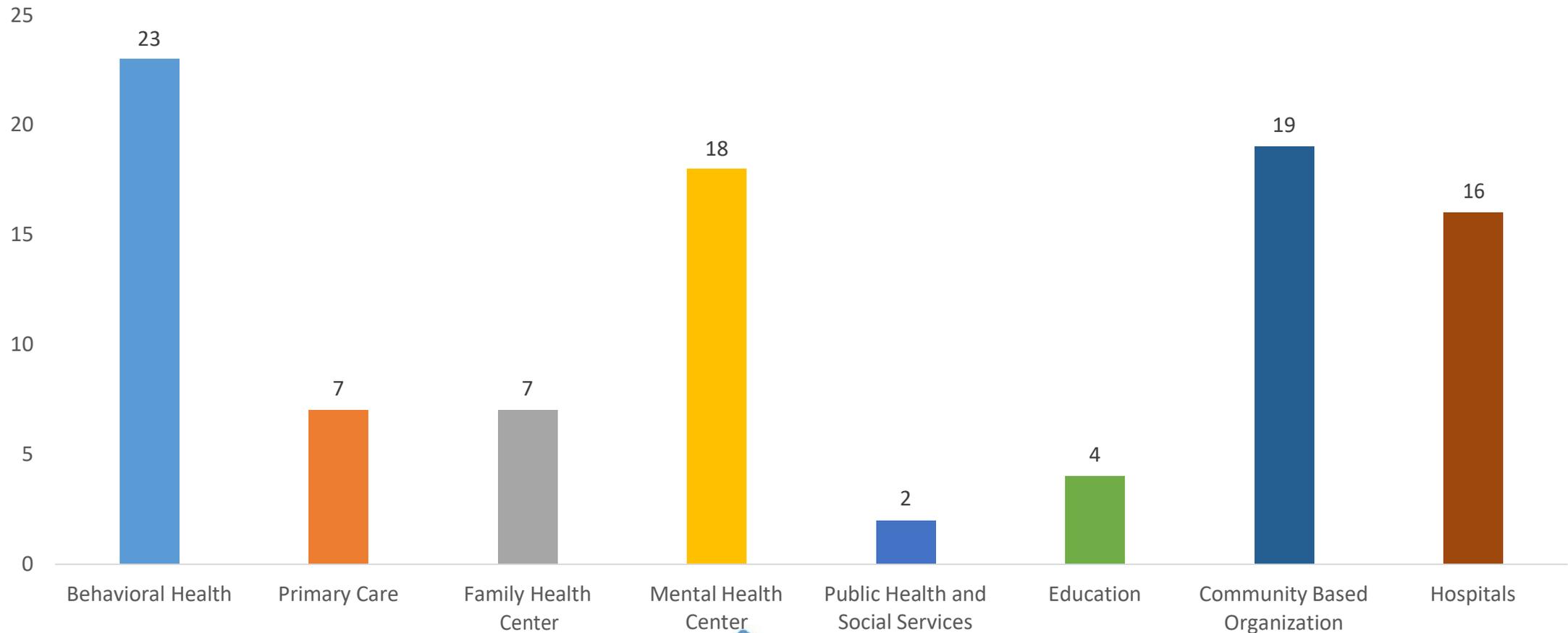
Q9. Which level of integration best describes your practice/clinic/organization? (41)



Q10. Partners you routinely collaborate with around integrated care or other health care services (38)



Q11. Please list partners or types of partners that would be most helpful for developing an integrated care program. (31)



Q11. Please list partners or types of partners that would be most helpful for developing an integrated care program.[2103]

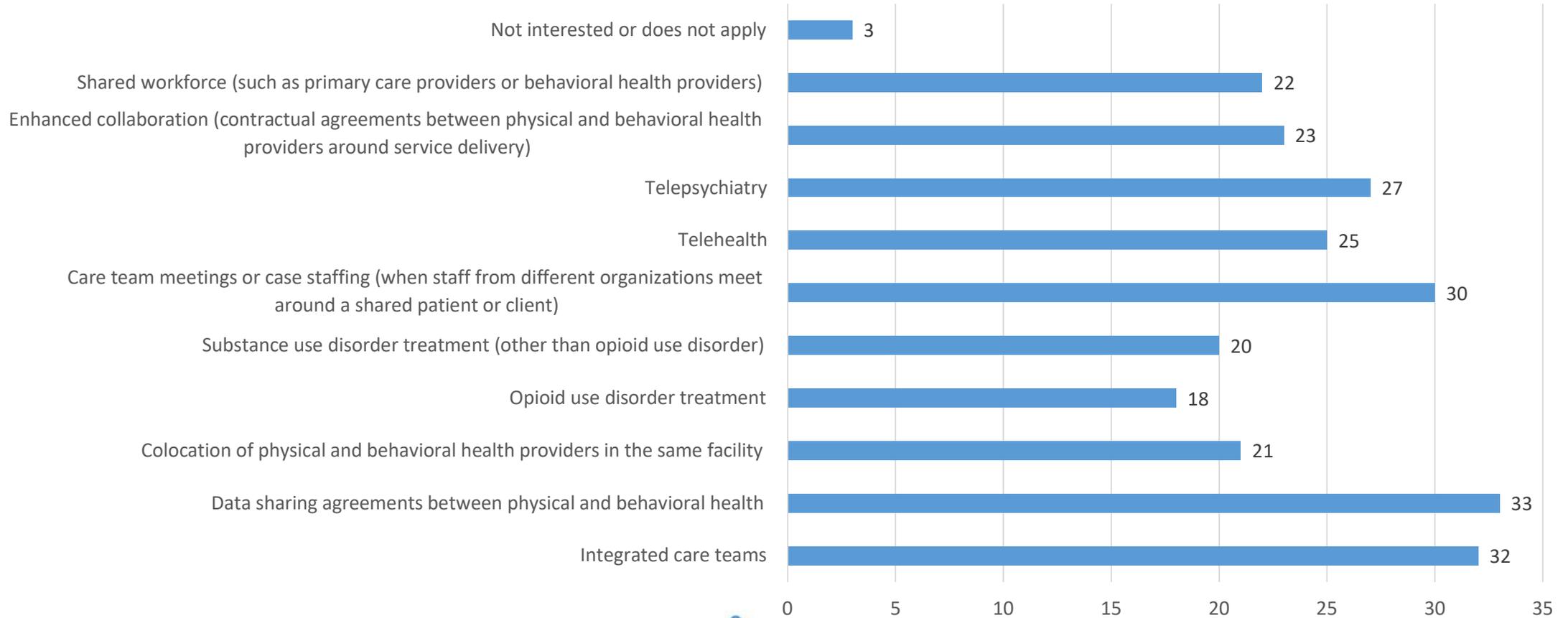
- Pediatric offices, Dental Clinics, Hospitals, FQHC & other clinics
- BHR and any of above
- community mental health centers UW AIMS
- SAMSHA/BHPCI CMS/CMMI, Hospitals
- MCOs, HCA, Psychiatry services, BHO
- All 7 hospitals within region, primary care providers, jails, courts, schools, juvenile detention centers, housing resources, employment resources
- HIE Providers, State, DOH, HCA along with partners listed above and BHO
- More psychologists/LMFT's
- BHR Primary Care Physician Veteran Court
- More Primary Care Doctors Maternal Health/Home visiting Children's Administration Family Courts School(s) Health OSPI—Health and Wellness Dental Providers Hospitals/Emergency Rooms
- Primary Care / Medical Practitioners. SUD providers.

Q12. What does your organization need most to implement an integrated care program? (29)

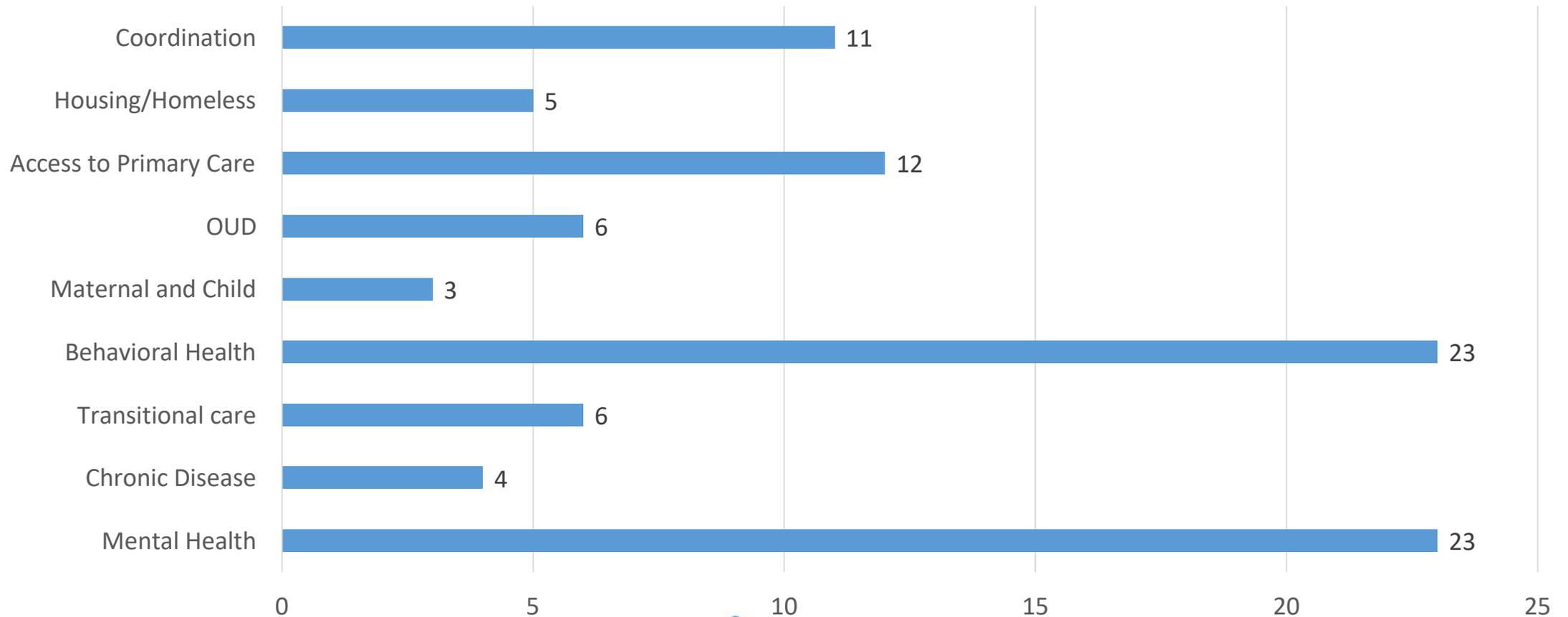
Some responses:

- Access to mental health resources, Social workers, community care providers who are willing to treat patients in an outpatient setting
- Current funding doesn't typically pay for planning and collaboration time, so some resources to
- Startup funds for placing a behavioral health therapist in a primary care clinic (or clinics), that we could then help to train and support. Startup funds are necessary to be able to reach a point a year or so down the line when billing can support the role.
- Extra funding and appropriate staff
- funding for FTE, education/training and clinic level buy-in
- Infusion of dollars from CPAA to do primary care services onsite from hired WBH staff (RN, NP/FNP-BC, CMA) to perform psychiatrically sensitive primary care onsite in our Long Beach and Raymond locations.
- Funding streams, Minimize bureaucracy, challenges around funding streams, partnership limitations with BHO
- health care exchange, rule and regulatory changes regarding primary care
- Funding, Protocols
- More therapists interested in the primary care behavioral health integration model Financial support
- Increase budget
- FHC is fully integrated
- Staffing resources, community resources, funding

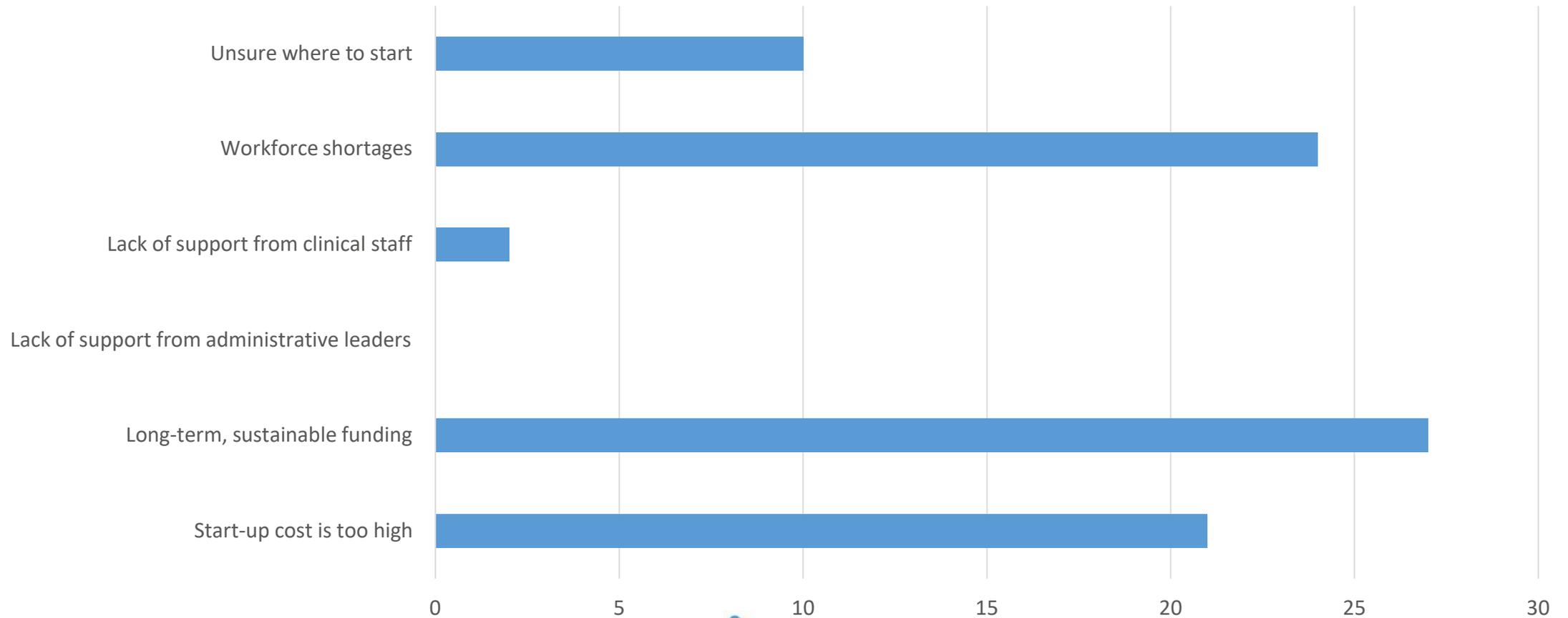
Q13. Integrated care that you are interested in exploring (39)



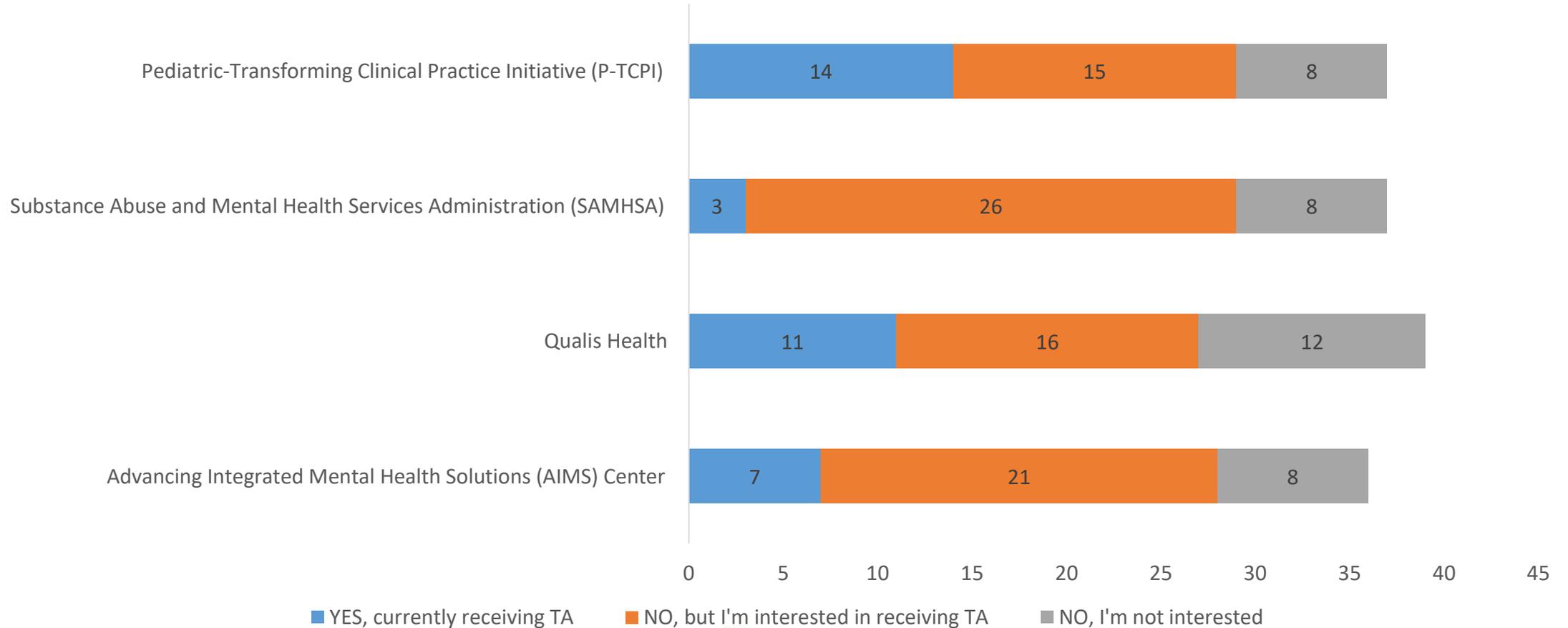
Q14. Most important needs in your patient population that could be addressed with integrated care? (37)



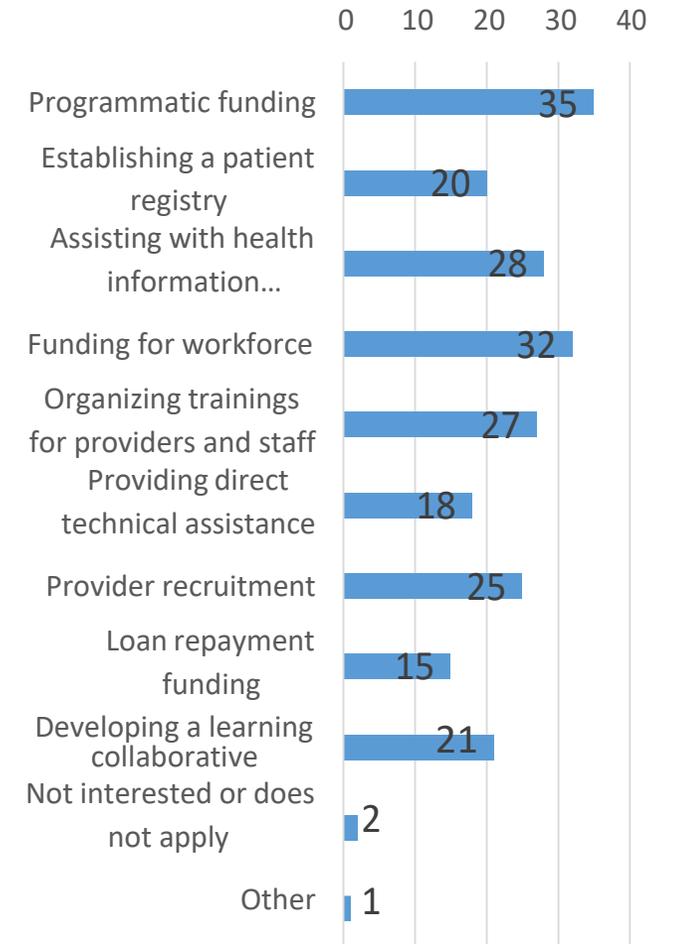
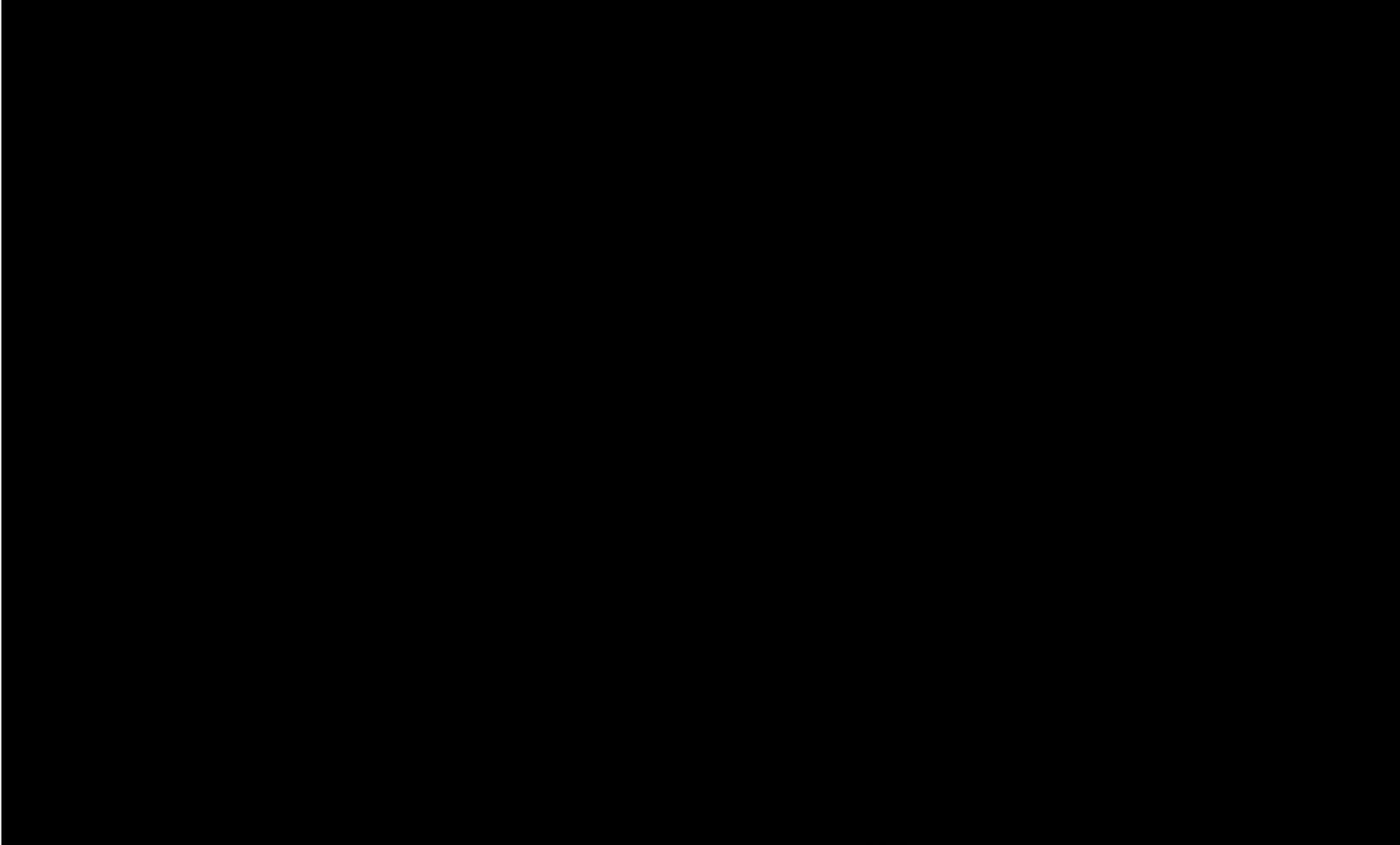
Q15. What are your biggest challenges to implementing an integrated care program?



Q16. Are you currently receiving technical assistance to implement integrated care from any of the following? (40)



Q17. How do you see CPAA supporting your efforts to develop or further implement an integrated care program?(40)

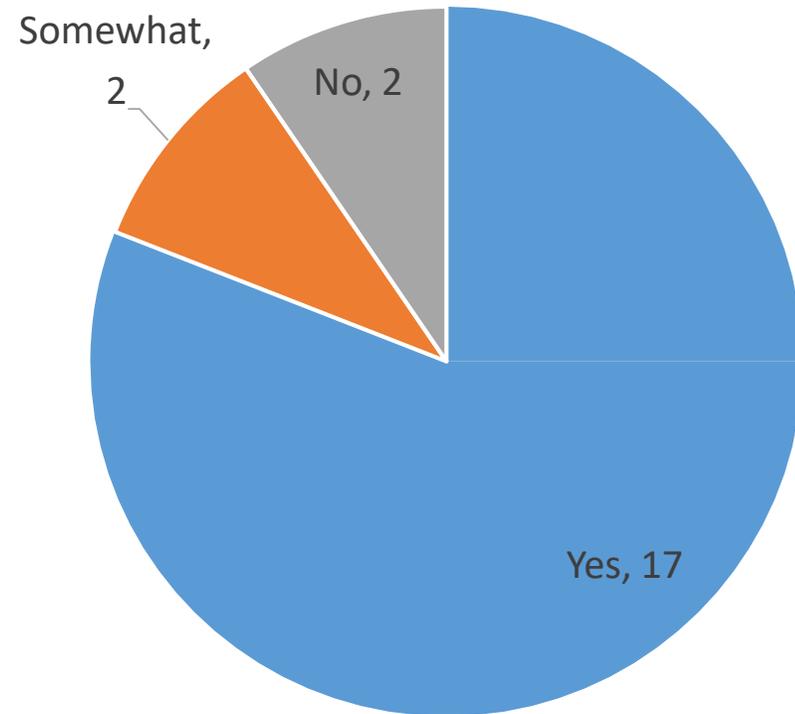


Primary Care

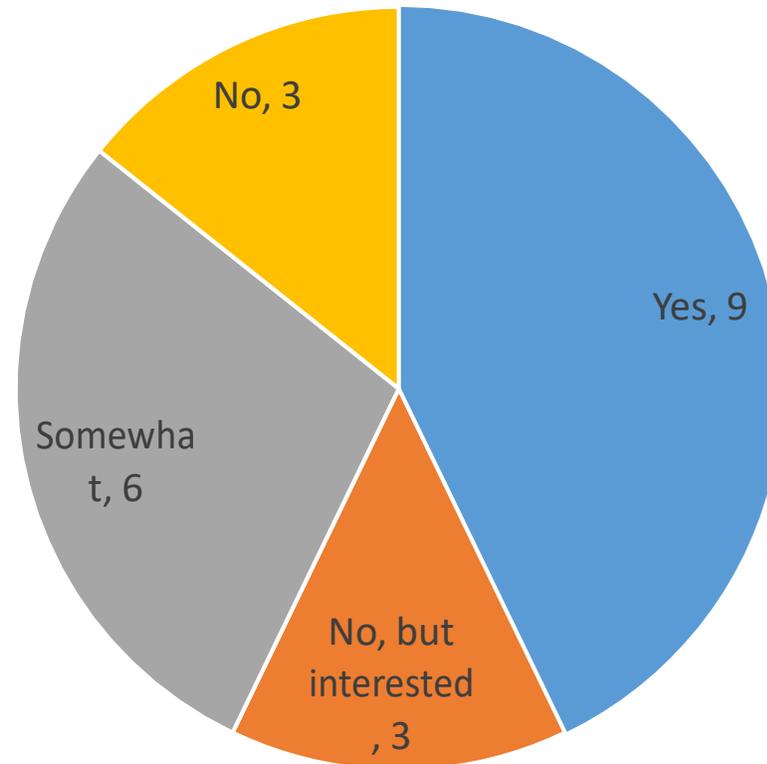
Q18. Does your organization offer primary care? (40)

Yes: 20, No: 20

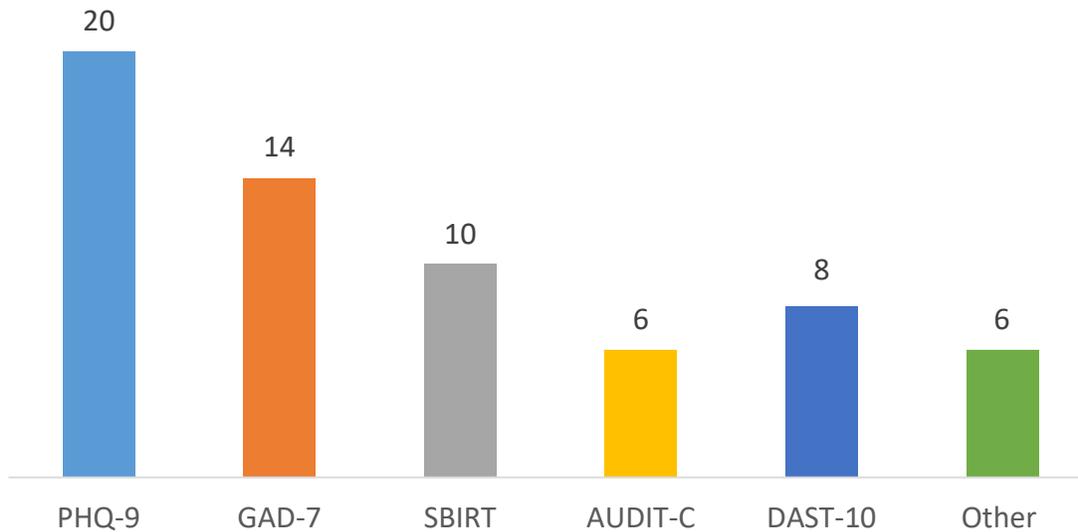
Q19. Is there involvement and support from key senior leadership and clinic leadership to implement an integrated care program?



Q20. Does your practice have a plan in place for integrating behavioral health?



Q21. Do providers screen for behavioral health conditions using valid instruments?



PHQ-9 - Patient Health Questionnaire

GAD-7 - Generalized Anxiety Disorder 7-item

SBIRT - Screening, Brief Intervention, and Referral to Treatment

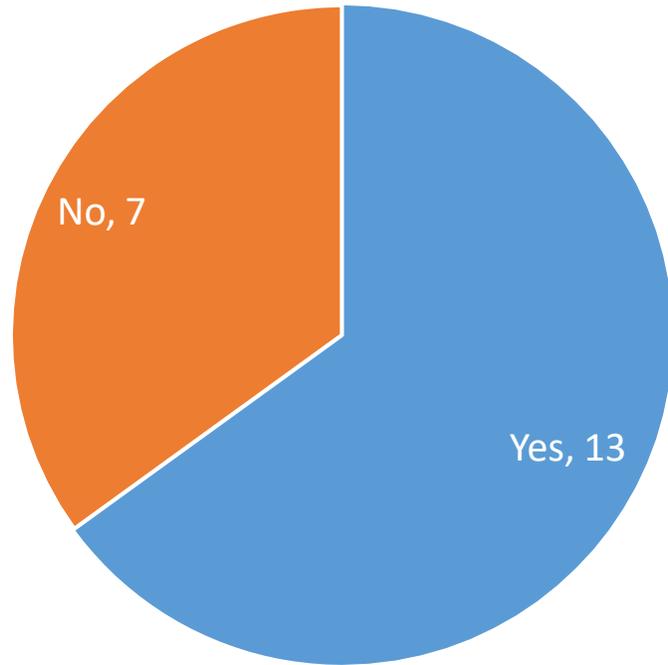
AUDIT-C - Alcohol Use Disorders Identification Test

DAST-10 - Drug Abuse Screening Test

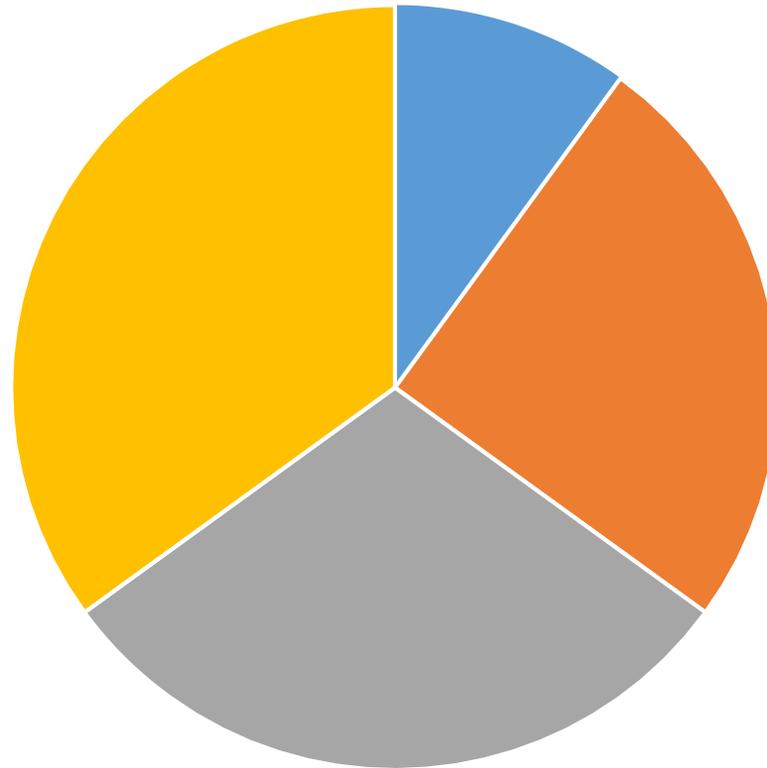
Other

- CRAFFT, Edinburgh post partum depression screens and developmental screens MCHAT and ASQ
- SBIRT w/ Audit and Dast used routinely at 2 of 11 clinics
- PSC-17, SCARED, SDQ, Edinburg Maternal Depression, SMFQ
- NICHQ, CARED, PSC 17, MCHAT, VANDERBILT, SMFQ, EAT-26, CRAFFT
- RAAPS, SCARED, Beck
- elements of AUDIT and DAST on screening form

Q22. Do providers in your practice prescribe opioids to treat patients for chronic pain? [2114]

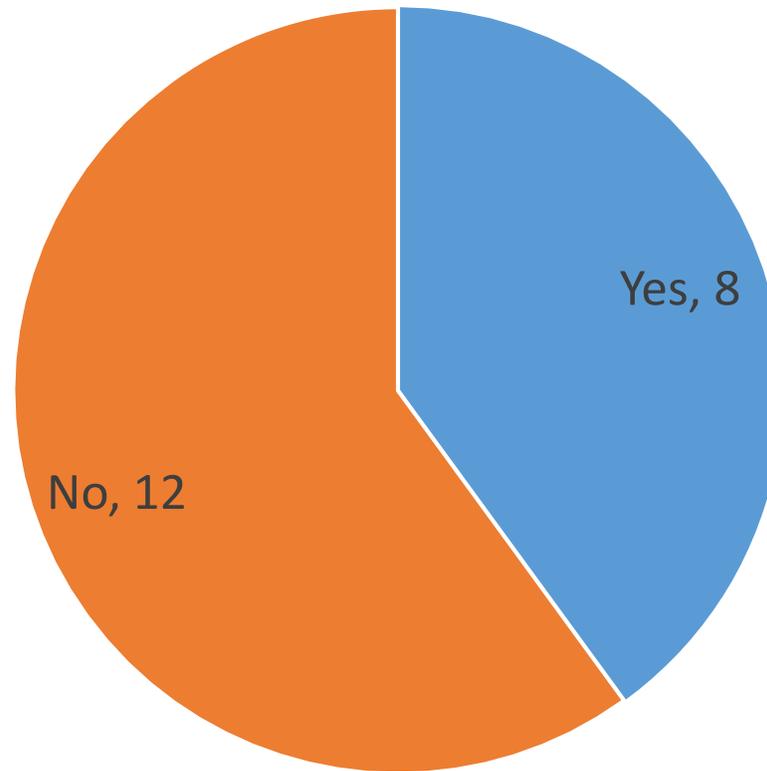


Q24. Do providers in your practice use a patient screening tool (e.g. Opioid Risk Tool or CAGE-AID Questionnaire) for opioid addiction or substance abuse before prescribing opioids? (20)

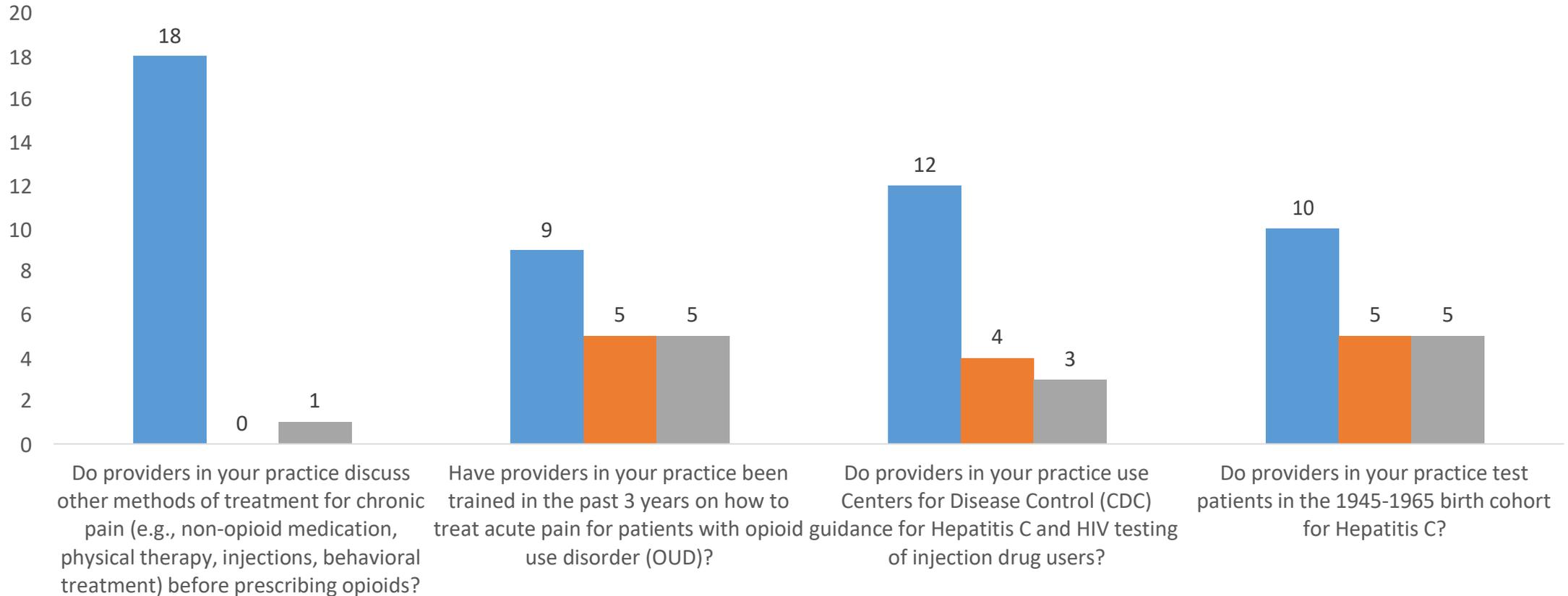


■ Yes, but we use some other form of assessment ■ Yes, we use a screening tool ■ Unsure ■ No

Q25. Do you currently have a behavioral health provider(s) who works in your primary care setting?

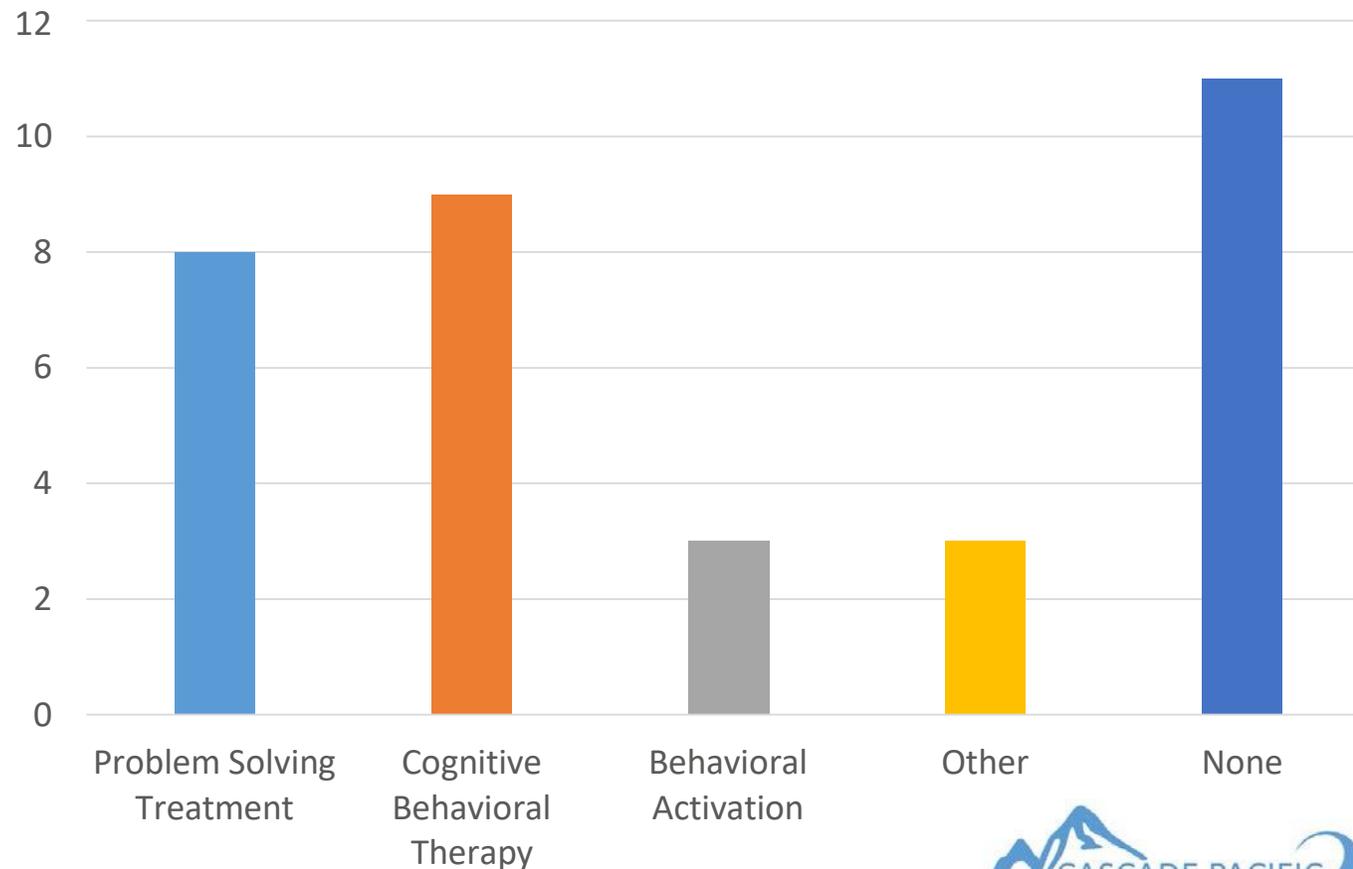


Q26. Please answer the following about providers: [2118] (29)



■ Yes ■ Unsure ■ No

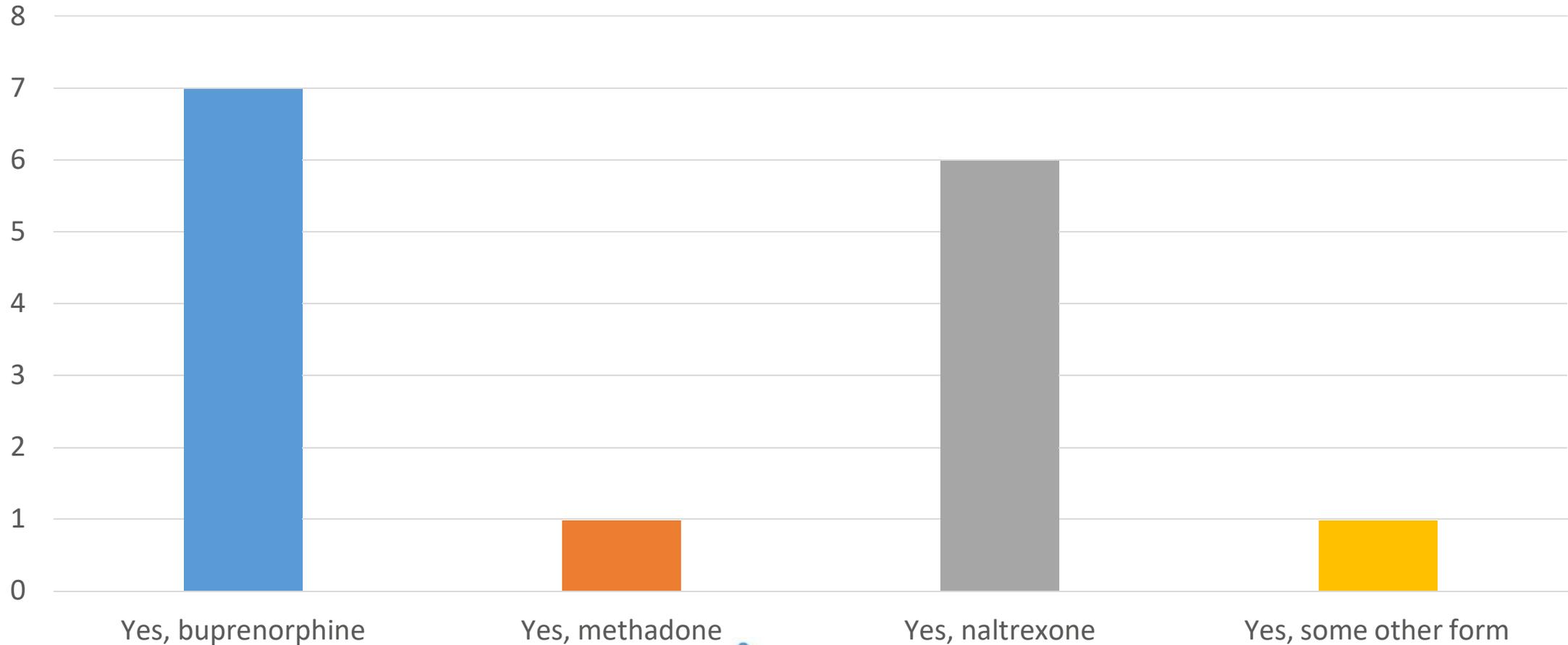
Q27. Which evidence-based brief interventions and psychotherapies are offered to your patients by a BH provider in your practice? (34)



Comments related to question

- Mindfulness, Solution Focused Therapy
- motivational interviewing, DBT, mindfulness, and SBIRT brief interventions
- We are contracted for medication evaluation and anticipating forefront will build their CBT and substance abuse program.
- medication
- Motivational interviewing, dialectic behavioral health therapy, CBT plus.
- Behavioral Health has limited CBT for patients facing SUD

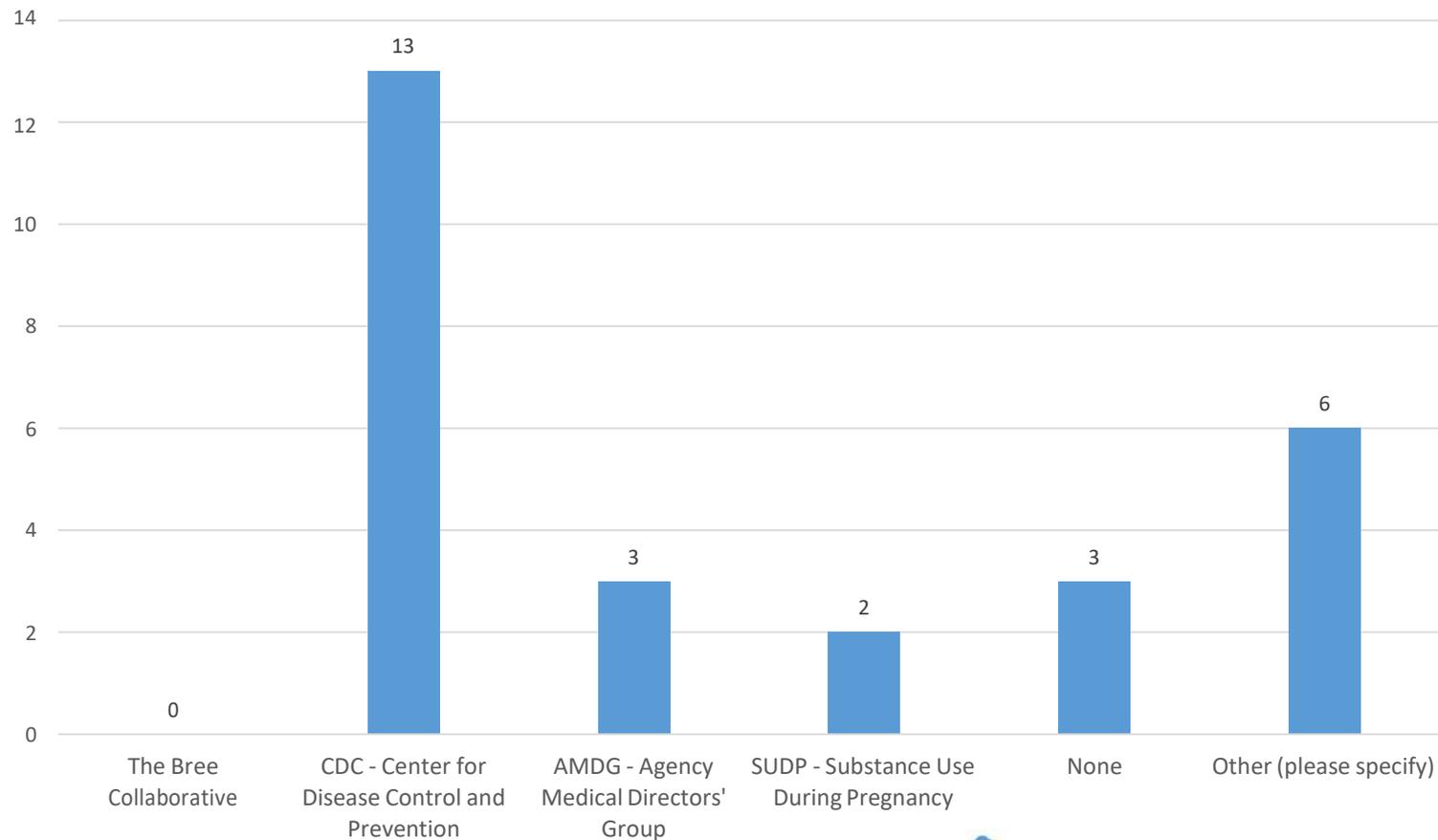
Q28. Do any providers in your practice prescribe medication assisted treatment (MAT)(15)?



Q29. Would new buprenorphine prescribers find a support program for new prescribers to engage with helpful?

Yes	<ul style="list-style-type: none">• Tribe 1• Hospital 1• Tribe 2• Family Practice• Community Health Center• Hospital 2
Unsure	<ul style="list-style-type: none">• Family Health Center• Hospital 3• Family Practice 1• Hospital 4• Family Practice 2
No	<ul style="list-style-type: none">• Hospital

Q30. Which opioid prescribing guidelines does your practice follow? (27)



Other Responses:

In pediatrics we prescribe minimally

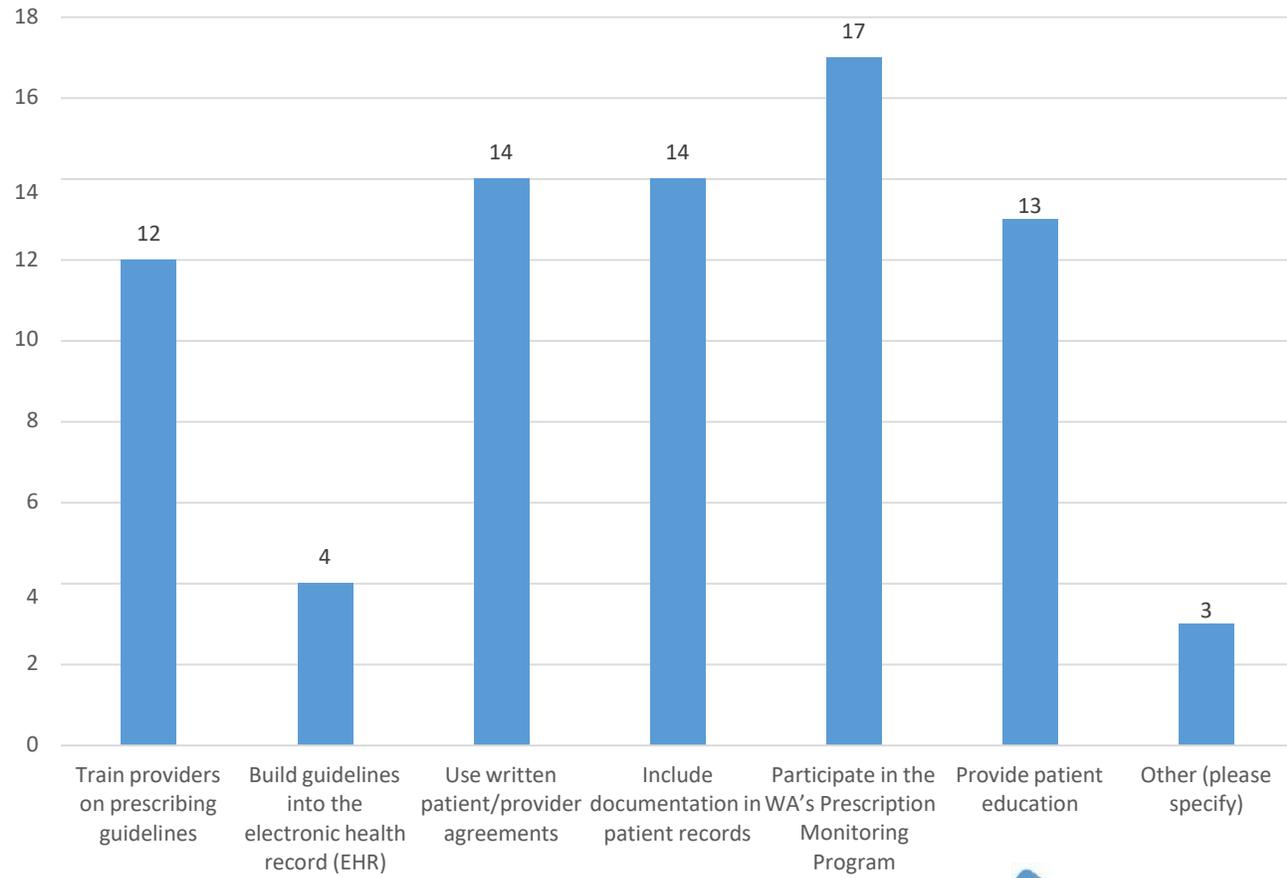
Providence Guidelines

AAP Guidelines

WAPMP

WA State Guidelines

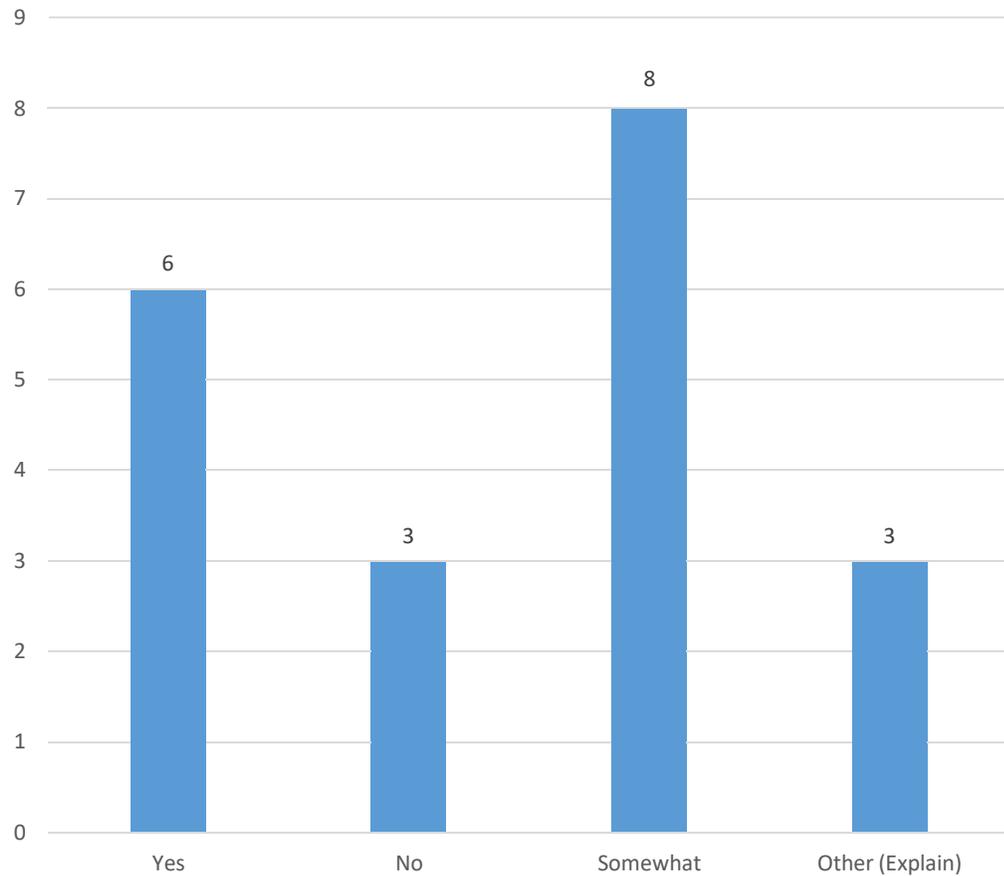
Q31. Are any of the following used in your practice to implement opioid prescribing guidelines and/or ensure safe opioid prescribing practices? (19)



Other: Minimal Prescriptions
N/A
Involvement of medical assistant in monthly scheduled prescriptions for suitable patients.

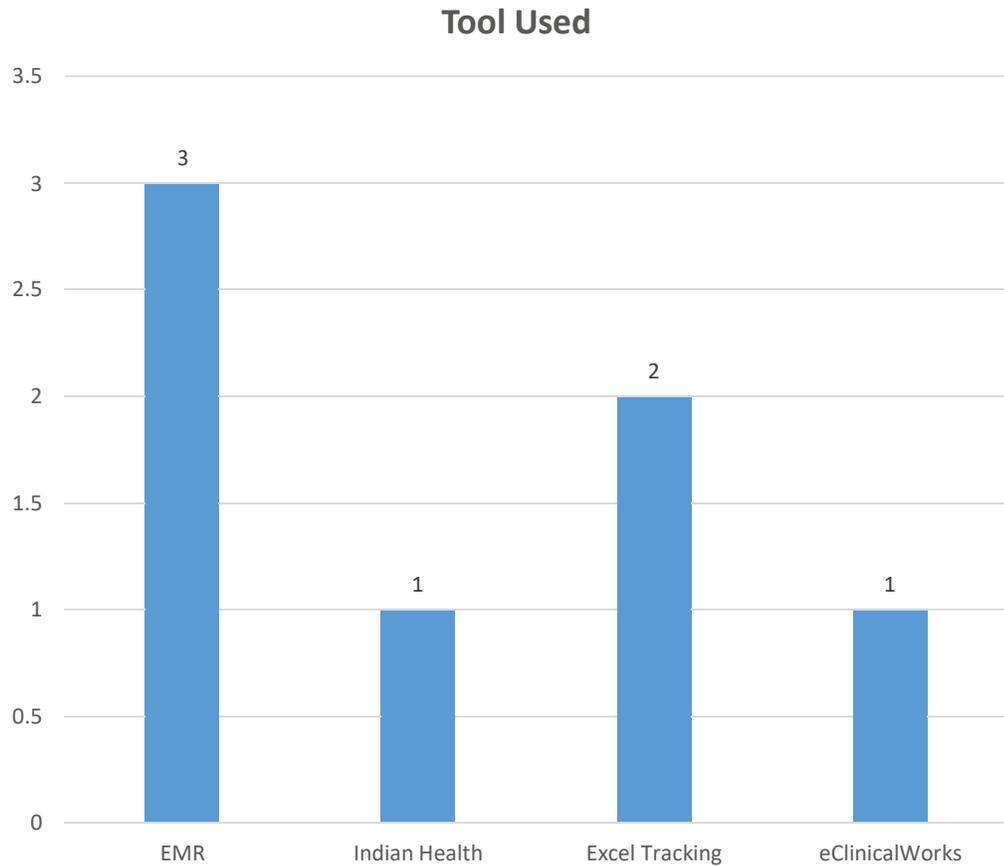


Q32. Do providers monitor treatment response at each contact with a valid outcome measure such as the Patient Health Questionnaire (PHQ-9)? "Provider" is a general term for a member of the primary care team. (20)



Other: Patient Disability quest
At well child visits/behavioral consultations
N/A

Q33. Does your practice use a population-based registry to systematically track patients? [2128] (7)



BH Metrics Tracked: PHQ/GAD, treatment duration, frequency of psychiatric consultation

Well visits; immunization status

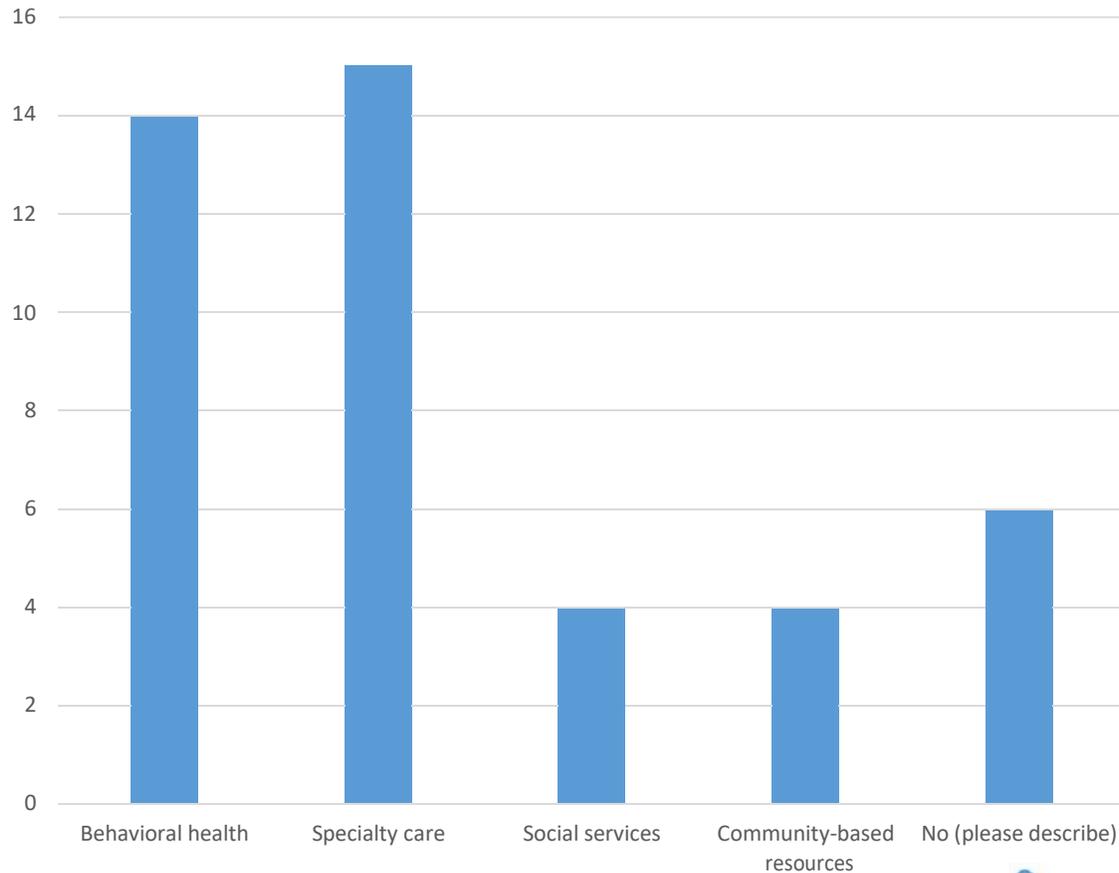
depression, anxiety, ADHD, autism

just by diagnosis

We can identify who is prescribed which medicines. For the scheduled prescription refills, a PMP report is routinely performed, and random urine tests are run.

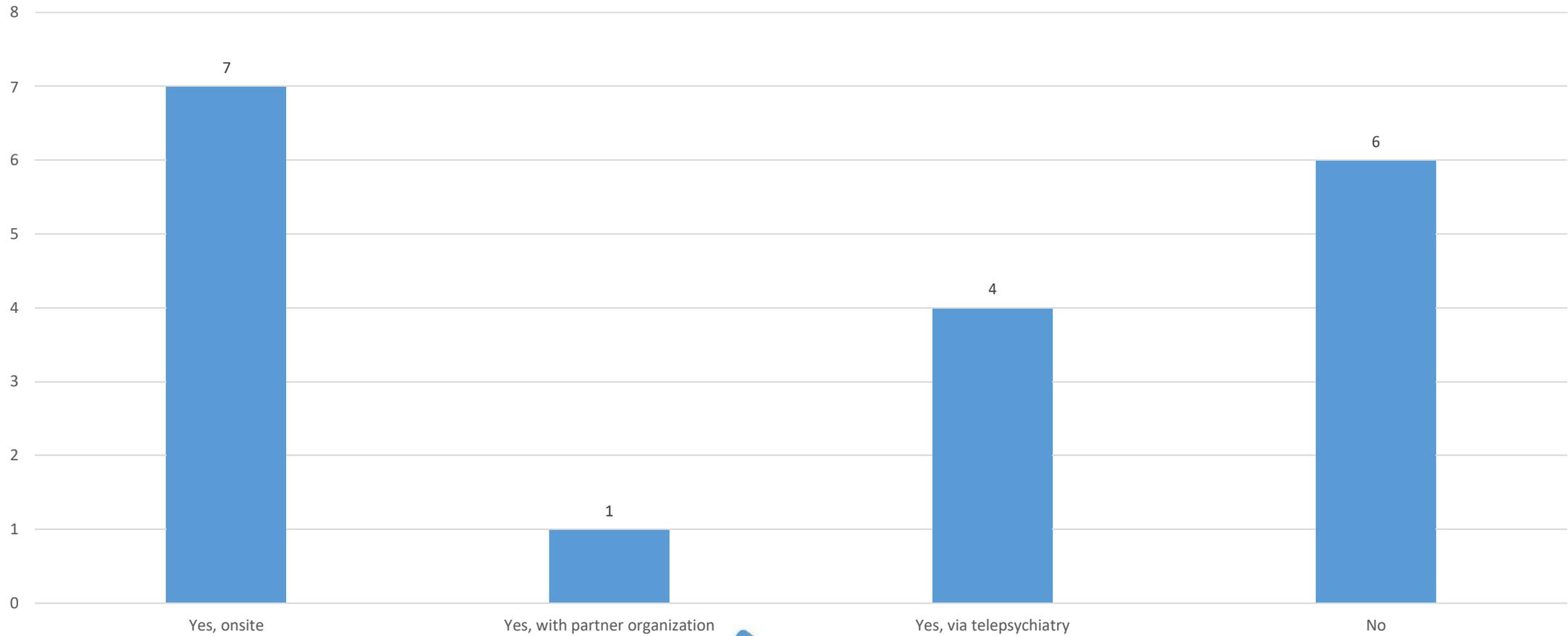
n/a

Q34. Does your practice track referrals to any of the following? (Please check all that apply.) [2129]

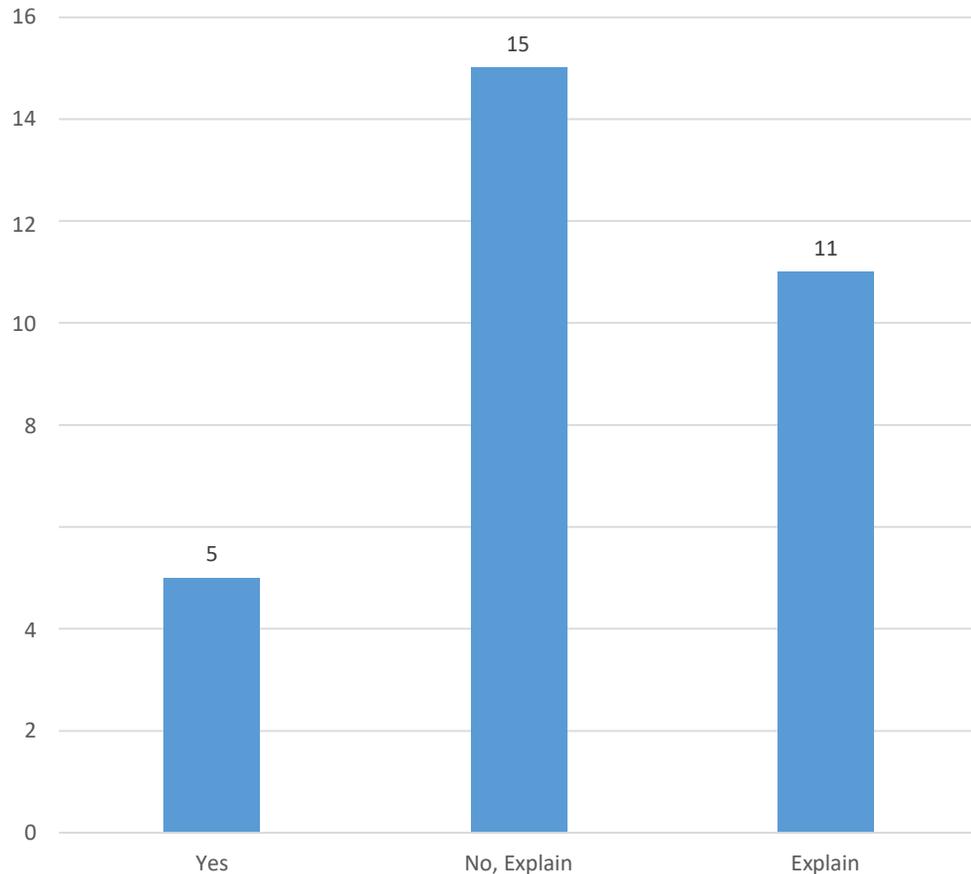


Other: I'm sure there is a way to pull referral info from EPIC, but no current workflow or staffing to do this type of work
Our registry does not allow us to easily select patients by referral type, or even by a specific referral destination.
For #35 - there is a co-located Mental Health Provider at the clinic site in Ocean Park - on a different floor - we've yet to purposefully leverage this.
There is follow-up questions at the next appointment
limited tracking in RPMS - not fully utilized
do not have a tracking system

Q35. Are psychiatric services available onsite, with a partner organization, or via telepsychiatry and coordinated with primary care? [2130] (18)

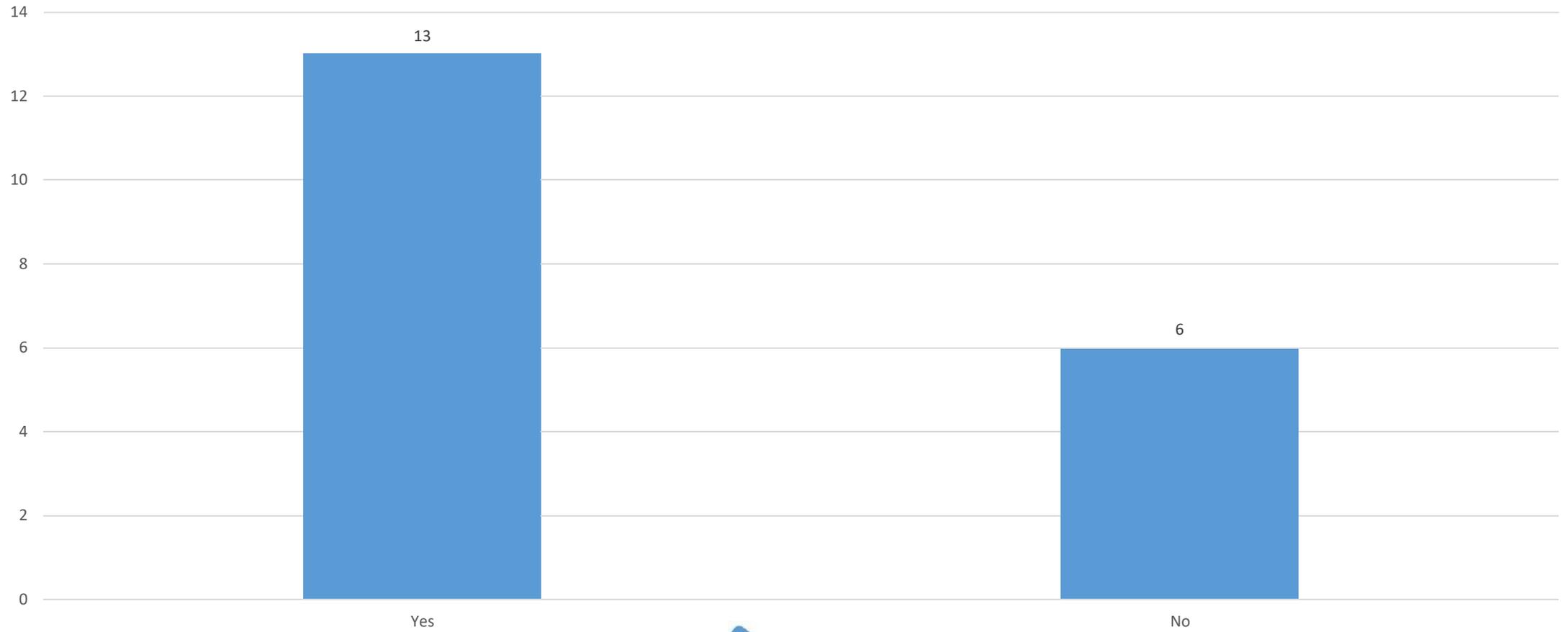


Q36. Does your practice conduct regular (e.g. weekly) psychiatric caseload review on patients who are not improving? [2131] (21)

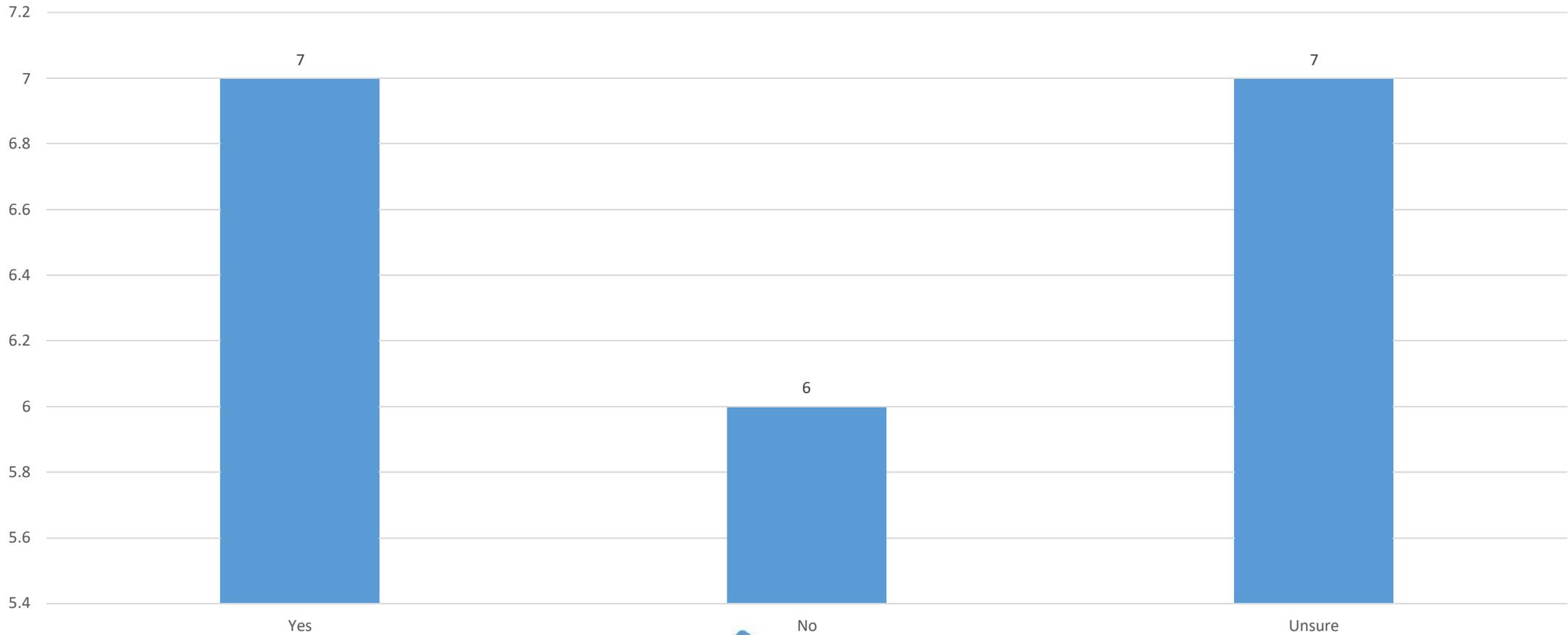


Explain: Not Currently,
Not Currently,
Each provider decides whether and when to refer patients to a higher level of care.
none
"Describe" does not make sense.
Caseload reviews occur, but not on a regular basis.
No we do not -
We don't provide and do not have a partner provider with which to do this
no caseload reviews
No

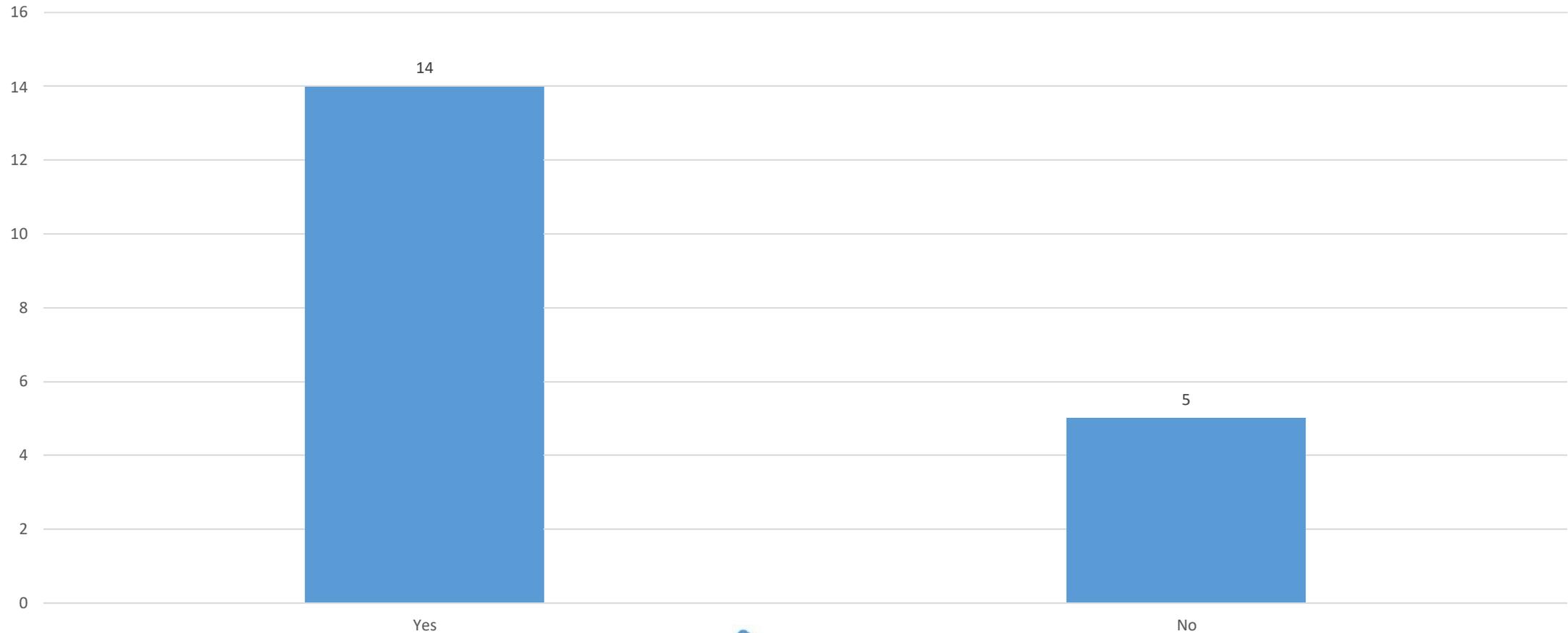
Q37. Are psychiatric assessments conducted for patients with high behavioral health needs in-person or via telemedicine? [2132] (19)



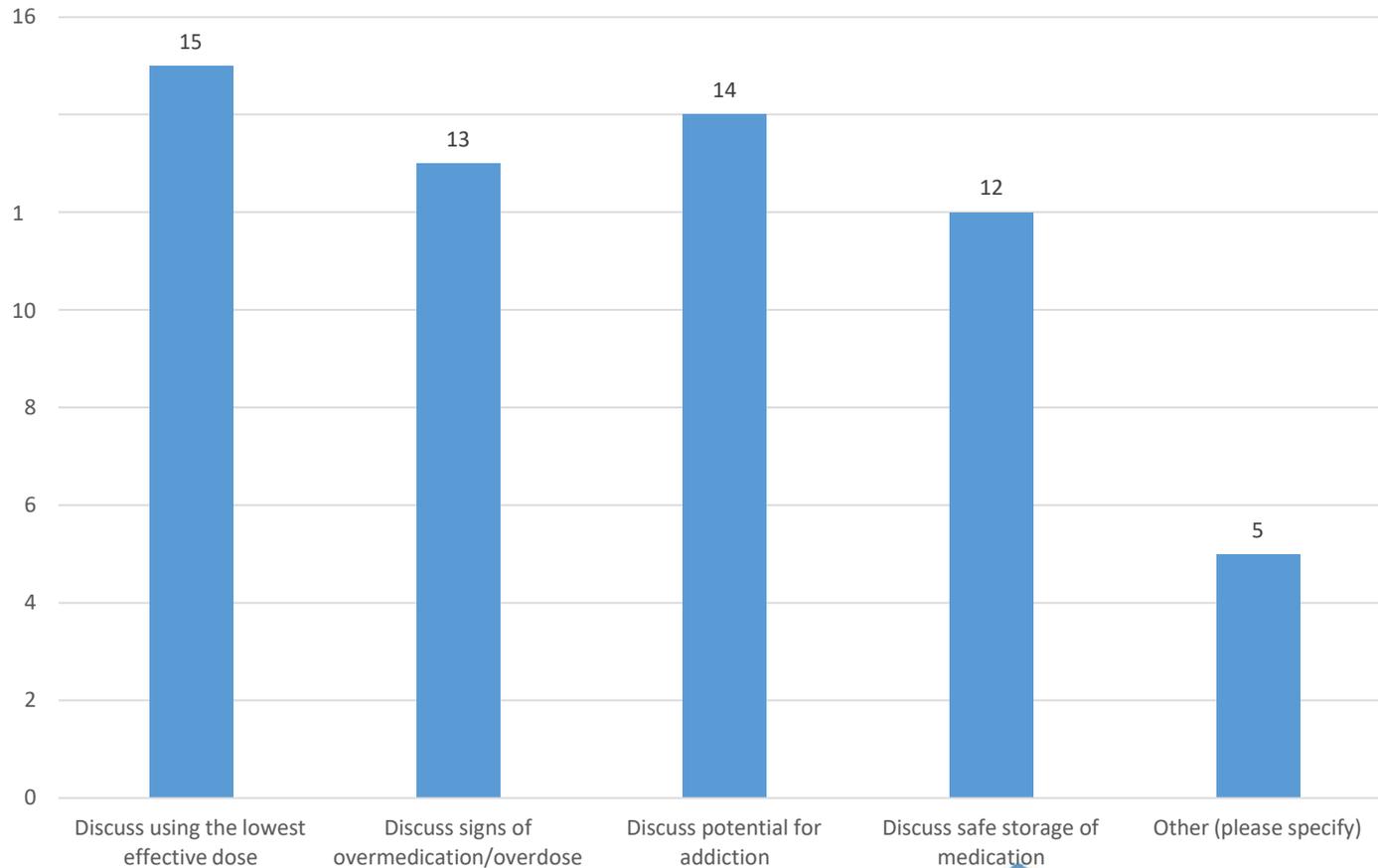
Q38. Is the practice open to learning more about facilitating low barrier buprenorphine treatment? (Low barrier: prescribed unobserved induction exclusively, saw patients no more than weekly, and did not require additional psychosocial treatment.) [2133] (20)



Q39. Do you routinely (e.g. monthly) examine provider and program-level outcomes (e.g. clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement?
[2134] (19)



Q40. Do providers at your practice do any of the following when they prescribe opioids for chronic pain? (Please check all that apply.) [2135] (18)



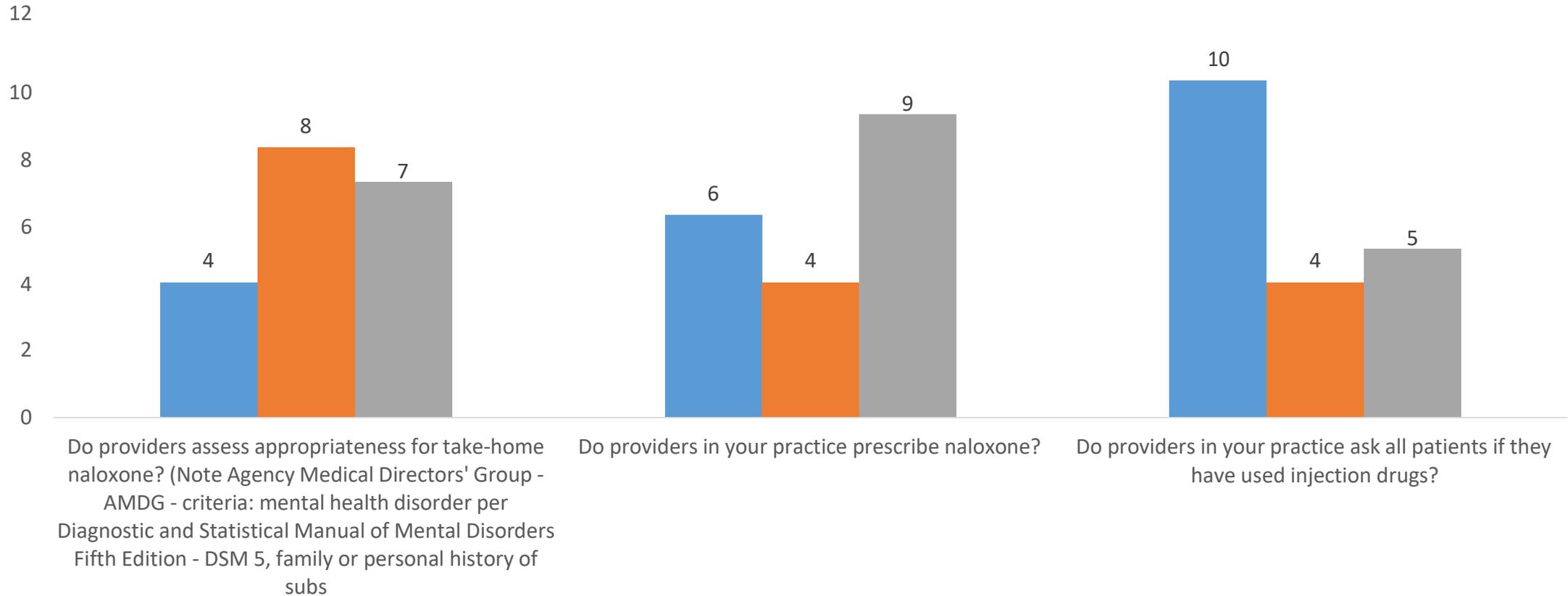
Other: N/A

We don't prescribe opiates for chronic pain

Co Rx Naloxone

Discussions regarding limiting dose rarely prescribe

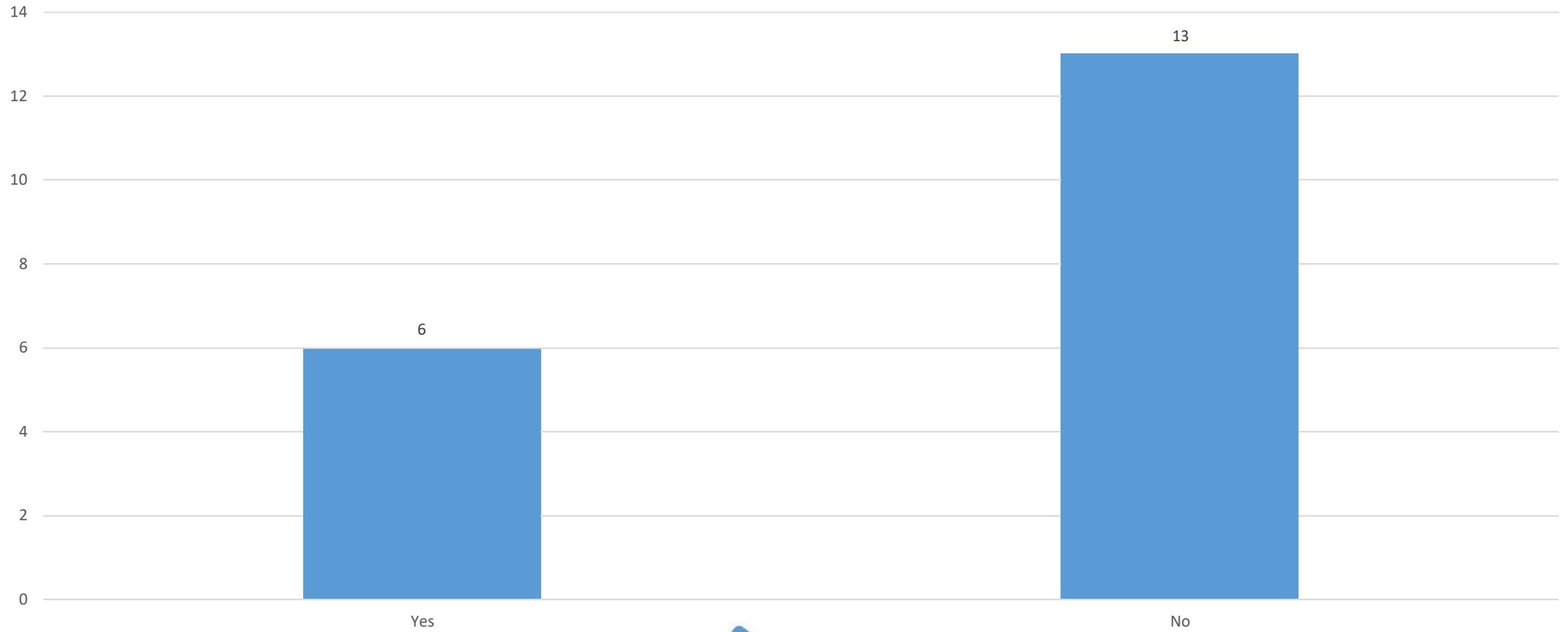
Q41. Please answer the following about providers: [2136] (19)



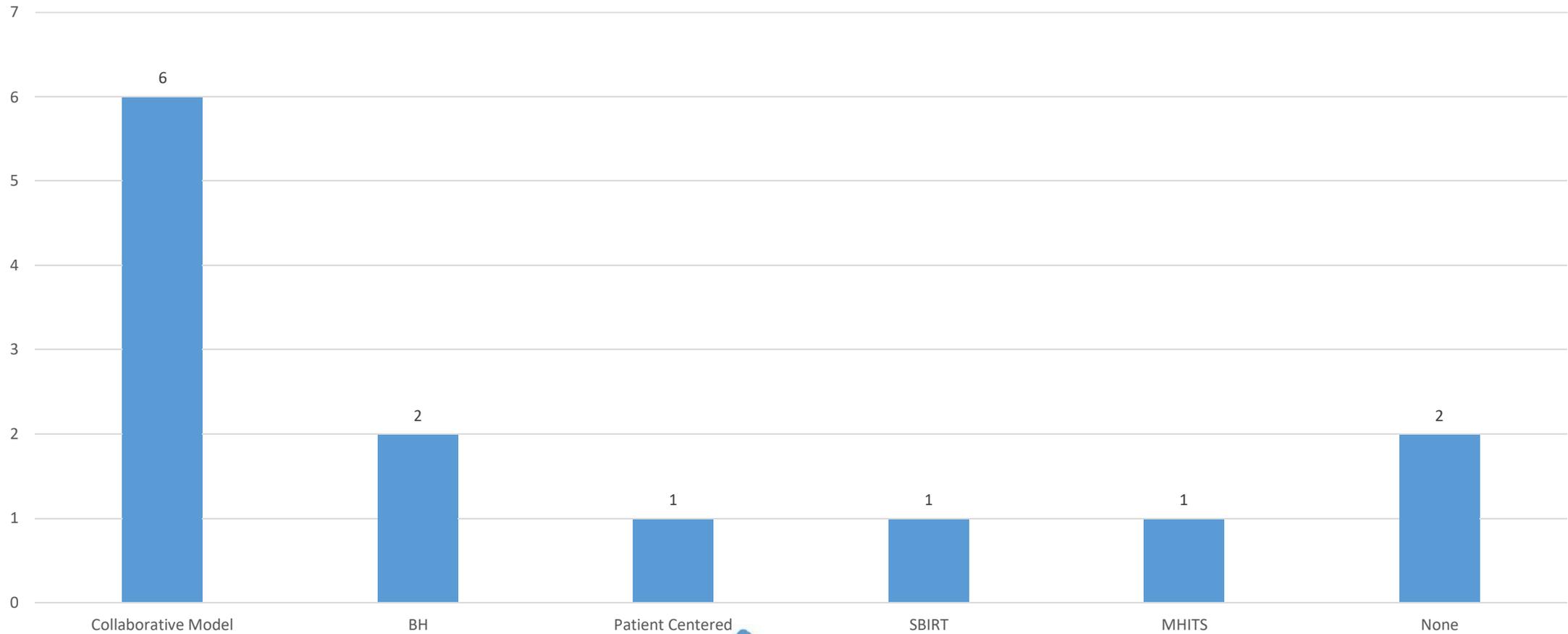
■ Yes ■ Unsure ■ No



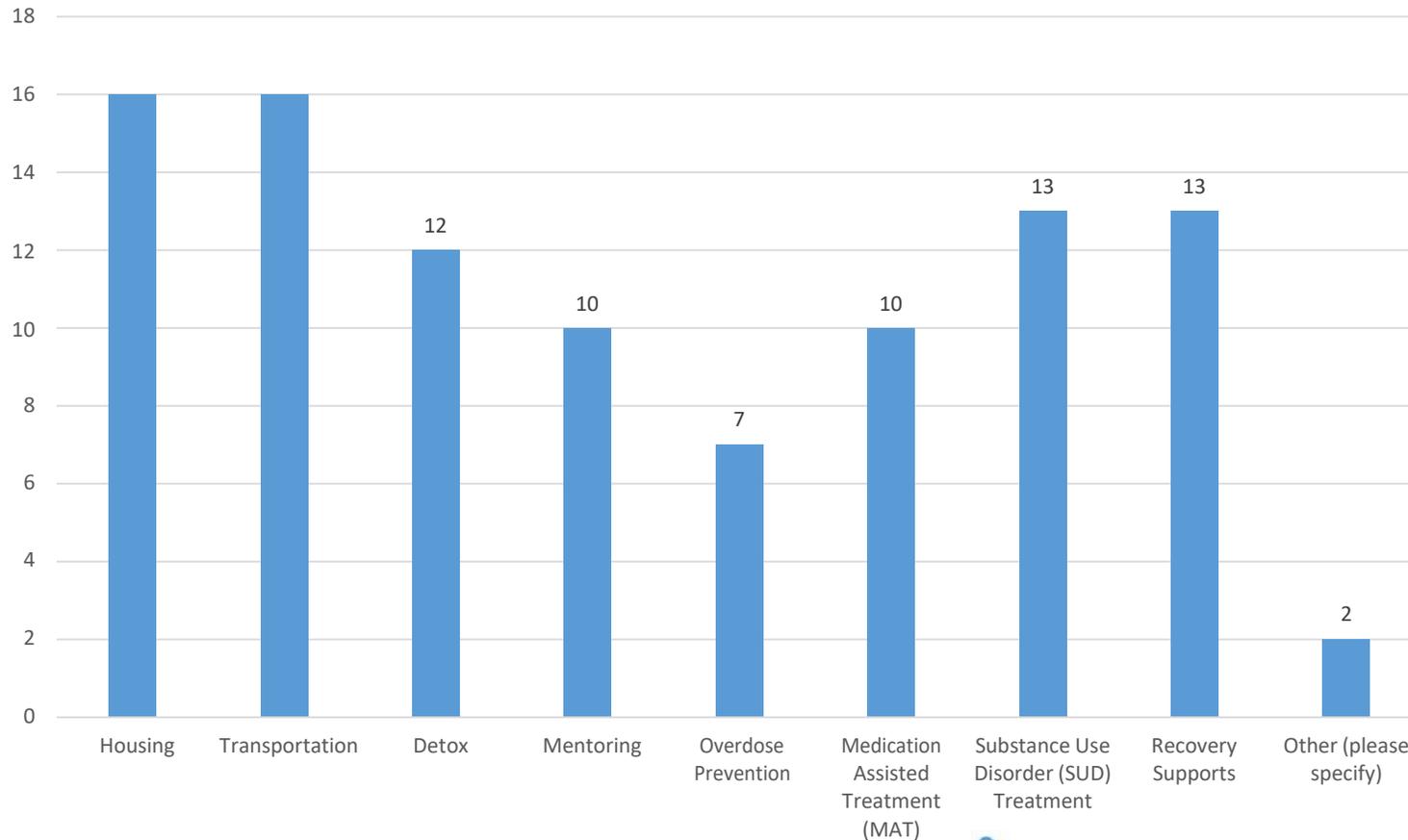
Q42. Does your program or practice discontinue care for patients with opioid use disorder or substance use disorder when they relapse? [2139] (19)



Q43. If you are implementing a specific integrated care model, which model or aspects of a model are you implementing? [2140] (13)



Q44. Related to social determinants of health, which of the following services do your patients or clients need most? (Please check all that apply.) [2141]

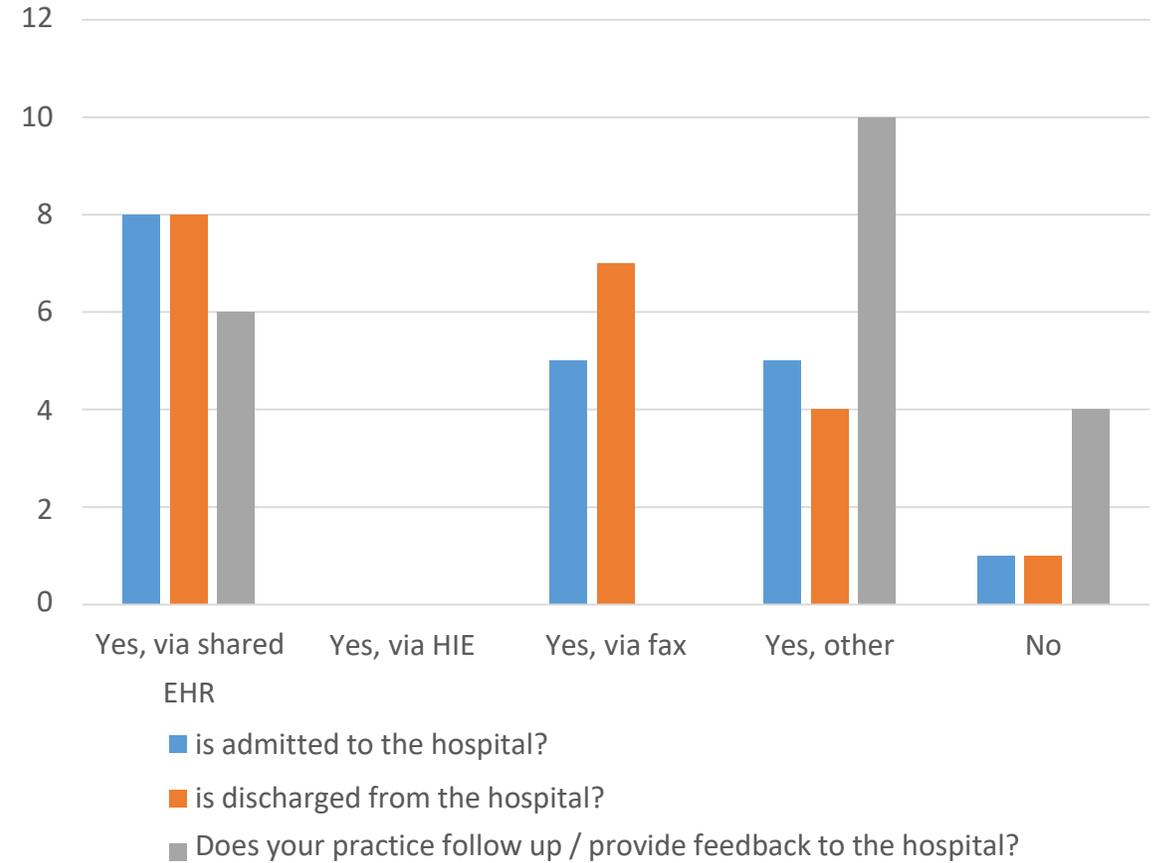
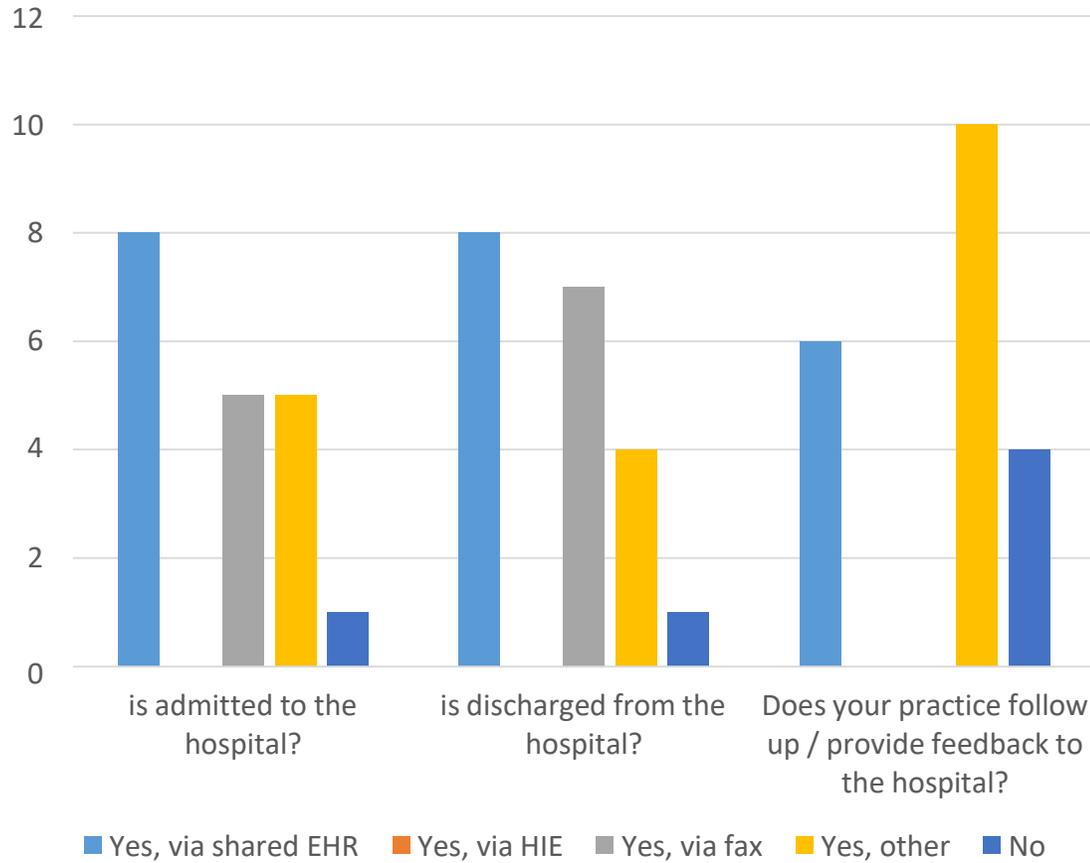


Others: None Apply to Us, Medicaid patients with substance use disorder can have a wide range of needs. Some are highly functional and could use help primarily with vocational skills and job availability. At

without a steady place of residence. Many have transportation problems due to cars breaking down and living

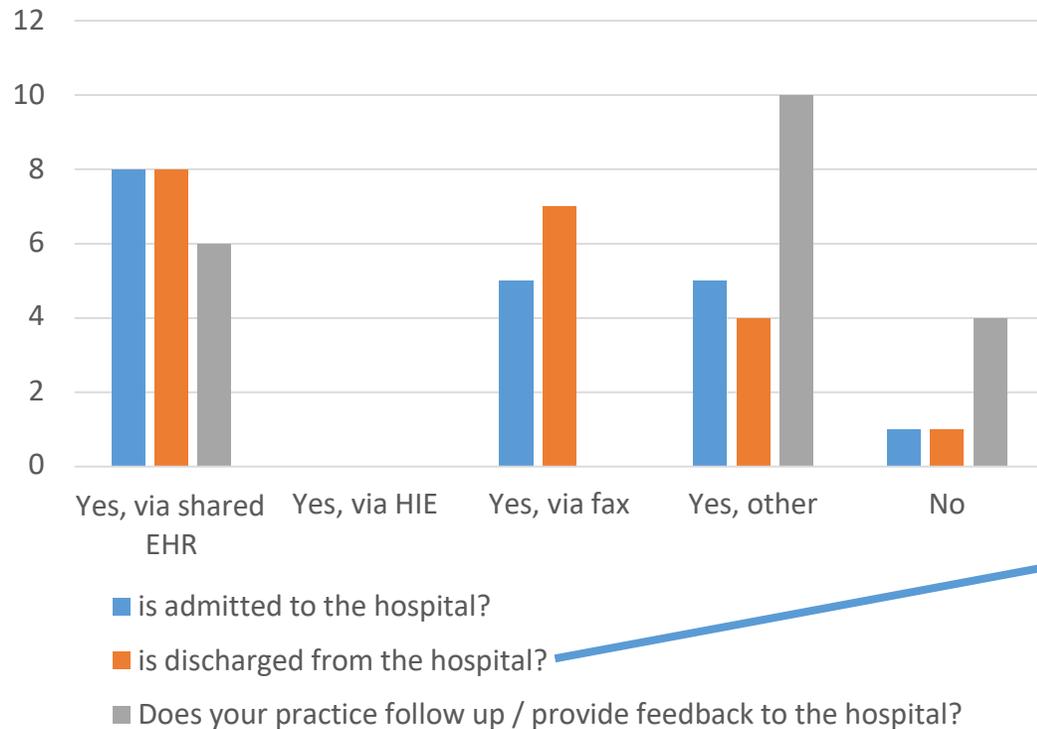
Medicaid patients do not have substance use disorder but could use all kinds of help - home nursing, diabetes education, nutrition education and mentoring, etc.

Q45. Does your practice receive notification when one of your patients (20)

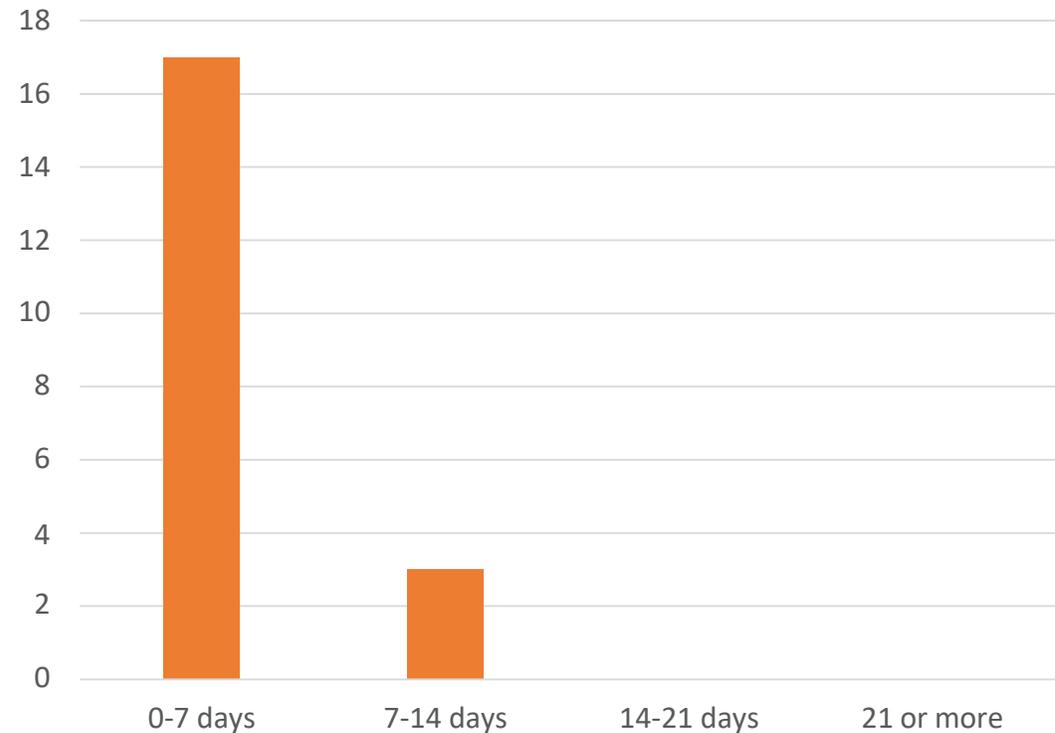


Comparison, average wait time for a scheduled follow-up appointment after hospital or in-patient discharge

Q45. Does your practice receive notification when one of your patients (20)

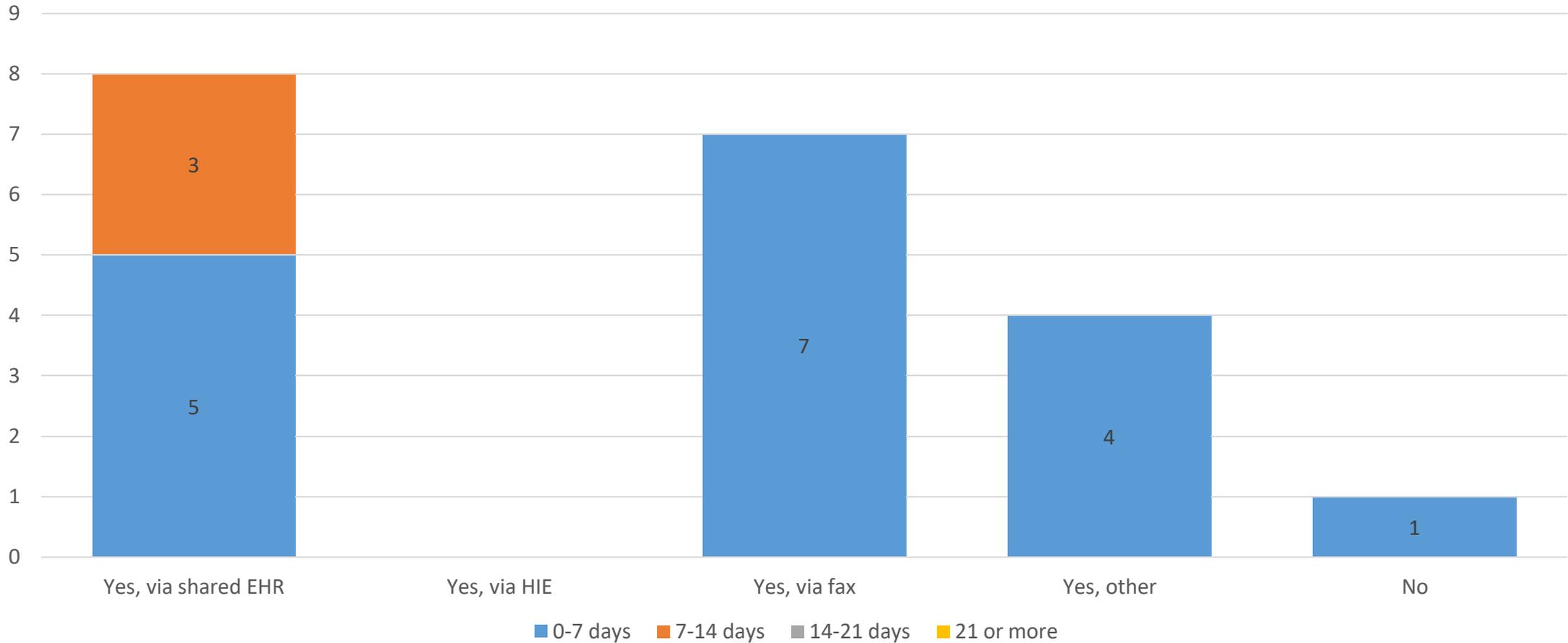


46. What is your average wait time for a scheduled follow-up appointment after hospital or in-patient discharge? (20)

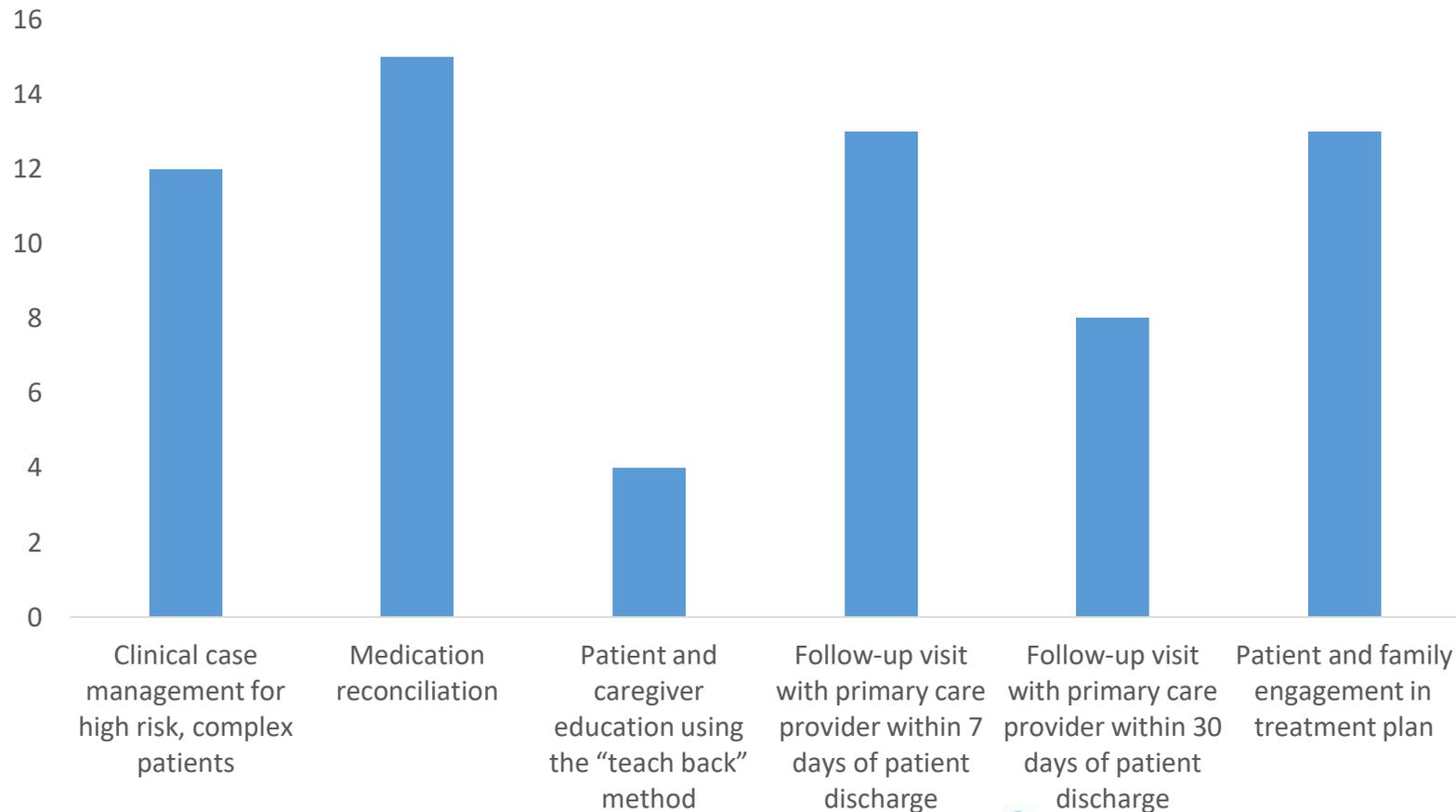


Q45. Does your practice receive notification when one of your patients is discharged from the hospital? (20)

46. What is your average wait time for a scheduled follow-up appointment after hospital or in-patient discharge? (20)

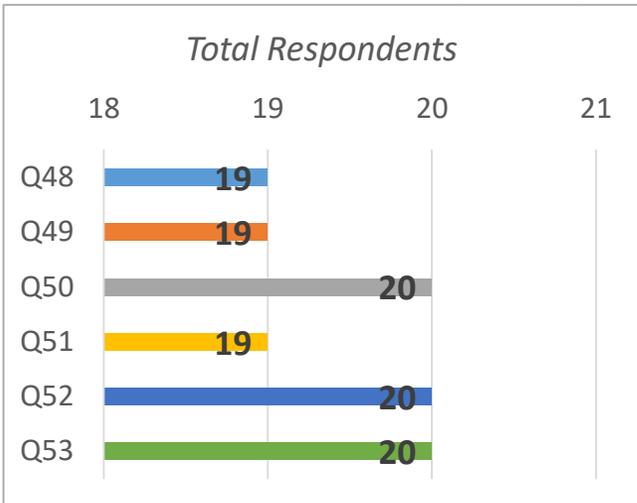
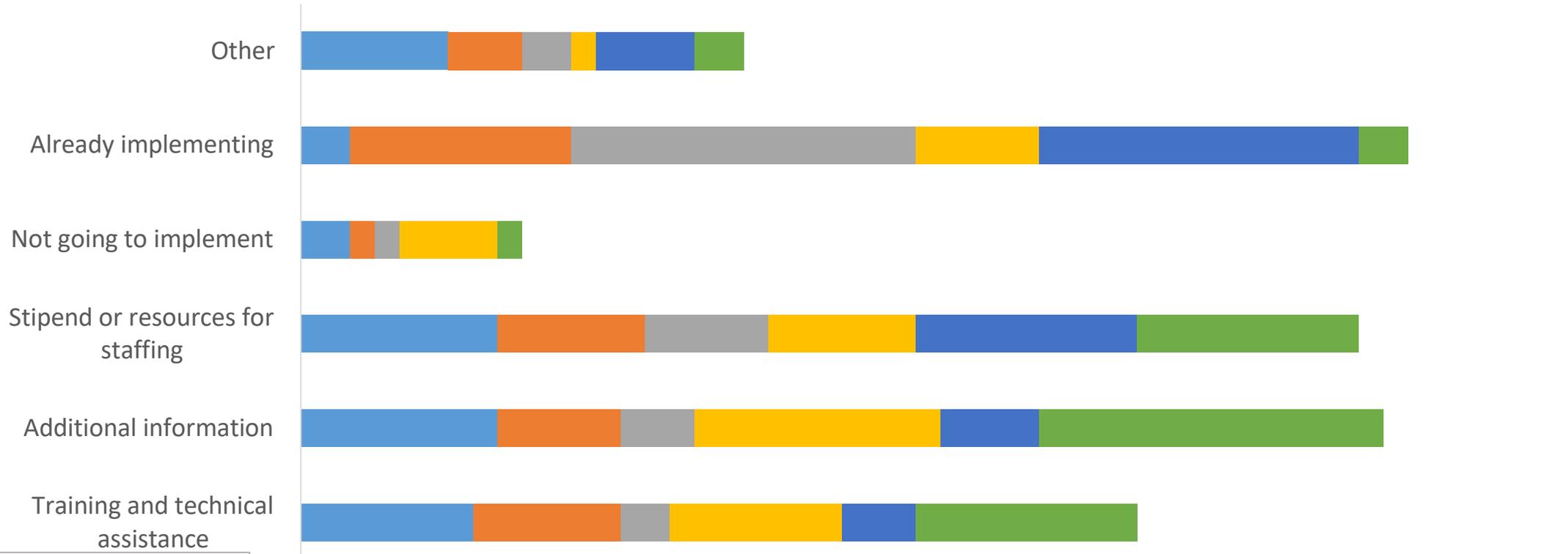


47. For patients who have been discharged from the hospital, which of the following elements has your practice adopted? (20)



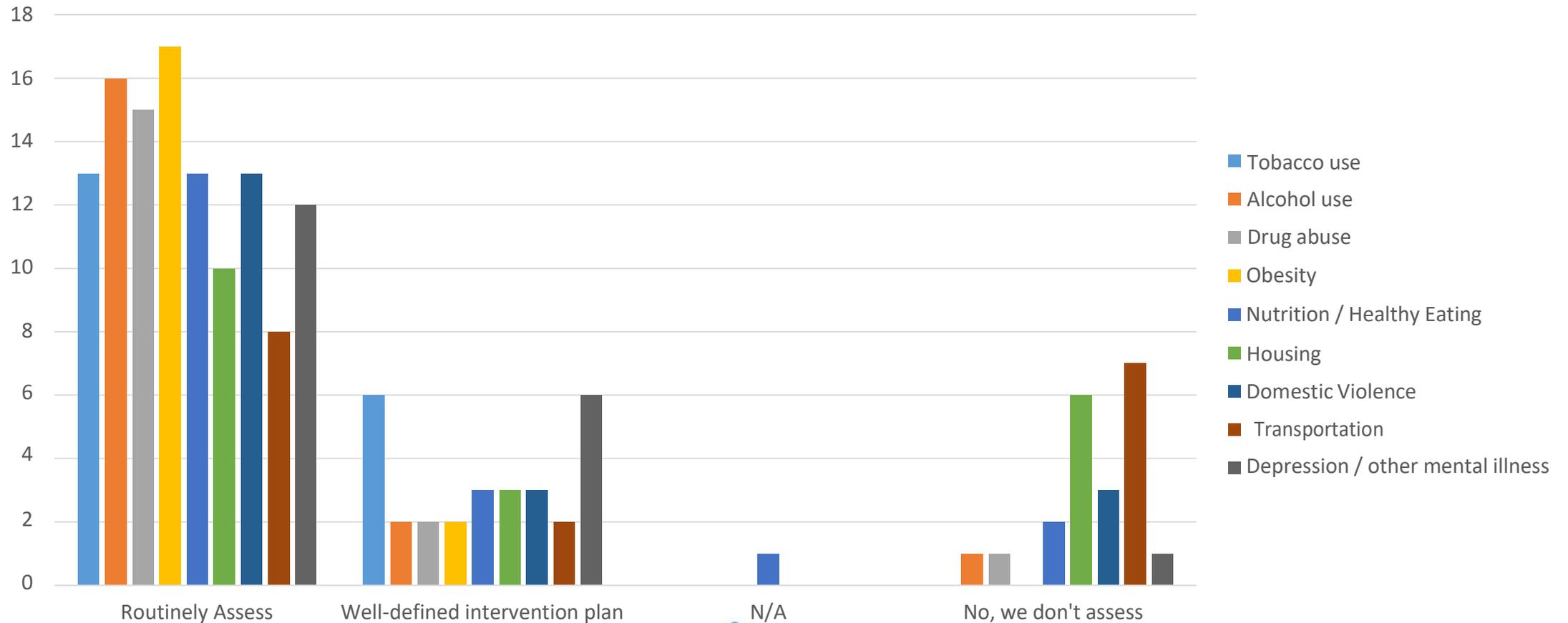
Other (please specify)

- Follow-up with family by phone/in office when appropriate
- Hospital follow-up period varies depending on severity and complexity of patient's medical condition.
- F/U appointment on discharge
- Initiating a structured transition of care for inpatient admissions. Process will include 2-3 contracts with a Care Management RN who will screen clients.
- We are typically an entry point for patients into the health care system.
- none

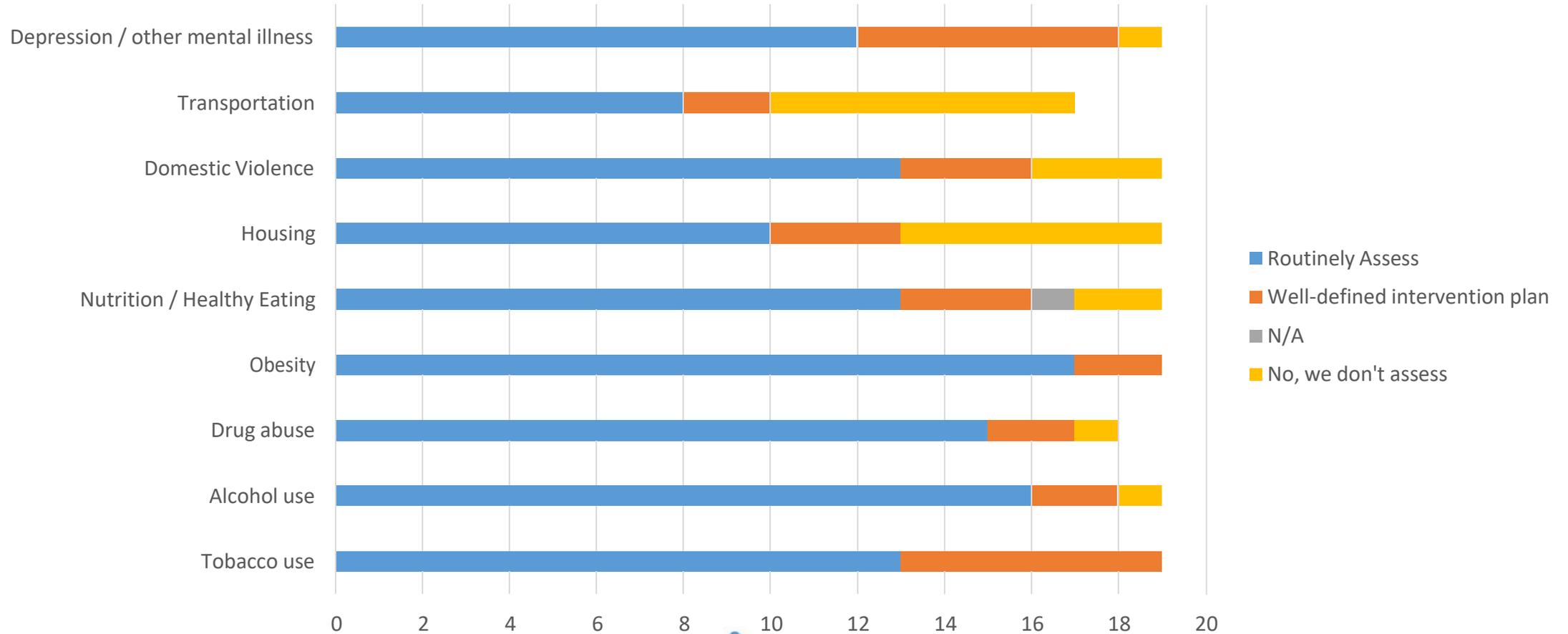


- Q48. What do you need to implement One Key Question?
- Q49. What do you need to provide long-acting reversible contraceptives?
- Q50. What do you need to increase chlamydia screenings in women ages 16-24?
- Q51. What do you need to implement Bright Futures or Enriched Medical Home Intervention?
- Q52. What do you need to increase immunization rates in children?
- Q53. What do you need to become a trauma-informed care practice?

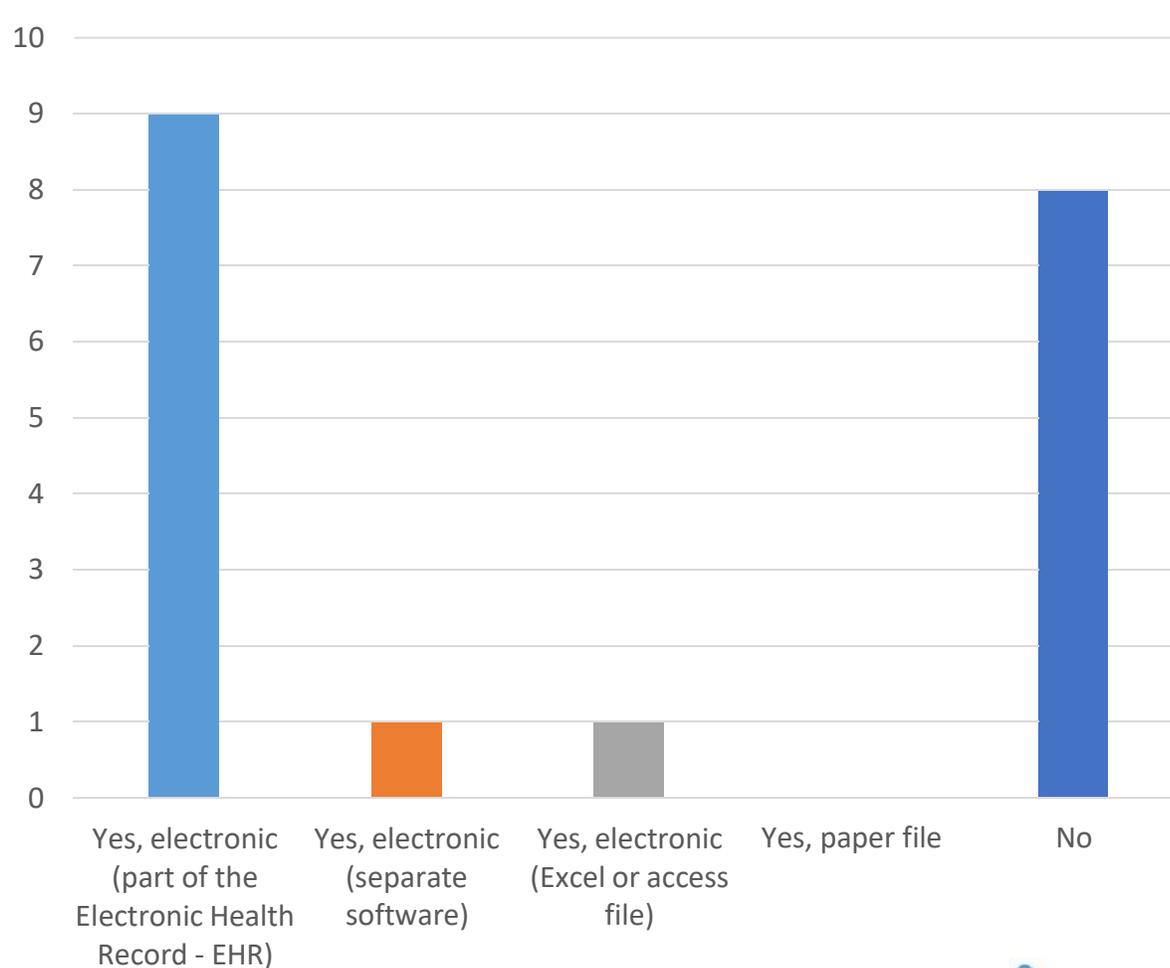
Q54. Does your practice routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors? (19)



Q54. Does your practice routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors? (19)

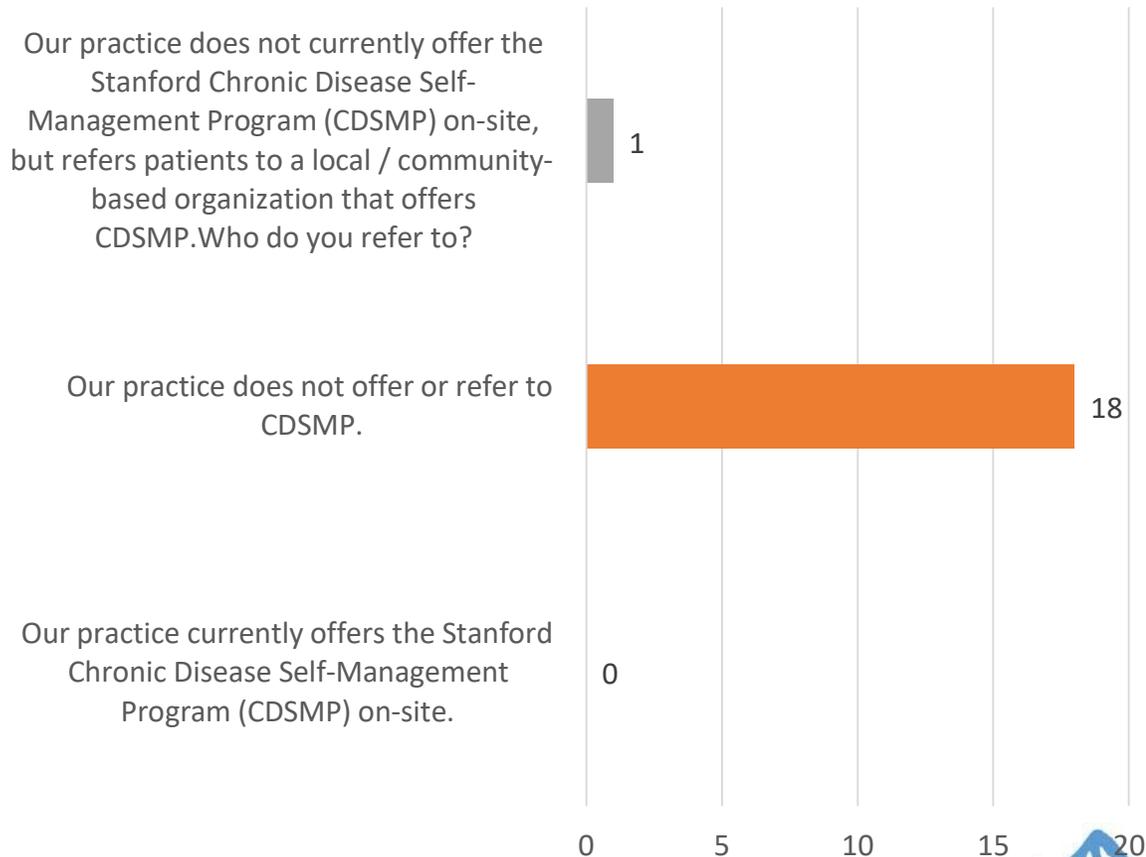


Q55. Does your practice maintain a chronic disease registry or registries? (19)

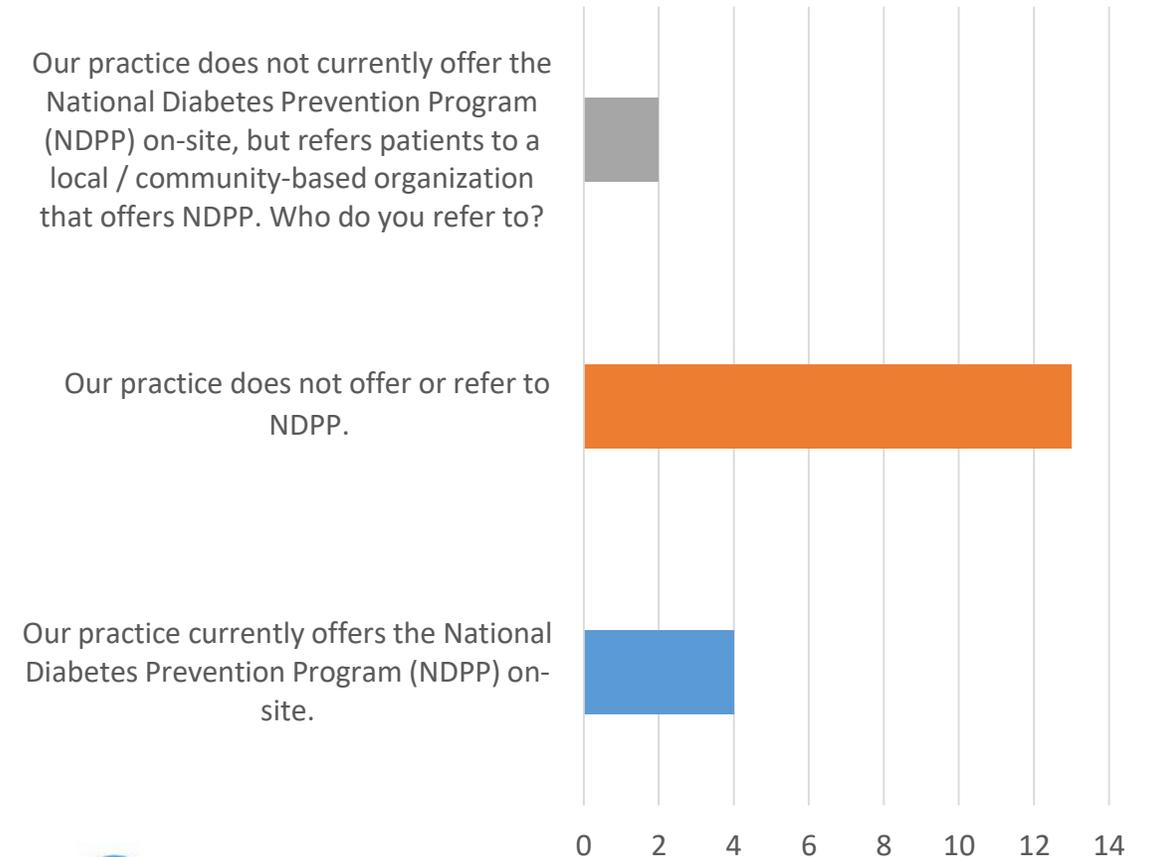


- **Yes, electronic (separate software)**
 - Yes electronic both by a separate software and by an excel file.
- **Yes, electronic (part of the Electronic Health Record - EHR)**
 - We keep a diabetes registry. We also explored the chronic disease registry in our EHR and found it cumbersome and not worthwhile.
- **Yes, electronic (Excel or access file)**
 - Only for our diabetic patients
- **No**
 - We have barely started a registry but can pull by diagnosis and have used this to call people with chronic conditions in for flu vaccine. We need one for ADHD, mental health conditions, diabetes and asthma at a minimum.
 - ability to track by disease state in EPIC, but not routinely utilized
 - We have registries but EHR has not went live with it yet.
 - Yes .. hopefully plan to start soon to track our behavioral health patients, esp depression
 - Will be part of Cerner's healthintent 2019
 - Yes, when we implement population health. Likely 2019 for conditions TBD based on our patient needs/population.
 - Hoping to establish registry for diabetes, COPD, behavioral health

Q56. Stanford Chronic Disease Self-Management Program (CDSMP): Please select the response option that best describes your practice. (19)



Q57. National Diabetes Prevention Program (NDPP): Please select the response option that best describes your practice. (19)



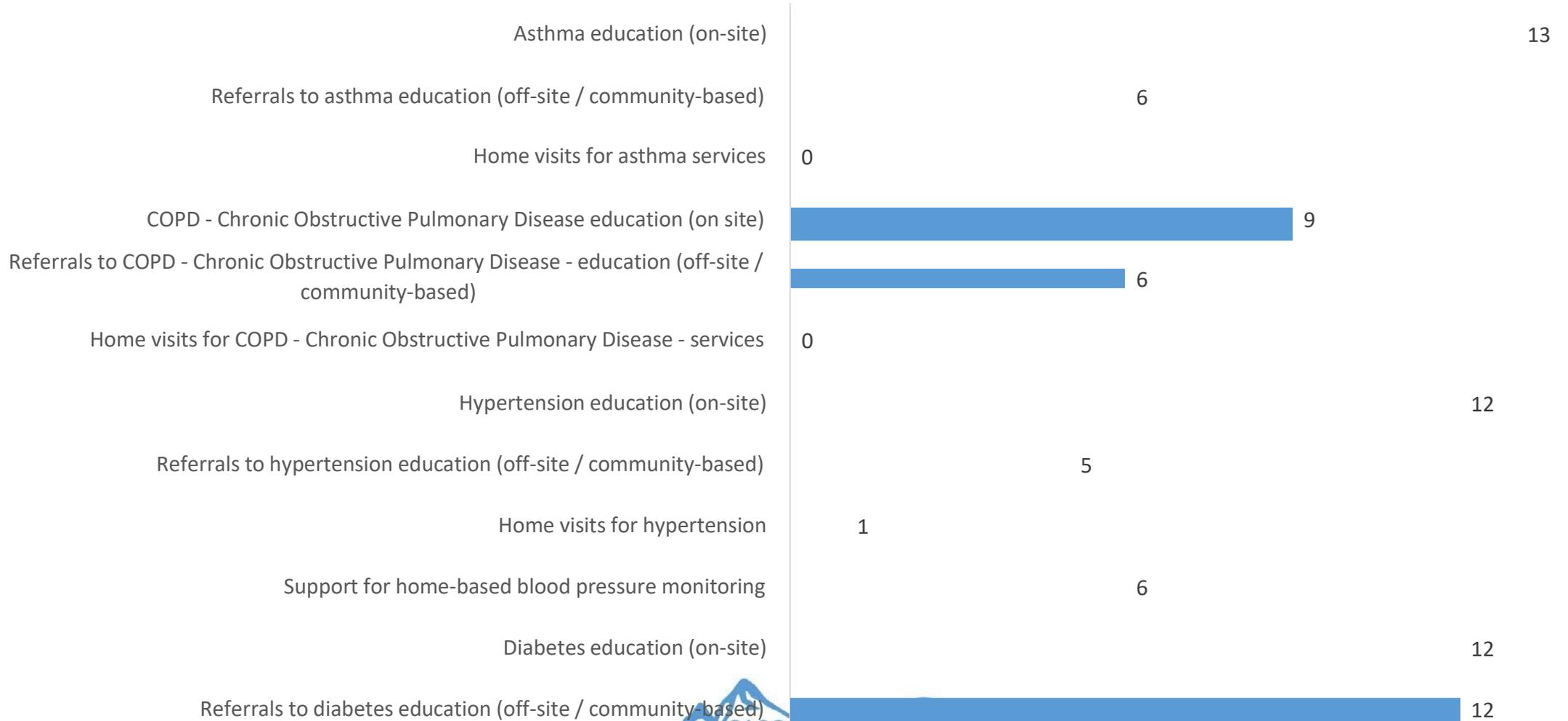
Q58. Our practice currently offers the following (19)

Asthma

COPD

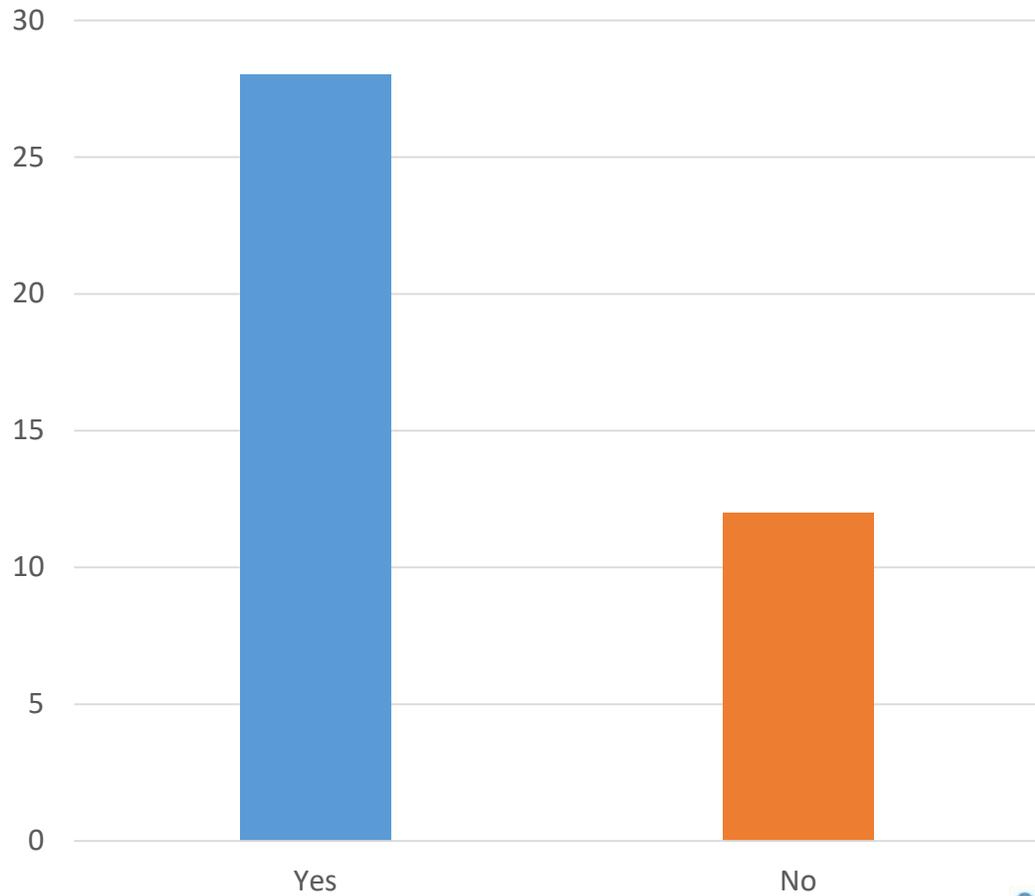
Hypertension

Diabetes

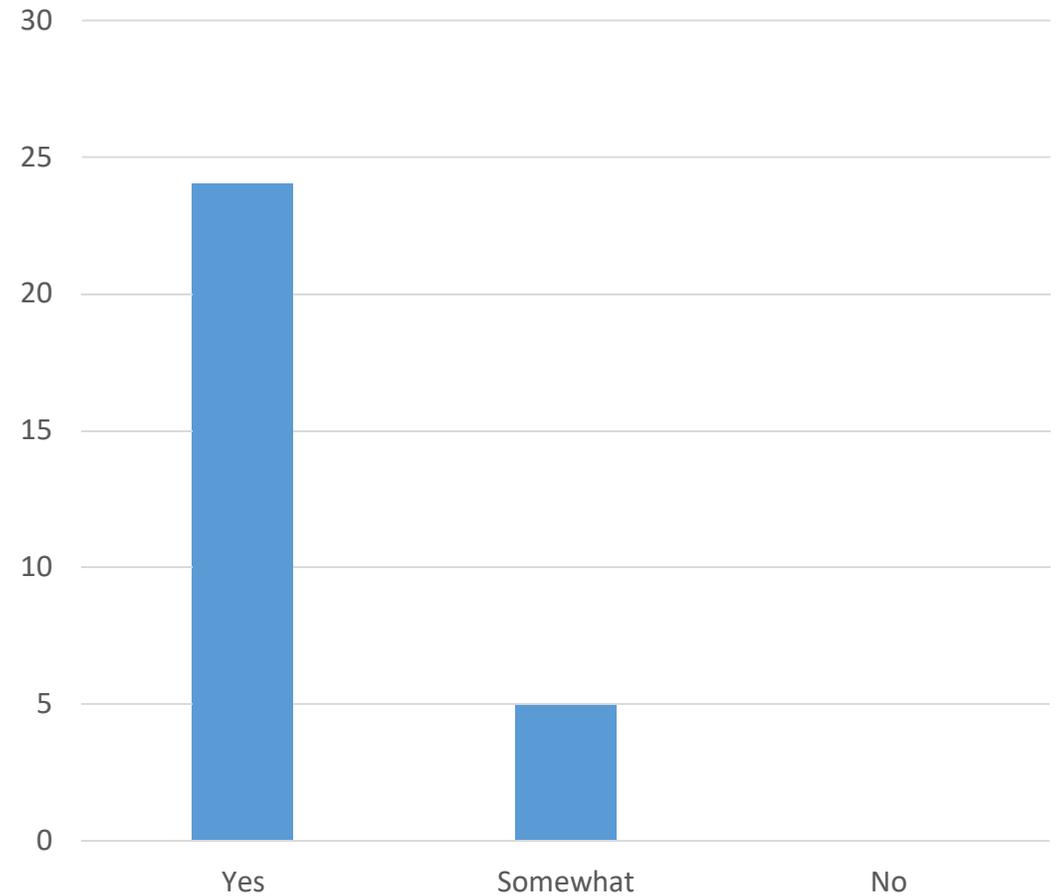


Behavioral Health or Substance Use Disorder

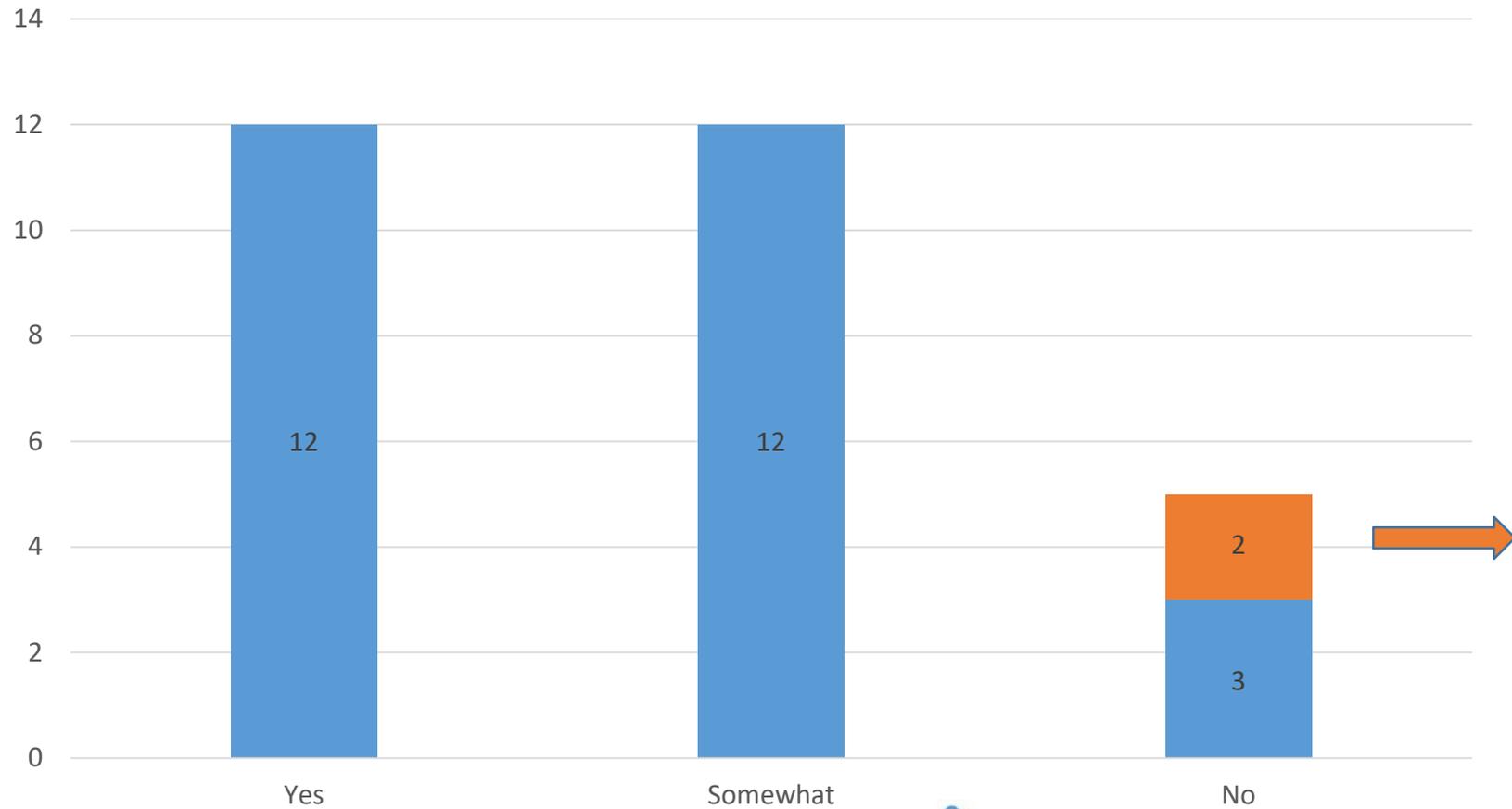
Q59. Does your organization offer behavioral health services (mental health and/or substance use disorder)? (40)



Q60. Is there involvement and support from key senior leadership and clinic leadership to implement an integrated care program? (29)

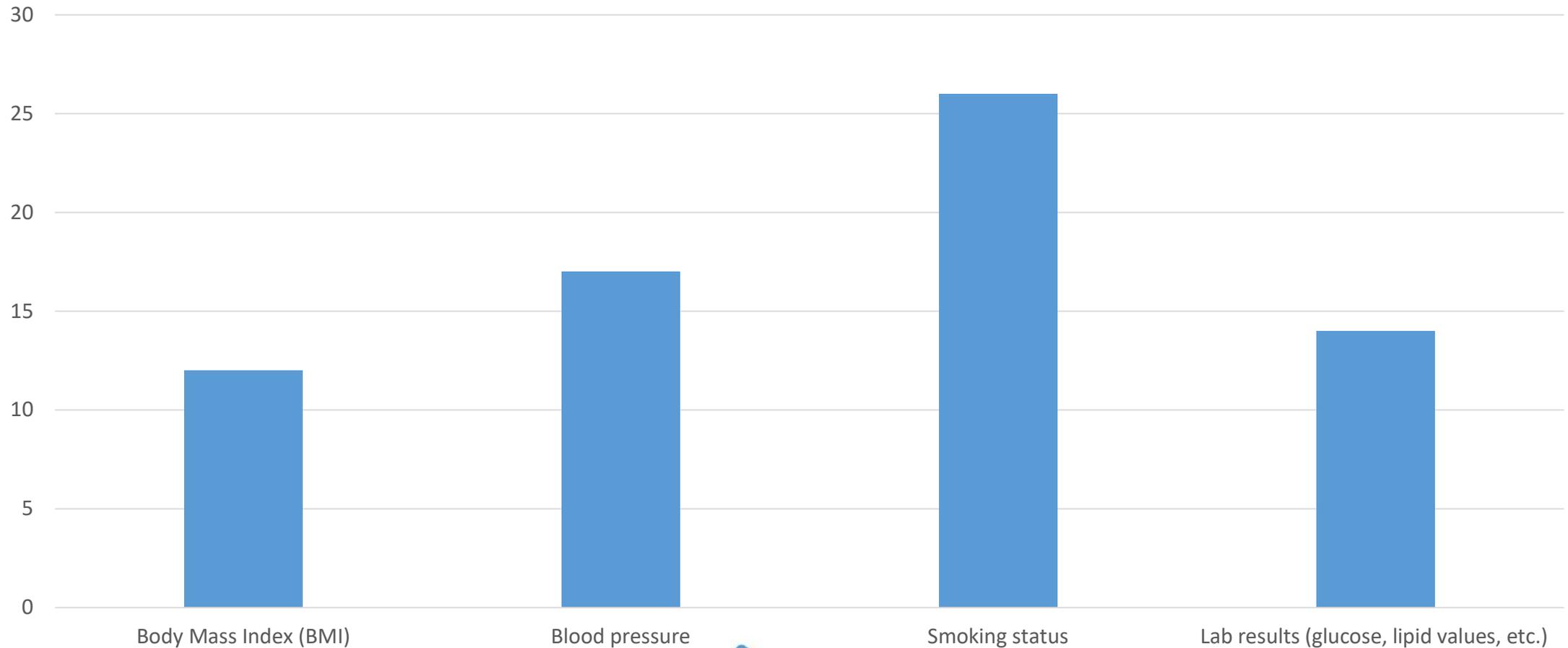


Q61. Does your practice have a plan for integrating primary care? (29)

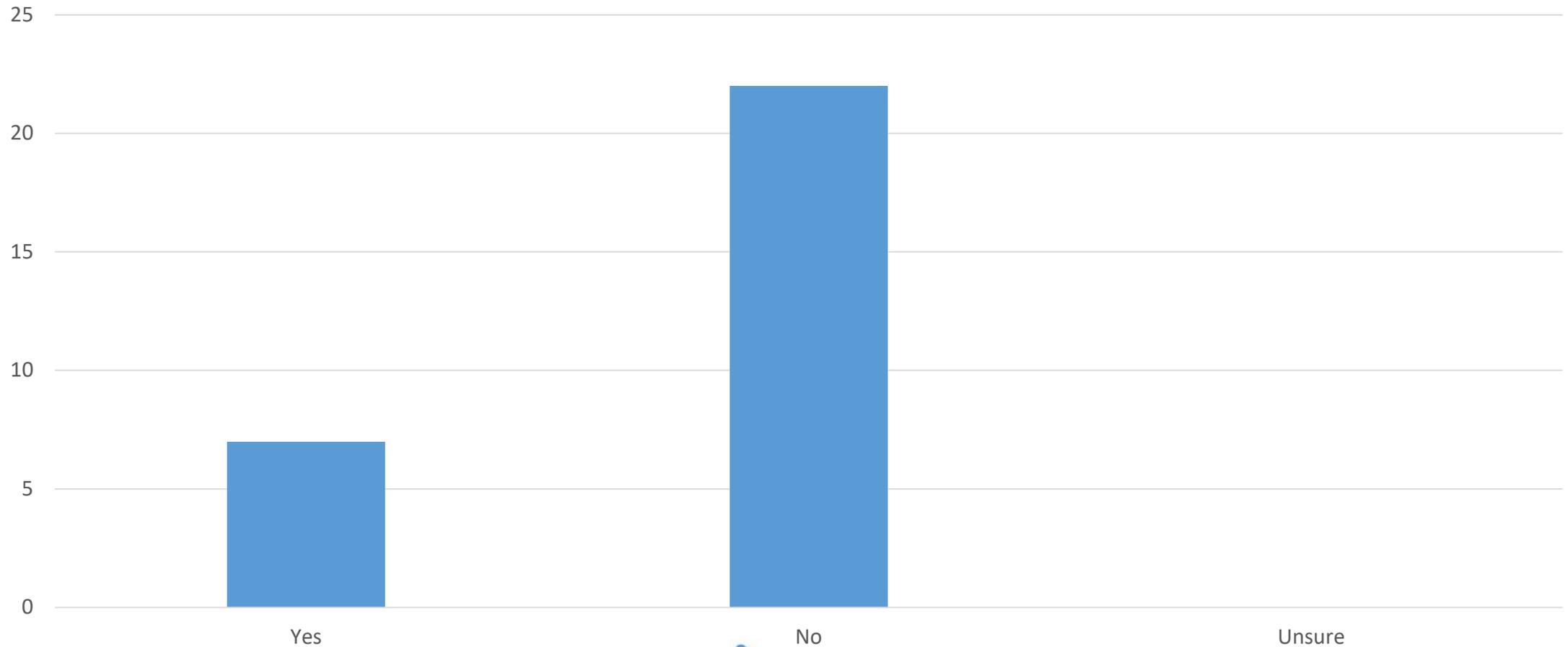


No, but we are interested in developing a plan (2)

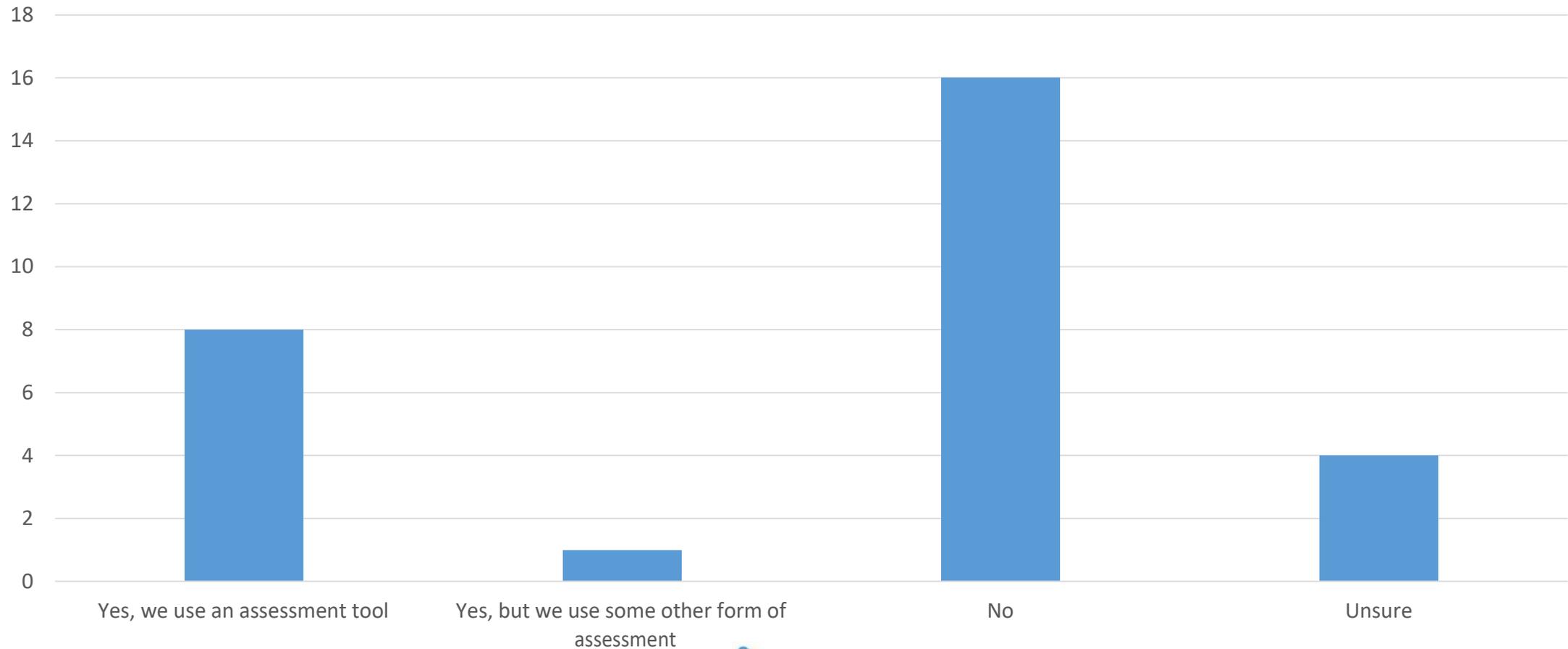
Q62. Do you record any of the following physical health indicators in a patient's record? (26)



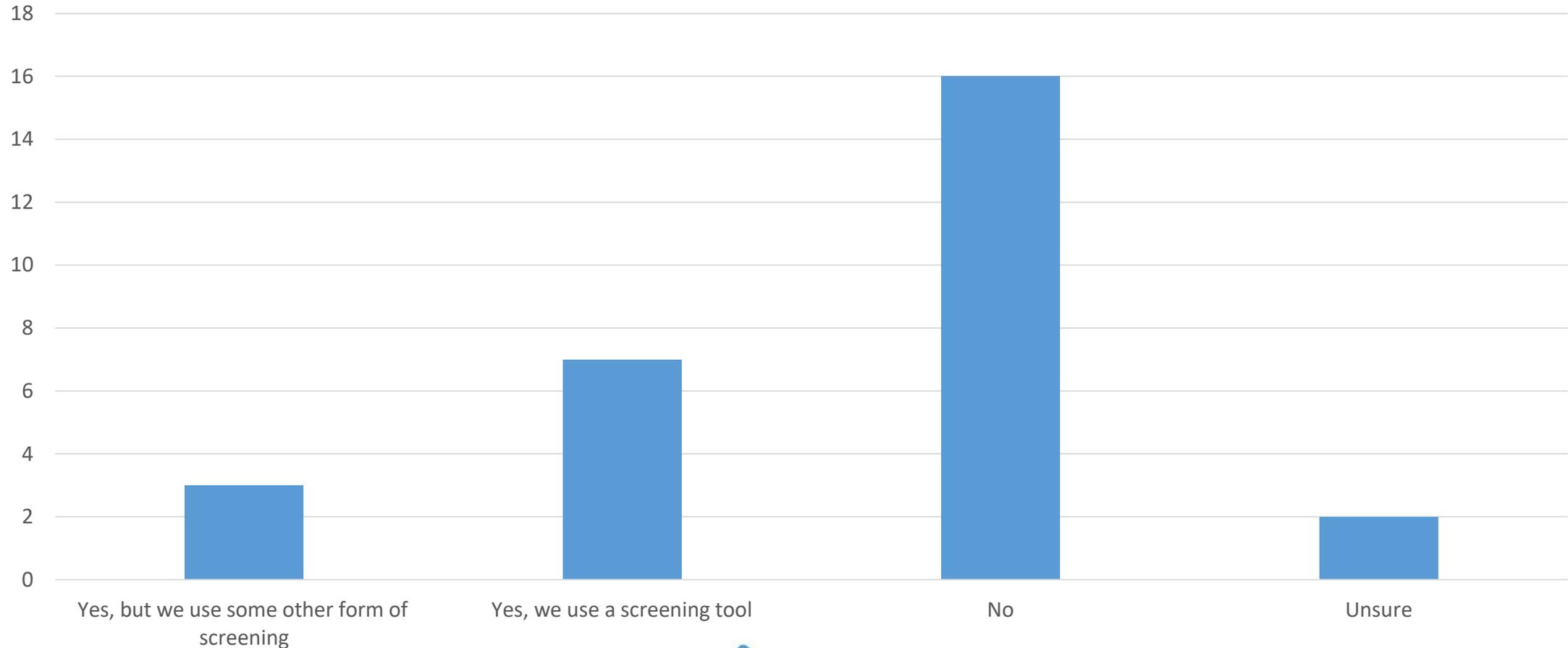
Q63. Do providers in your practice prescribe opioids to treat patients for chronic pain? (29)



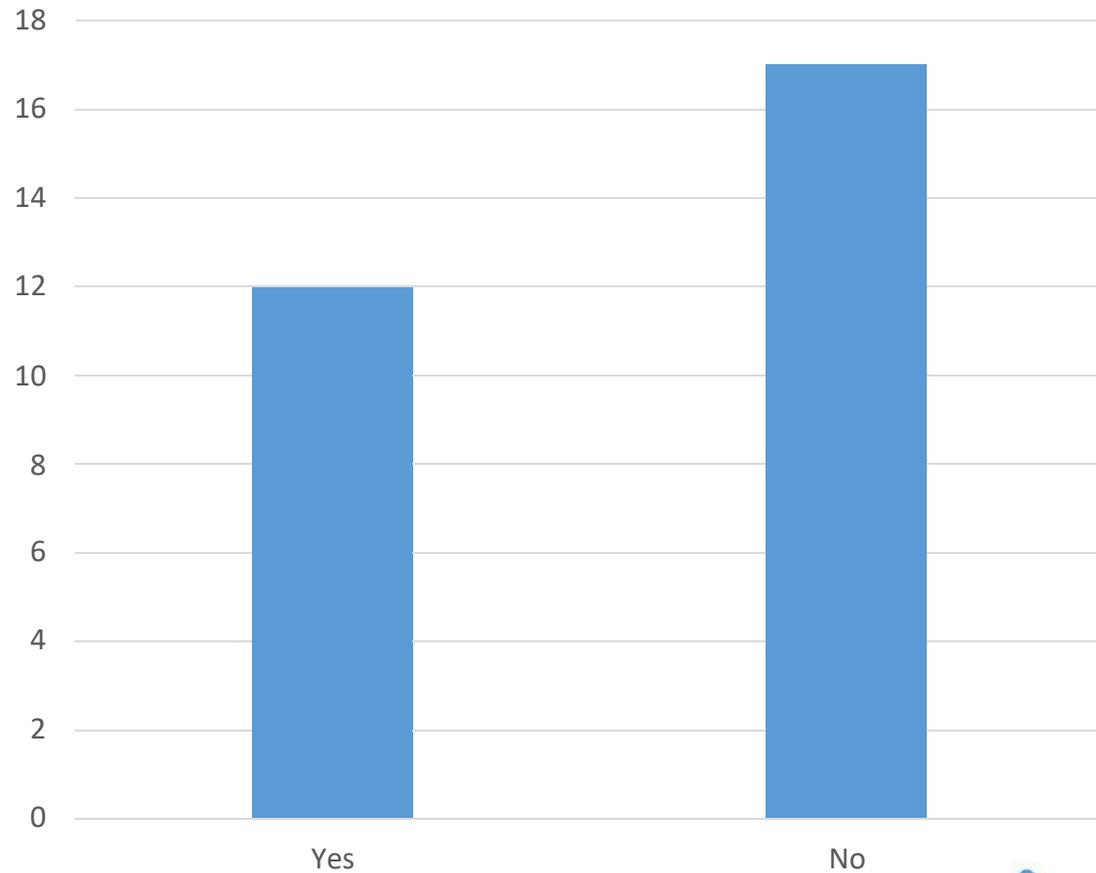
Q64. Do providers in your practice use an assessment tool (e.g. Pain, Enjoyment of Life, General Activity Scale, or Graded Chronic Pain Scale) to assess pain before prescribing opioids to patients? (29)



Q65. Do providers in your practice use a patient screening tool (e.g. Opioid Risk Tool or CAGE-AID Questionnaire) for opioid addiction or substance abuse before prescribing opioids? (28)



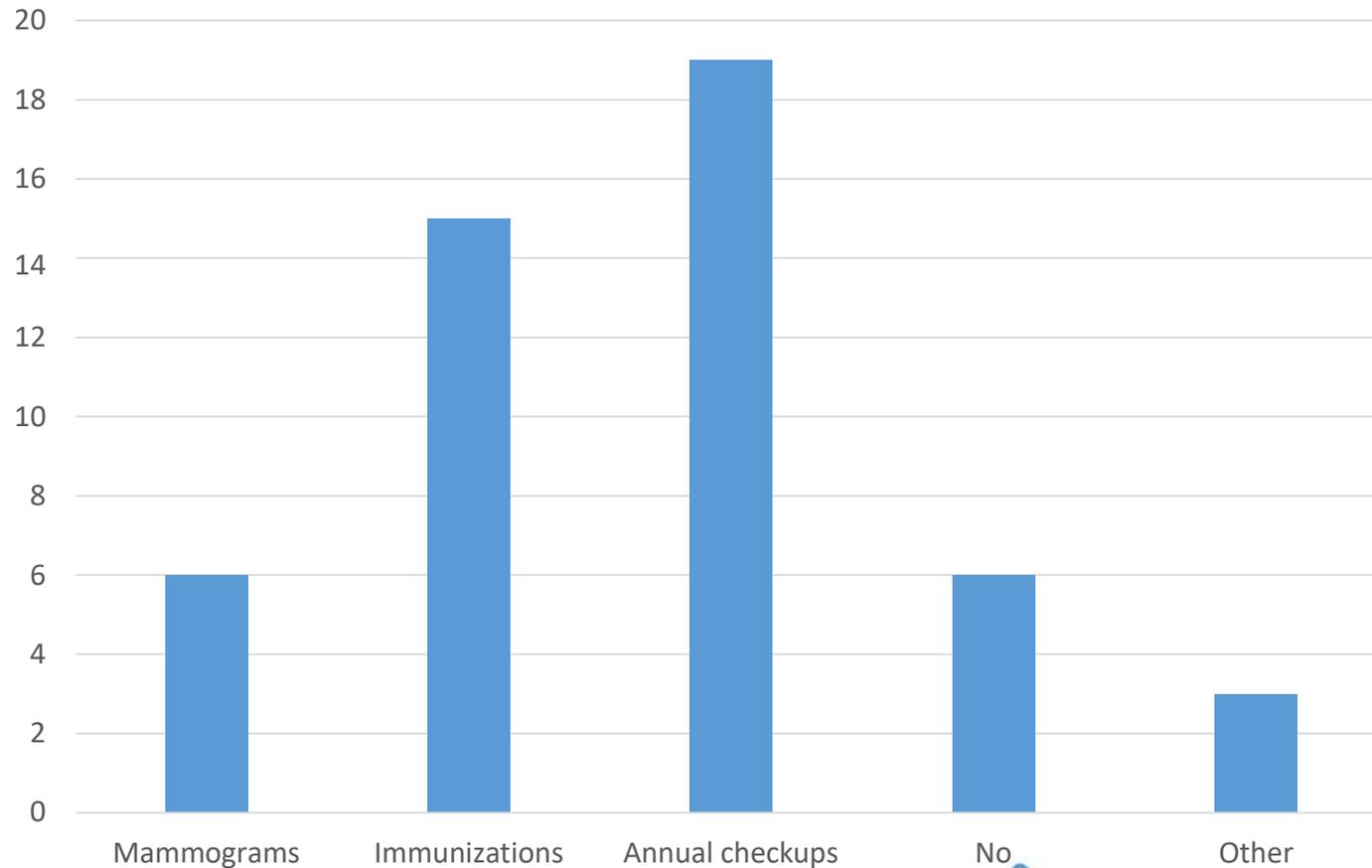
Q66. Are physical health diagnoses made in your practice? (29)



If yes, please specify which diagnoses:

- A variety, it is primary care...
- PCP provides in integrated primary care
- We are primary care pediatrics, which involves PCP-managed behavioral health.

Q67. Do providers ask about any of the following routine preventative care? (28)



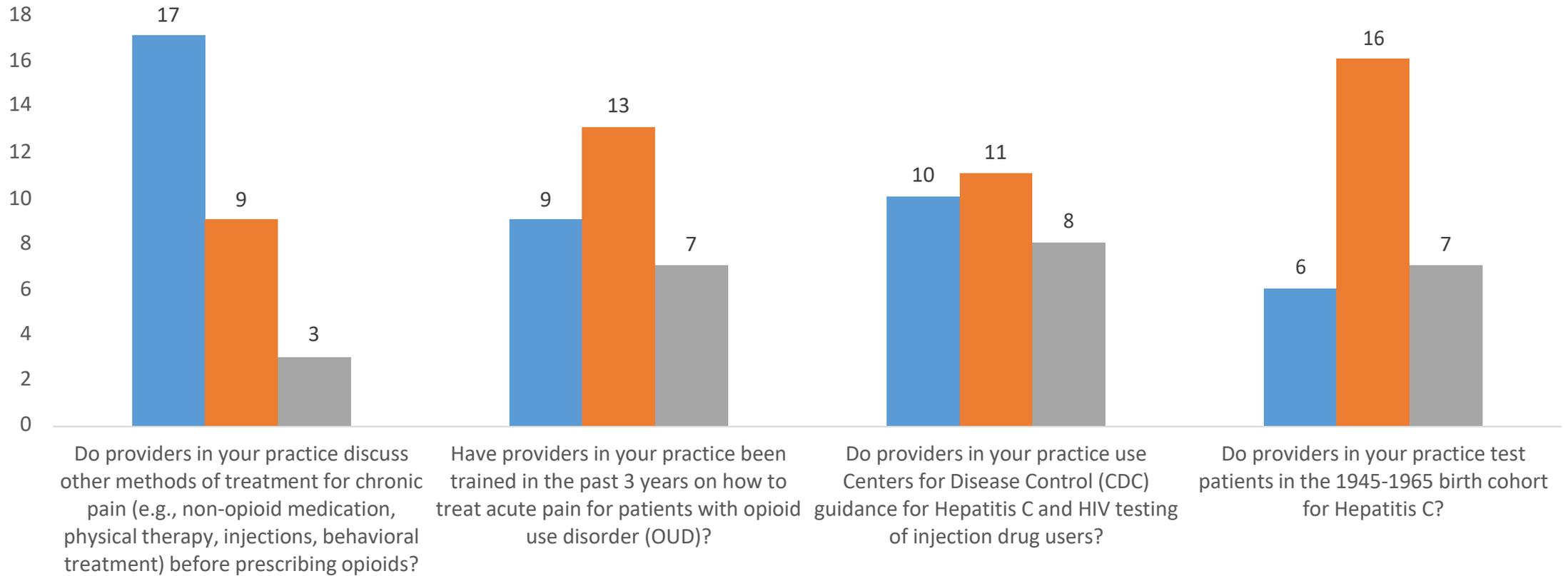
If No, please describe.

- Schools do ask for and record immunization records
- Our group provides psychiatric consults to primary care--as such we don't directly provide routine preventative care

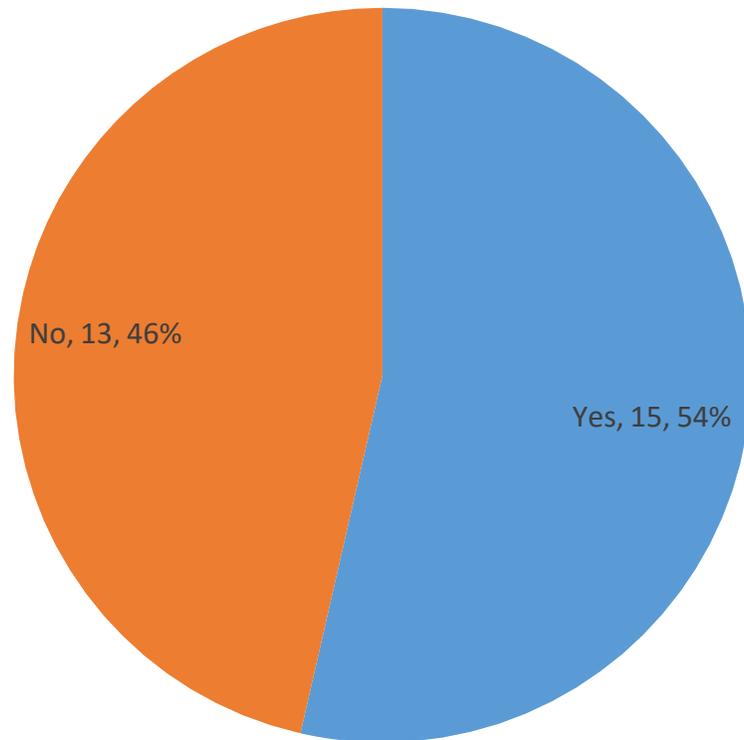
If Other, please specify.

- Cervical Cancer Screenings, Colorectal Cancer Screenings
- HEDIS Measures
- unsure if we routinely ask this in behavioral health

Q68. Please answer the following about providers. (29)



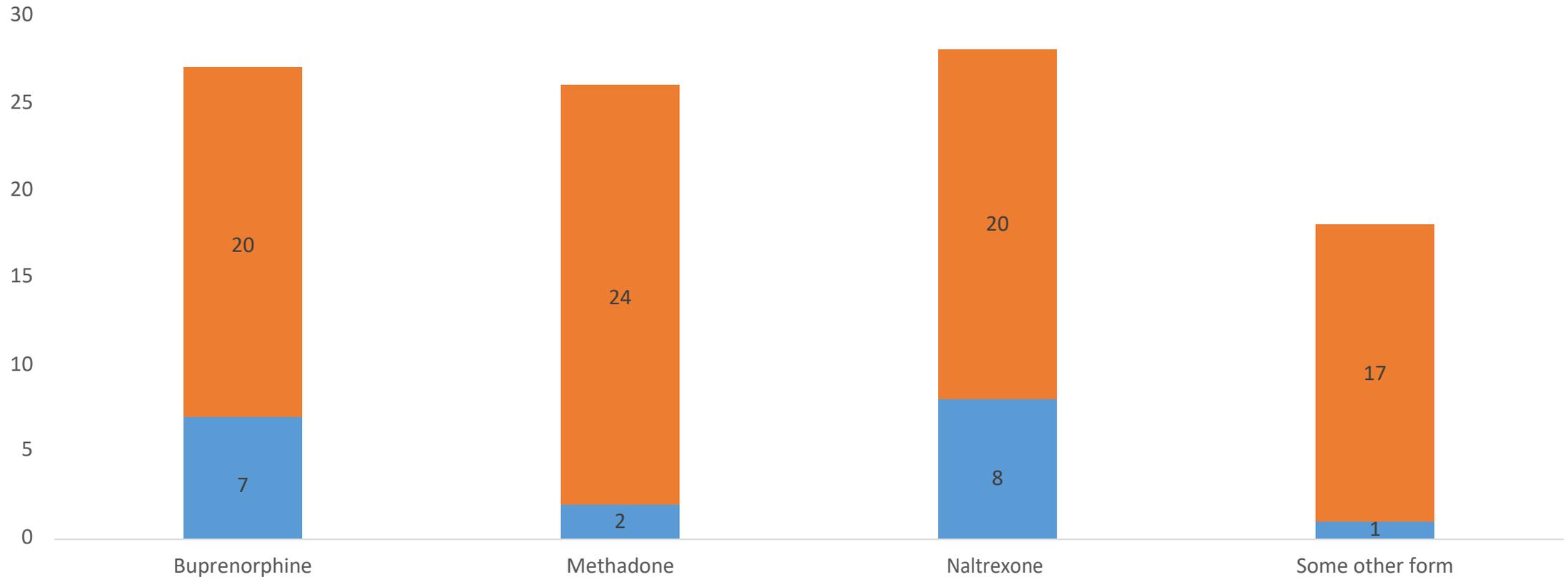
Q69. Do providers prescribe and manage chronic disease medications as clinically indicated? (28)



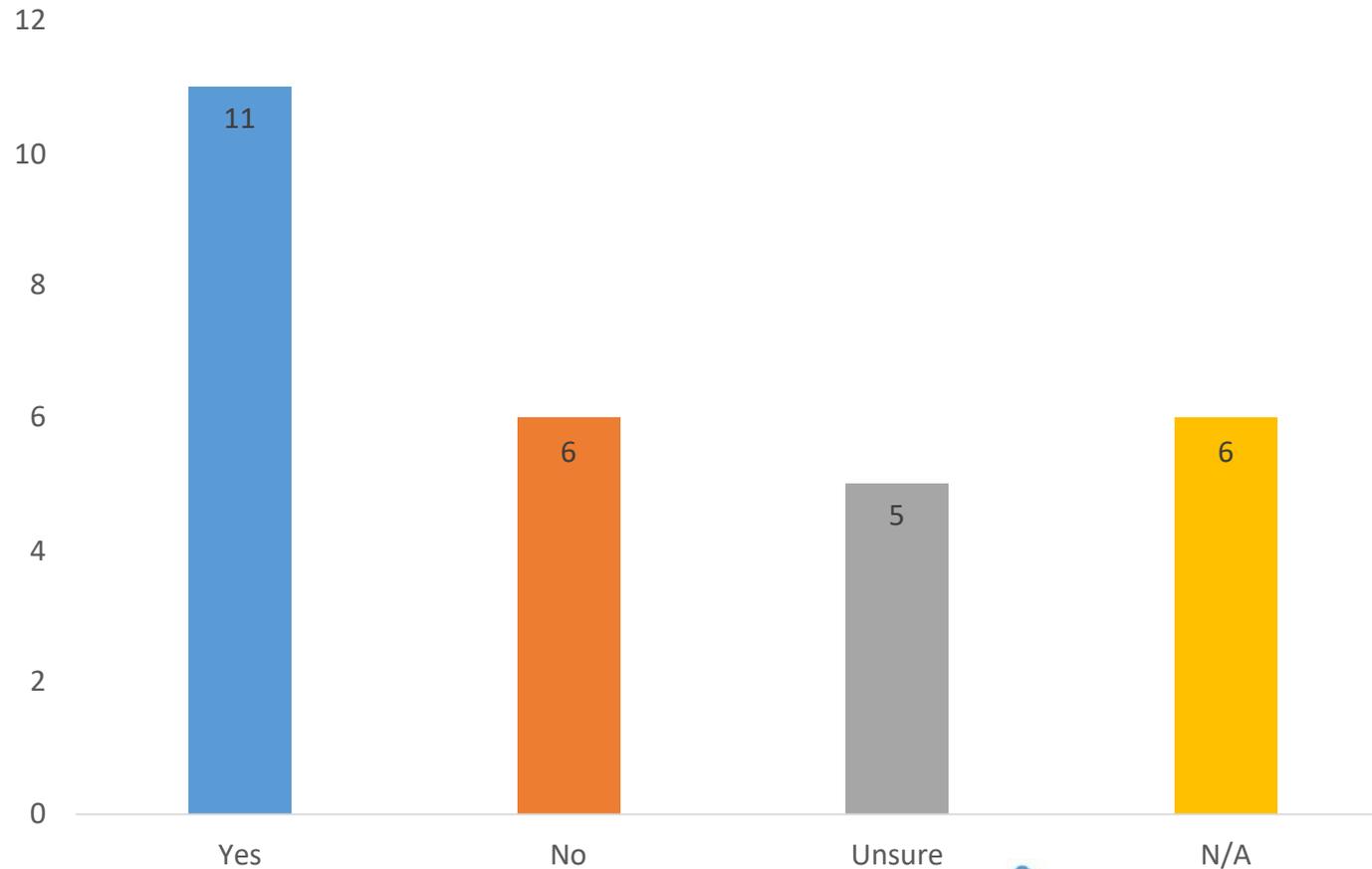
If yes, for which conditions?

- chronic mental health diseases
- diabetes, COPD, CHF, and others
- In collaboration with PCP we assist in medication management but do not prescribe
- asthma, adhd, diabetes
- Diabetes, hypertension and mood disorders most frequent
- ASTHMA, DEPRESSION
- We are primary care pediatrics, which involves treatment for many pediatric chronic conditions.
- Diabetes, hypertension
- For psychiatric conditions only - we only have psychiatric providers, no physical health providers.
- Psychiatric only

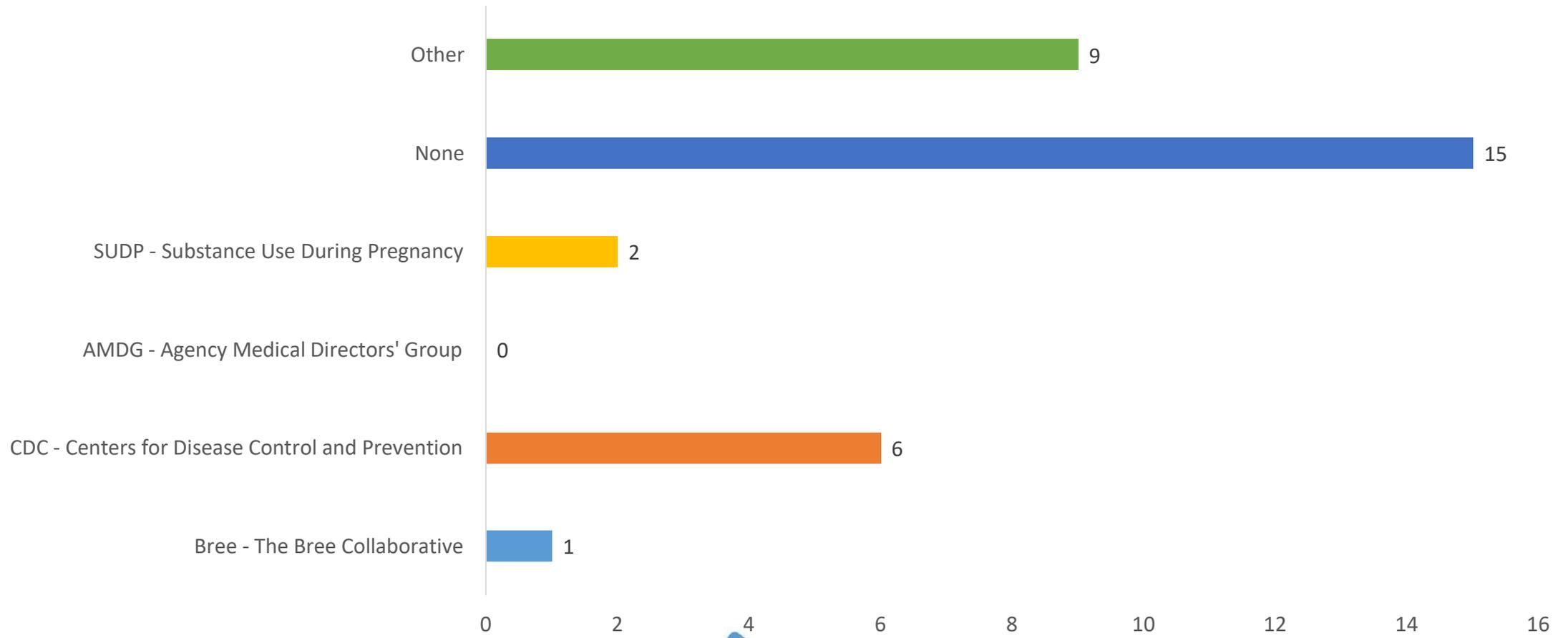
Q70. Do any providers in your practice prescribe medication assisted treatment (MAT)? (28)



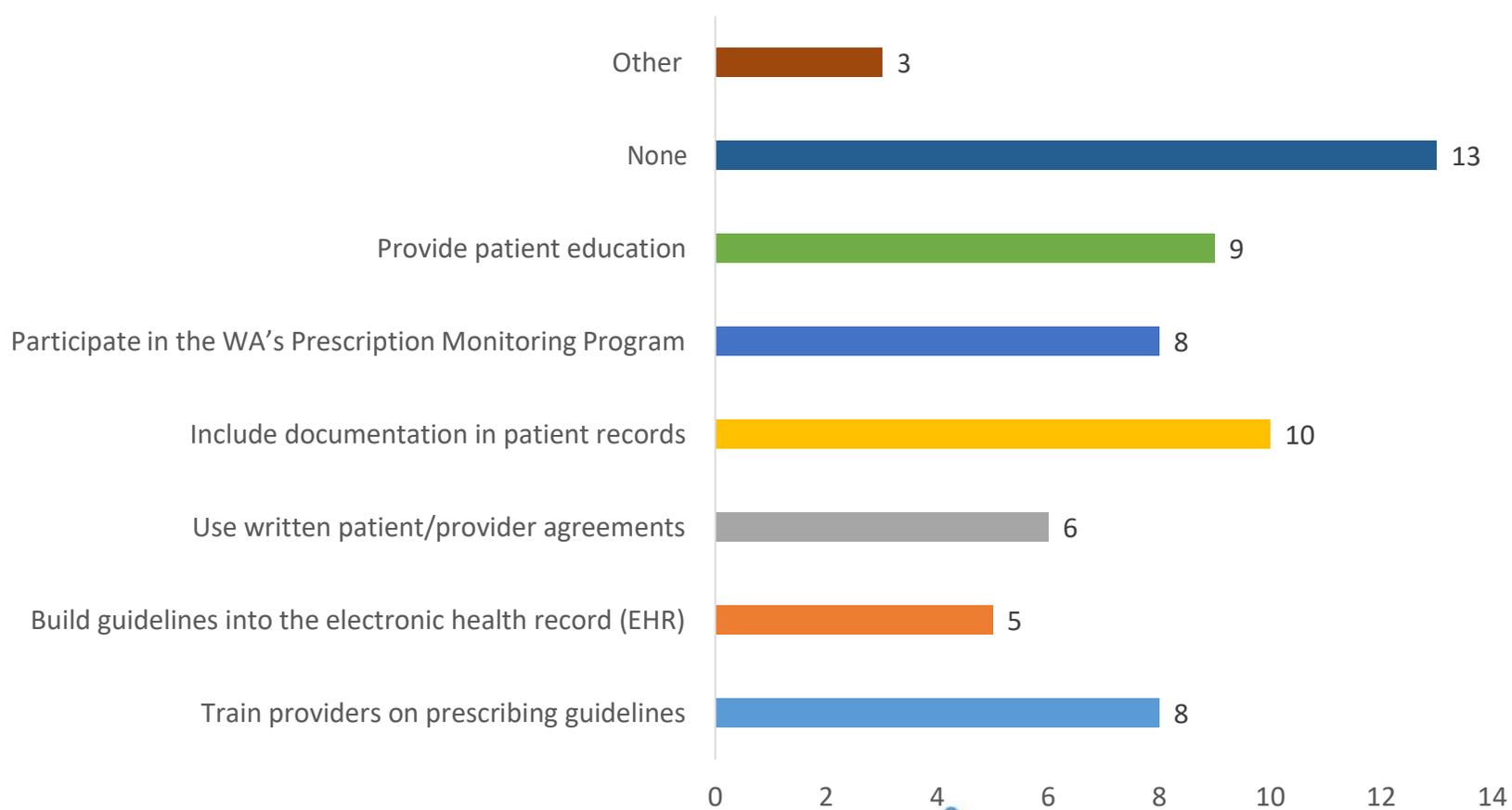
Q71. Would new buprenorphine prescribers find a support program for new prescribers to engage with helpful? (28)



Q72. Which opioid prescribing guidelines does your practice follow? (28)



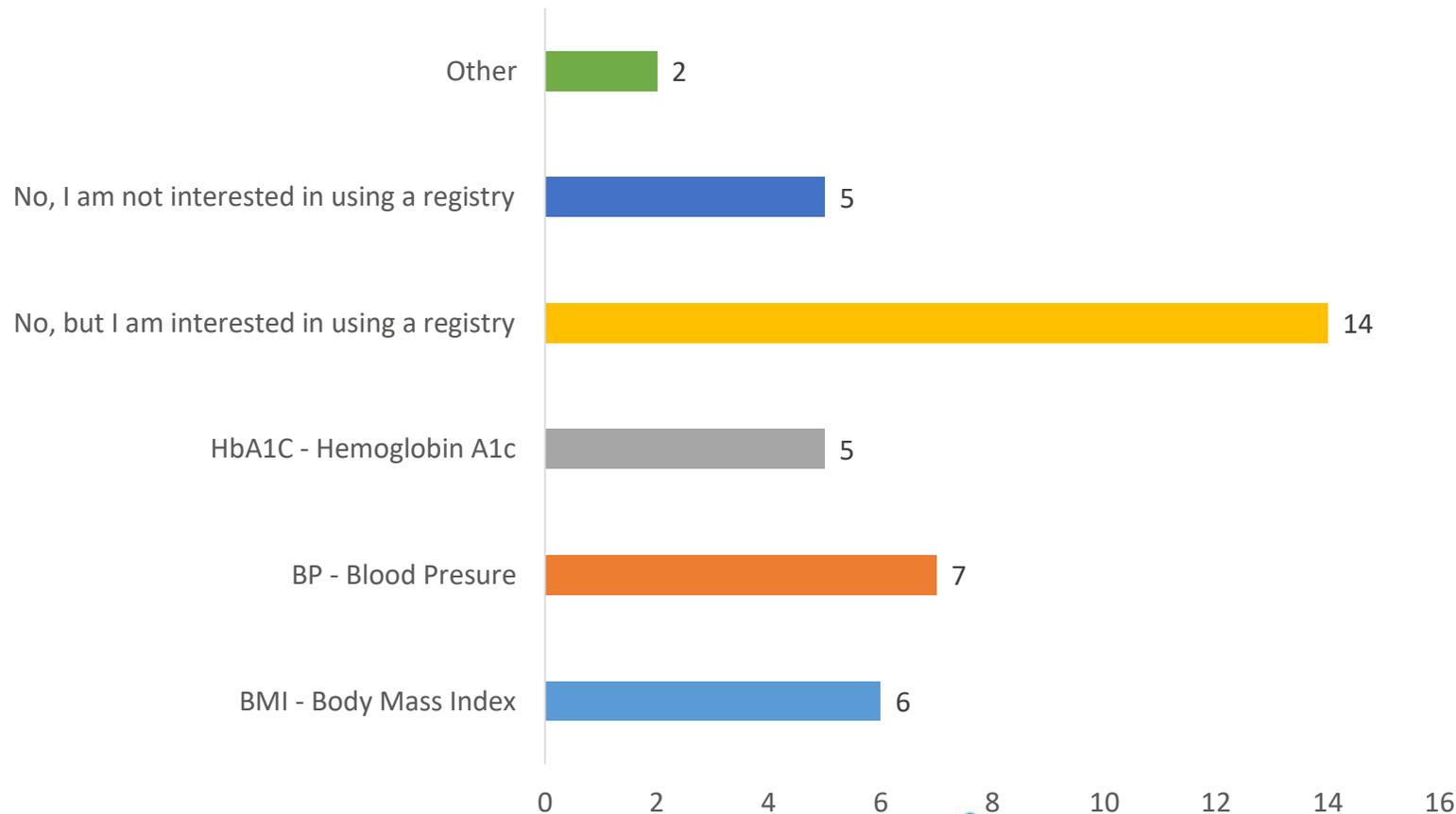
Q73. Are any of the following used in your practice to implement opioid prescribing guidelines and/or ensure safe opioid prescribing practices? (28)



Other:

- We don't prescribe – 3 respondents

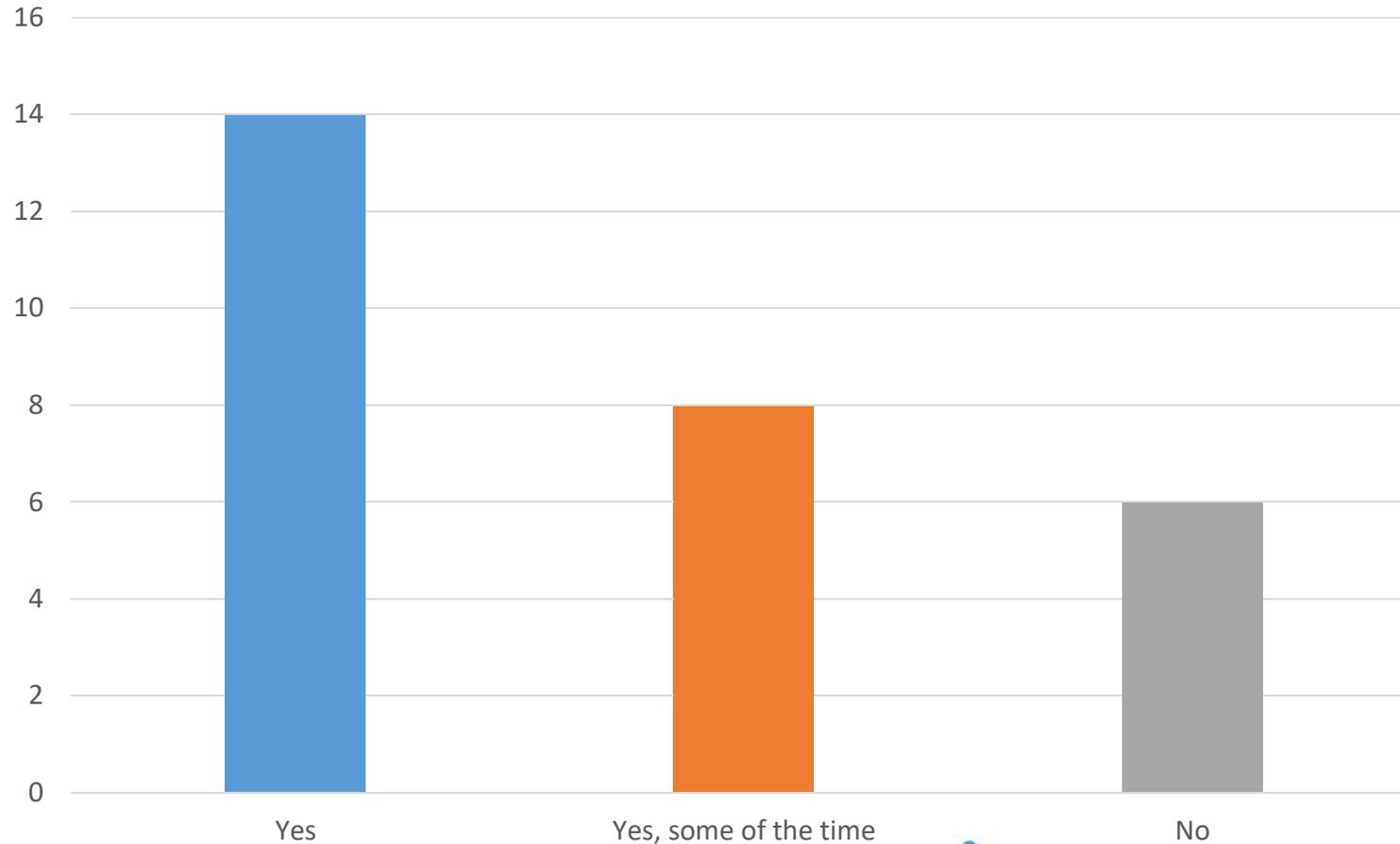
Q74. Is your practice using a population-based registry to systematically track any of the following physical health metrics? (29)



Other:

- We have created a mental health care tracking registry in collaboration with the AIMS center for use with children
- depends on whether or not there is interoperability with our EHR

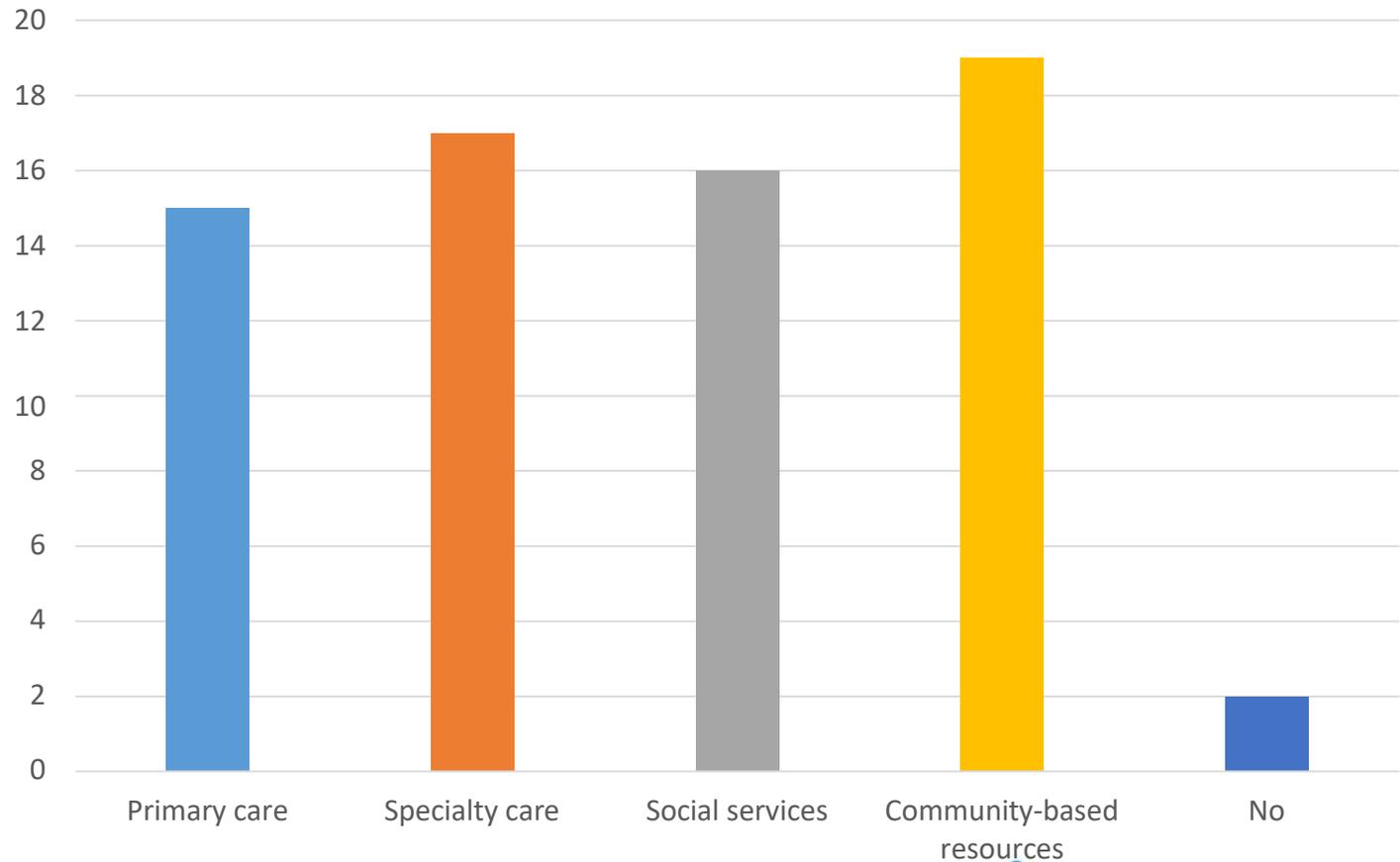
Q75. Does the integrated care team proactively reach out to patients who do not attend follow-up appointments in primary care or specialty medical care? (28)



No (please describe)

- We don't currently have hired staff to do this work yet.
- We offer recovery support. if they don't come we follow up
- We currently do not have an integrated care team in Mason County. We are interested in establishing one.
- We currently do not have primary care fully integrated in our behavioral health programs
- BHR does not currently have an integrated model.
- integrated cared team not yet established

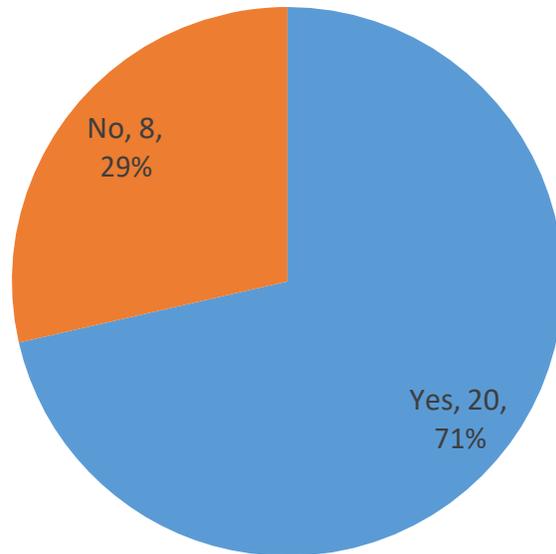
Q76. Do providers track referrals to any of the following? (28)



No (please describe)

- able to track referrals through EPIC, but no current workflow
- We ask about PCP visits and issues discovered.

Q77. Are care managers and/or coordinators in place to support an integrated care program? (28)



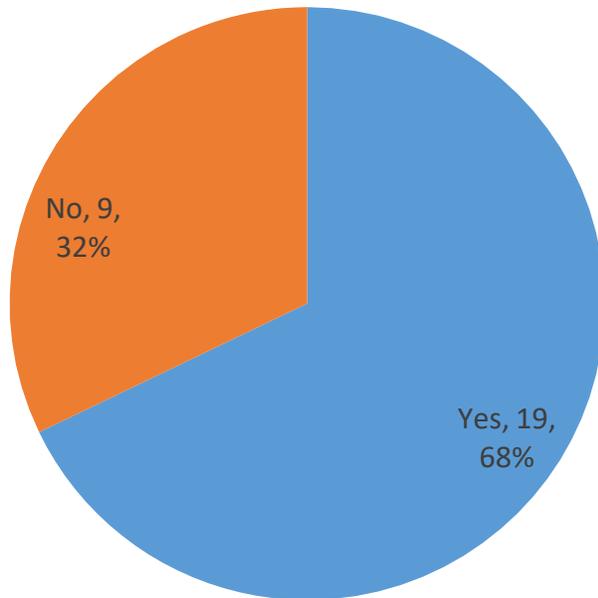
If Yes, what position types do you have?

- We don't have the level we need , we are currently in the process of training Nursing staff to provide this level of support but it is still a work in progress we need to figure out how to have care managers stay long term with the organization because the RN staff they we are currently using are constantly coming and leaving the organization making it difficult to maintain caseloads and patient engagement.
- School Based Systems of Care Coordinators, Nurse Case Managers
- RNCNs at 10 of 11 clinics Behavioral Health Providers at 2 of 11 clinics are providing care management services
- care coordinators provided at the payer and provider level
- No specific position, but we have a close working relationship (including some data sharing) with Valley View.
- Care Coordinators and Health Home RN manager
- Care Coordinators
- SM and SW
- Care Coordination, discharge planners
- Integration specialists with either BA, MS. Social workers with experience in primary care and BH.
- For our largest program, we employ Care Coordinators who are responsible for developing and coordinating Wraparound teams
- Wraparound Facilitators, Case Managers, Clinical Transition Specialists

If No Please describe

- We have care management for our PAL Plus program in Benton/Franklin counties, but do not yet have a similar paid care management partner in SW Washington
- We have a psychologist in place and are in the process of hiring a social worker but don't have the funding in place

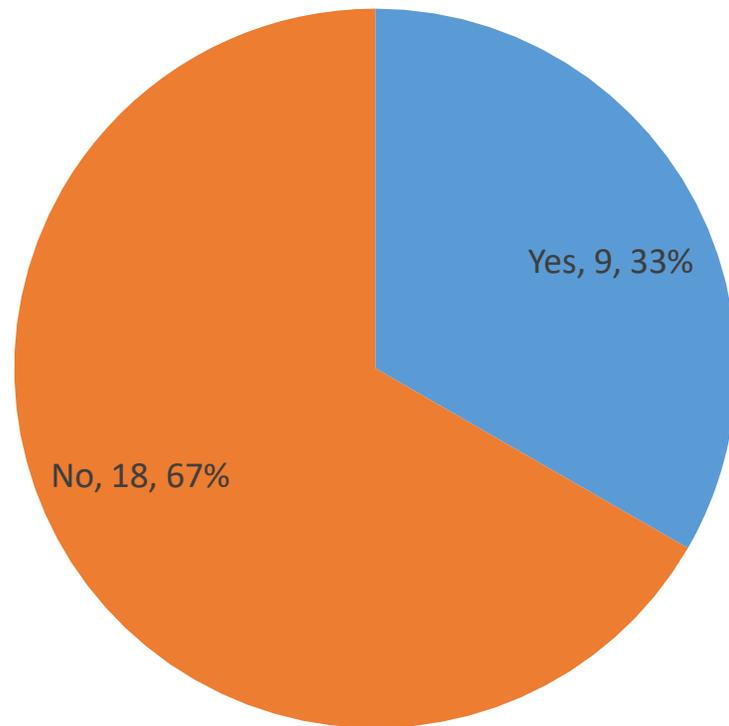
Q78. Do you have effective communication mechanisms for care coordination and to promote effective communication with primary care providers? (28)



If Yes, explain

- There are weekly or daily huddles with the care teams to review patients that and treatment plans to ensure continuity across different services of care.
- We have paid for and are using an adaptation of the AIMS center's CMTS system, designed for pediatric primary care
- no centralized treatment plan or longitudinal plan of care in EHR
- access to premanage, access to certain provider EHR (EPIC)
- Psych and PCP share the same chart, do warm hand-offs and discuss treatment plans
- We are interacting more and more with medical providers
- Shared clinical records
- Communication within the EMR following PCMH guidelines
- Via encrypted emails.
- in place, but needs improvement
- EHR, face-to-face huddles, warm hand-offs
- We follow EPSDT guidelines, so primary care physicians are aware when their patients are working with us. When needed, primary care provider representatives participate on our Wraparound teams. Regular, ongoing coordination for wellness is not occurring and we could improve in that area.
- phone, secure email, fax

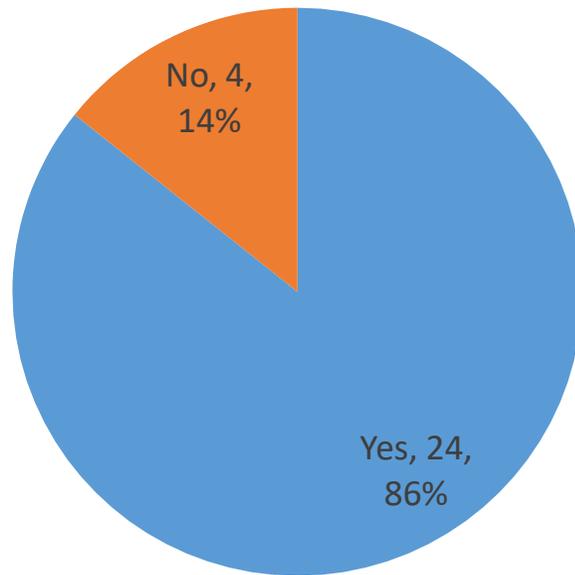
Q79. Is a primary care practitioner or consultant hired or under contract for consultation and/or direct patient care? (27)



If Yes, explain

- Meds management
- We are a PC office
- We are a private, single specialty, pediatric clinic.
- ARNP and Psychiatrist Consultants
- many pcp's
- We have a staff psychiatrist and nurse, but not for primary care

Q80. Do you routinely examine provider and program-level outcomes (clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement? (27)

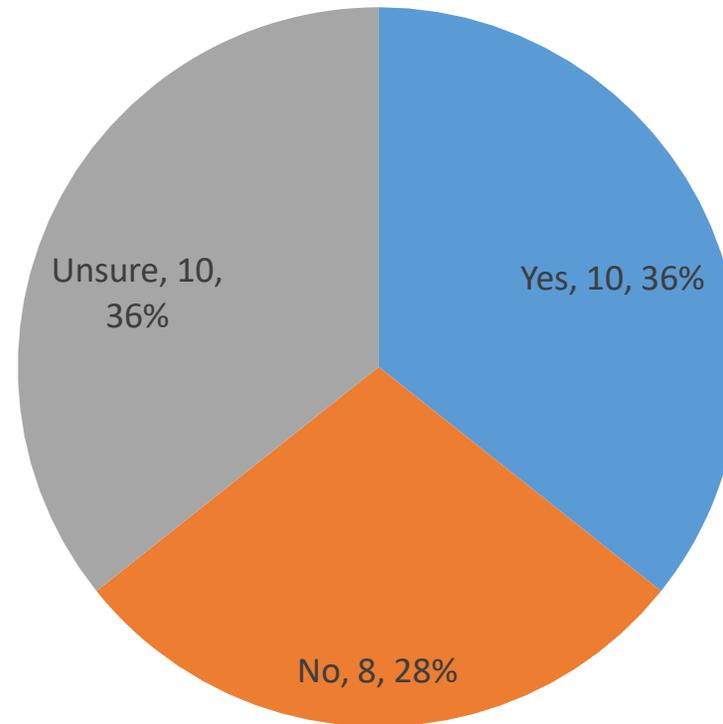


If Yes, explain

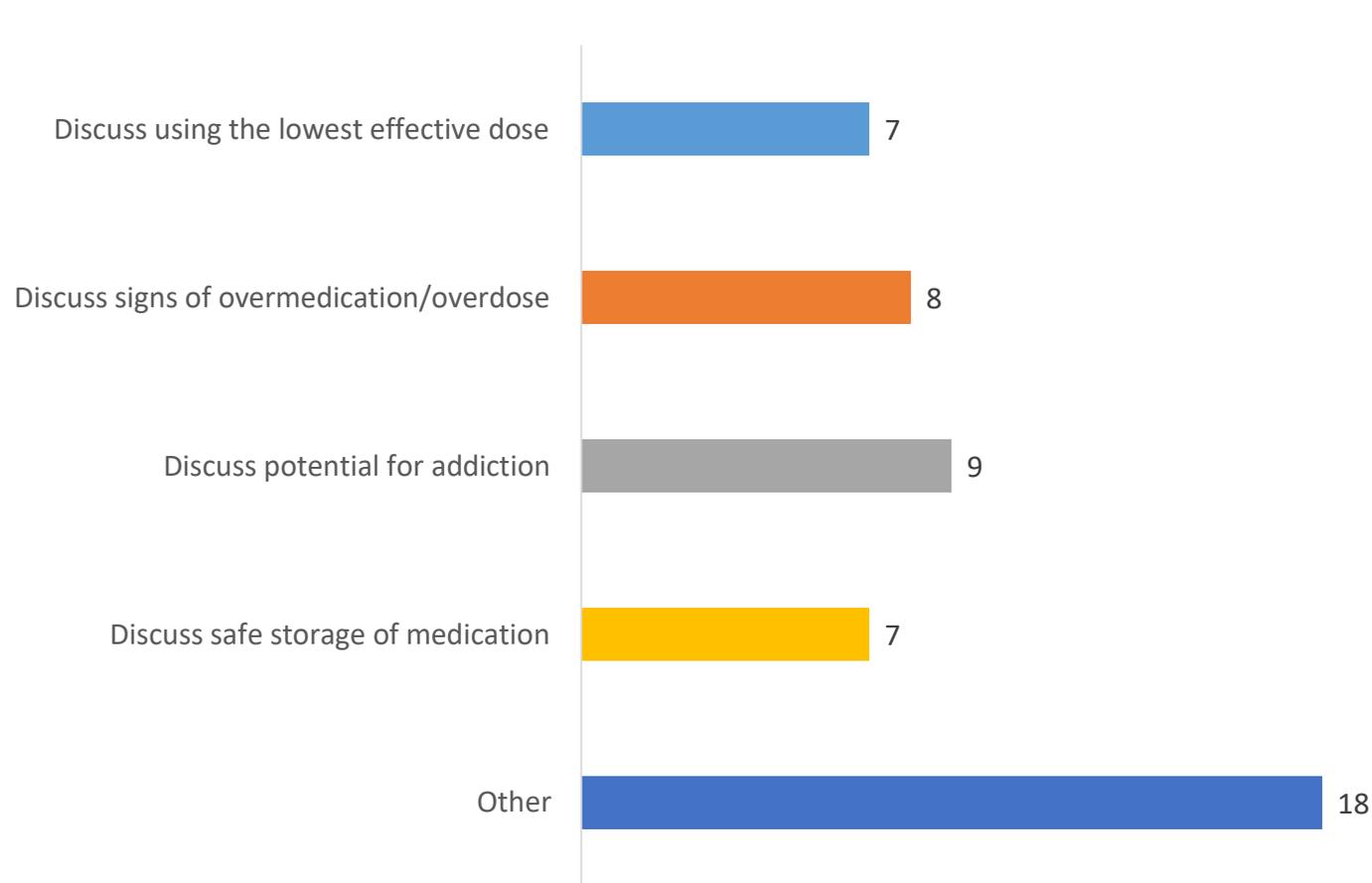
- Yes, we routinely review our quality improvement projects through our Clinical Quality Improvement Committee reviewing State HEDIS Metrics, Federal Grant Metrics, Meaningful Use Metrics, and other internal metrics.
- Data reporting and quality improvements required by funders including BHOs, SAMHSA, County Boards of Health, ...
- computerized care tracking system, highlight kids with failed follow up or failing to improve per symptom rating scales
- Press Ganey
- We have an entire quality management plan - we can send
- Starting to track this for our PsyD
- We look at this quarterly/semi annually
- Only minimal use of satisfaction surveys. Currently measure performance measures related to Medicaid requirements
- limited use of client satisfaction surveys, but focus on Medicaid requirements and access requirements. Monthly dashboard used for key performance indicators as established by BHR
- Some key performance indicators are tracked on a monthly dashboard - primary related to Medicaid and Access requirements
- Weekly quality improvement meetings with all affected clinicians and employees, discussing topics pertinent to quality care for our patients.
- Data tracking, incident reporting, and CQI meetings.
- patient satisfaction and quality indicators
- EHR data is reported to the QI department for monitoring of clinical outcome measure progress.
- We provide high-fidelity Wraparound and staff providing the service and families receiving it participate in outcomes studies completed by the University of Washington. Families complete fidelity measures, a Caregiver Strain Questionnaire, a Strengths and Needs inventory, and intake and follow up forms. Reports are shared with our community WISe Steering Committee, and recommendations for improvements are made based on steering committee feedback. We also have internal QI activities, including regular structured file reviews, and we are audited by our BHO, the state Division of Behavioral Health and Recovery. and others, and feedback is incorporated into our work.
- outcomes based CQI process as well as external research on participant outcomes by the UW's Evidence-based Practice Institute.
- Quality Improvement

Q81. Is the practice open to learning more about facilitating low barrier buprenorphine treatment? (28)

(Low barrier: prescribed unobserved induction exclusively, saw patients no more than weekly, and did not require additional psychosocial treatment.)



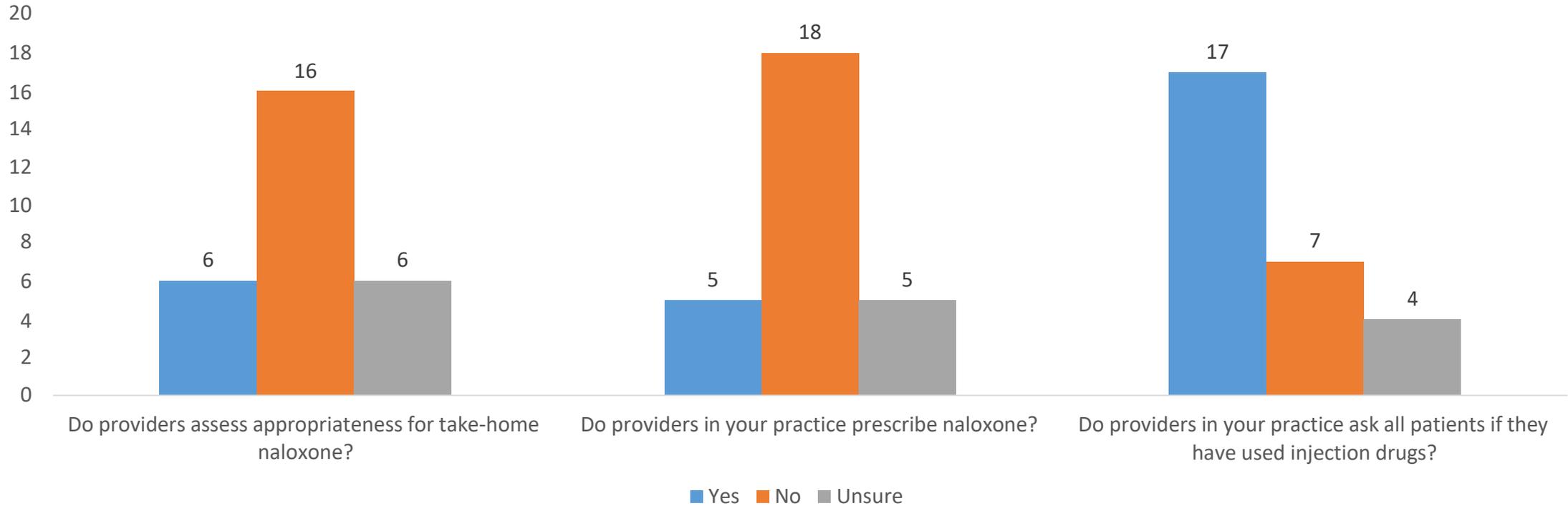
Q82. Do providers at your practice do any of the following when they prescribe opioids for chronic pain? (26)



Other (please specify)

- We do school based substance use prevention services in several schools across the region
- We don't prescribe opiates.
- We don't prescribe meds
- Do not prescribe opioids

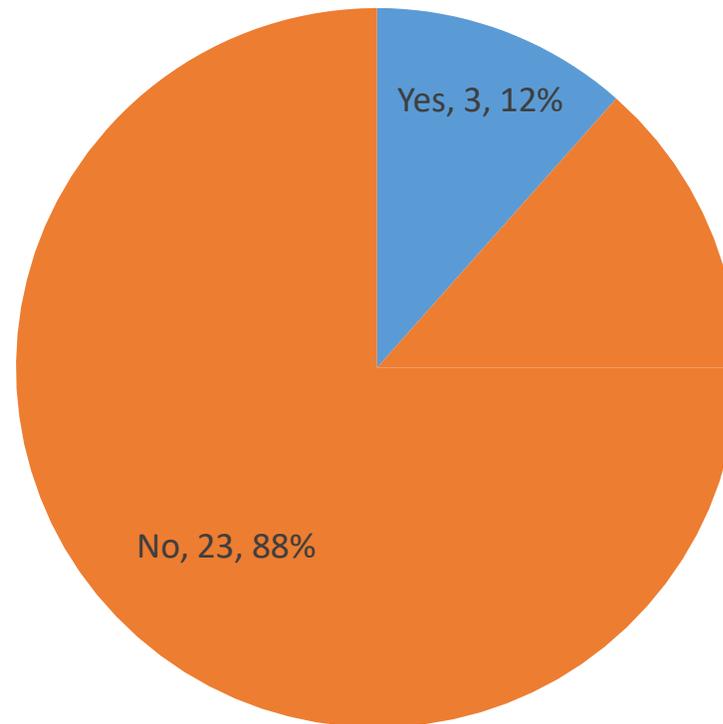
Q83. Do any providers in your practice. (28)



(Note Agency Medical Directors' Group - AMDG - criteria: mental health disorder per Diagnostics and Statistical Manual of Mental Disorders Fifth Edition - DSM 5, family or personal history of substance use disorder, medical condition that could increase sensitivity to opioid-related side effects, current use of benzodiazepines, tobacco use)



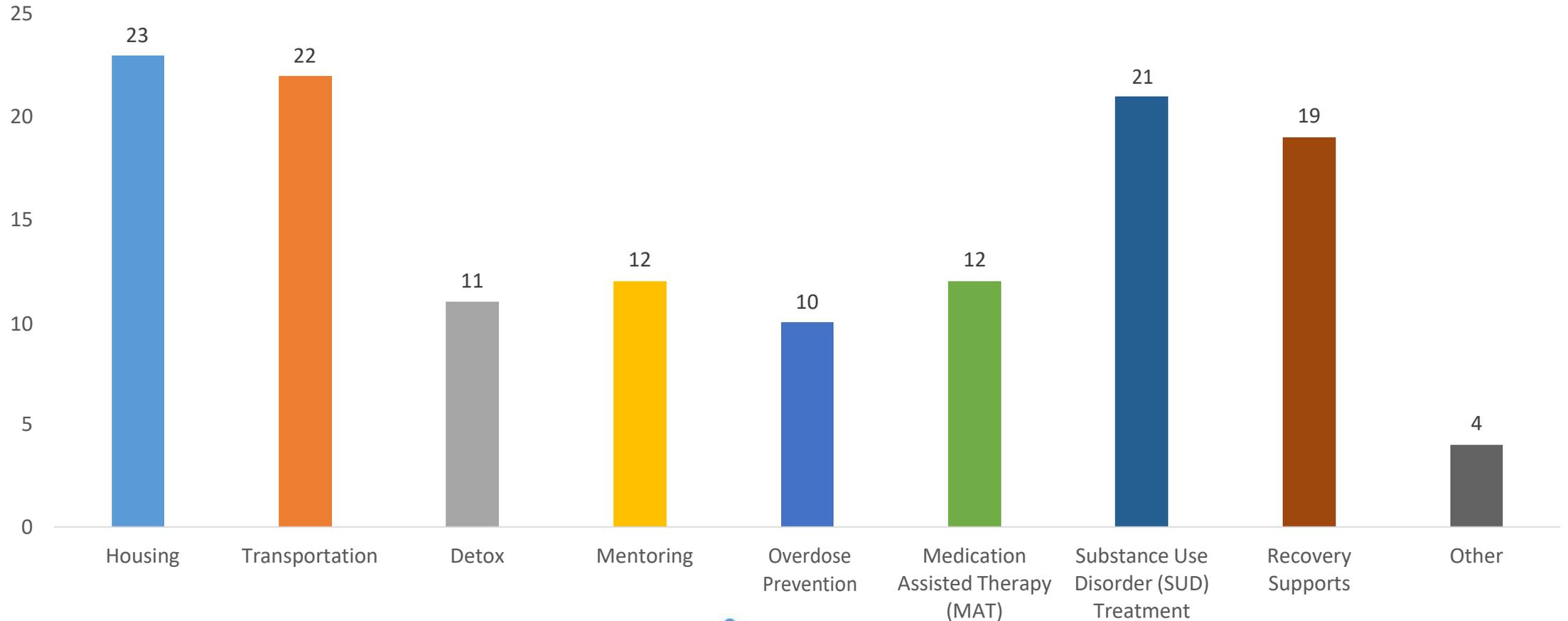
Q84. Does your program or practice discontinue care for patients with opioid use disorder or substance use disorder when they relapse? (26)



Q85. If you are implementing a specific integrated care model, which model or aspects of a model are you implementing?(12)

- PAL currently delivers consultative care in the region, has a program of collaborative care in Benton/Franklin counties. We have created a brief, evidence supported behavioral intervention for kids age 4-12 with disruptive behavior and for adolescents with depression.
- Collaborative Care at 1 of 11 clinics
- AIM and Bree Collaborative
- Part of the diversion care model
- Primary Care Behavioral Health Integration Model
- We integrate Recovery Support and Recovery Support Community and Mental Health
- Patient Centered Medical Home, Tier 3
- Co-located services and increased collaboration with bi-directional care communication.
- BHI (co-management of depression)
- n/a
- We are looking at the idea of developing a registry. Supervisors and a few staff here are working on becoming credentialed to provide integrated behavioral health and substance abuse treatment.
- Would fold primary care into our current Evidence-Based Practices and Transitional Age Youth Care team model. Currently utilizing Multisystemic Therapy and Managing and Adapting Practices. General approach of Motivational Interviewing and Positive Youth Development used across the continuum of care in our agency. Utilize CANS/ANSA to identify needs, drive treatment, coordinate care and measure outcomes.

Q86. Related to social determinants of health, which of the following services do your patients or clients need most? (25)



Skilled Nursing or Long Term Care Facility

Q87. Are you a skilled nursing or long term care facility? (Yes:0, No: 40)

88. Does your organization routinely receive referrals from patients being discharged from in-patient services? (0)

- Yes, via shared EHR - Electronic Health Record
- Yes, via HIE - Health Information Exchange
- Yes, via fax
- Yes, via telephone
- No, we only provide services at patient request, not by referral
- Yes, Other (please specify)

90. How do you receive reimbursement for your services? (0)

- Via Medicaid reimbursement
- Via a grant
- Via state funding
- Via donated funds
- Other (please specify)

89. Do you receive a discharge summary or treatment plan? (0)

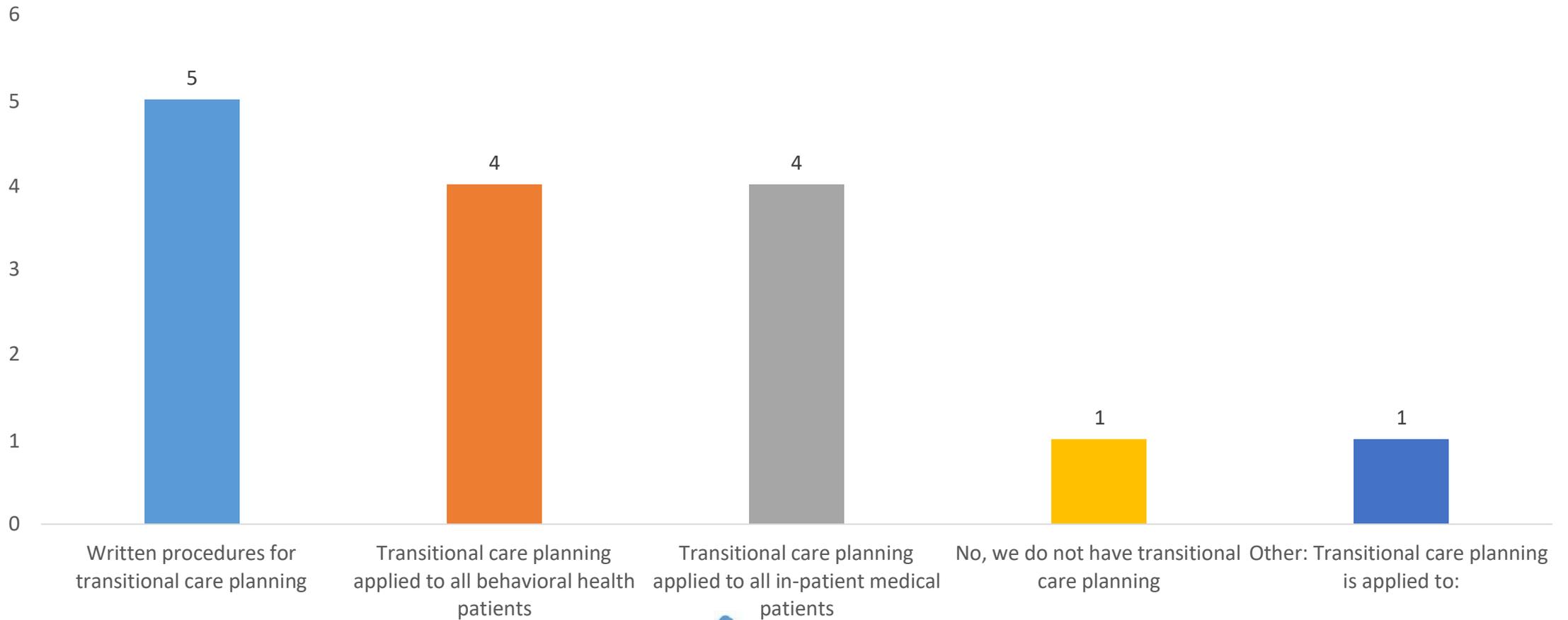
- Yes, directly from the discharging facility
- Yes, the patient provides a copy
- No
- Yes, Other (please specify)

91. Do you contact the discharging hospital or primary care doctor with any discharge concerns? (0)

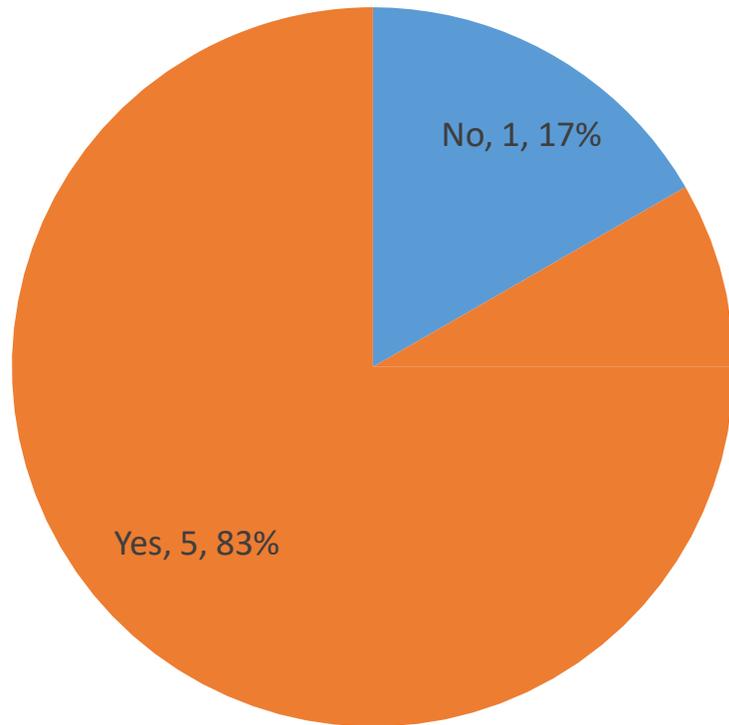
- Yes, we regularly exchange information
- Yes, but communication varies based on the provider
- Yes, but we seldom get feedback in return
- No, we do not regularly communicate with medical providers
- Other (please specify)

Hospital Partners - In-patient

Q93. Does your organization have any of the following (7)



Q94. Does your organization use an evidence-based method for screening patients for transitional care planning needs? (6)



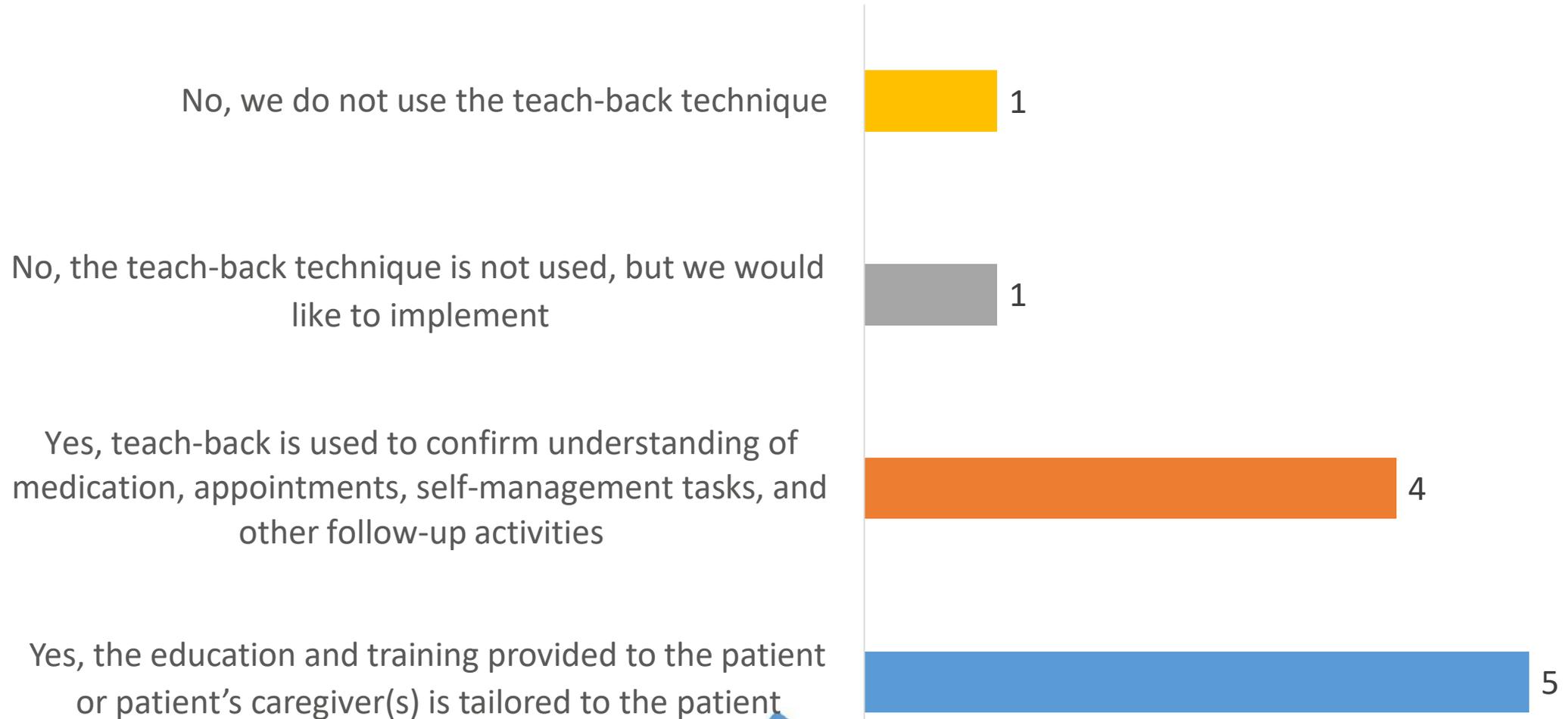
Yes, please list the evidence-based method(s) used

- We follow TCM guidelines through CMS
- Risk screening
- PASRR - Pre-Admission Screening and Residence Review
- yes, but I am unsure of the method

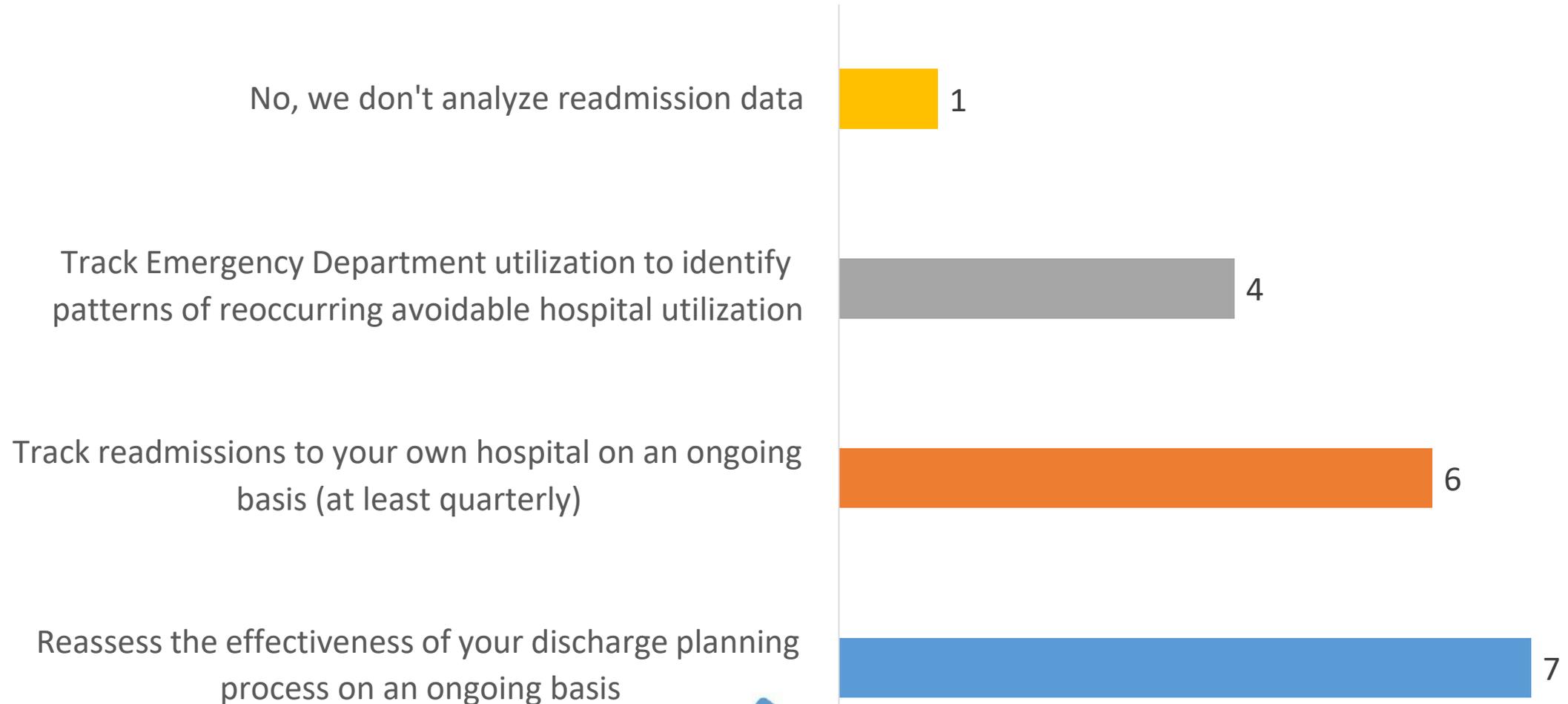
Q95. Does your organization: (8)



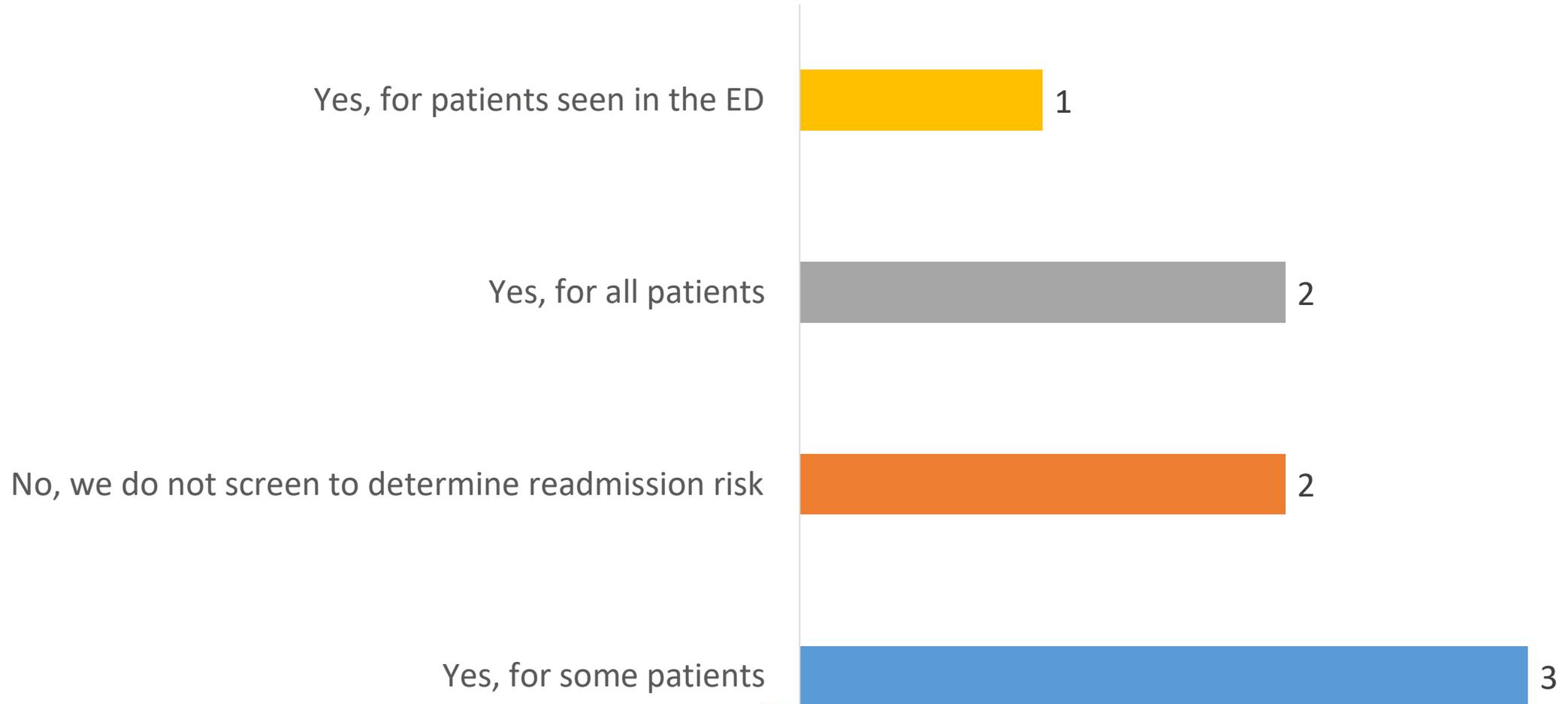
Q96. Does your organization teach patients and their families self-care skills using the teach-back technique (8)



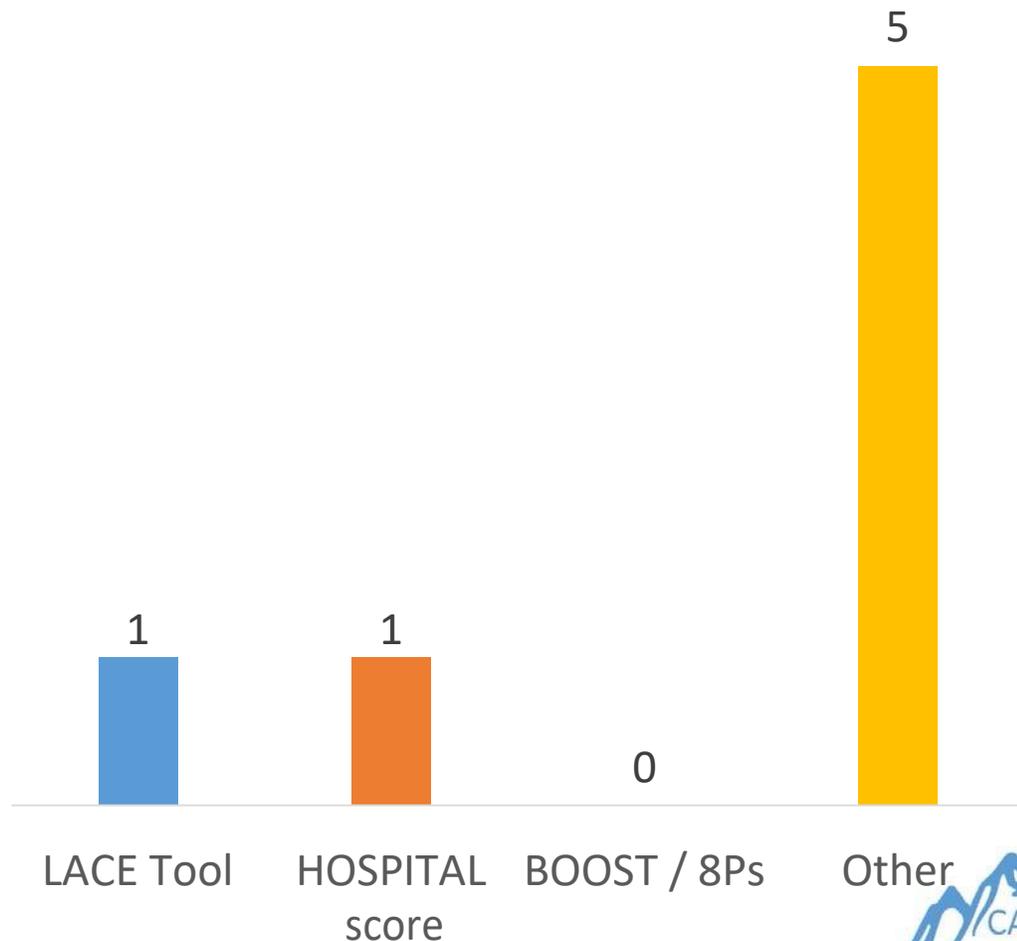
Q97. Does your organization analyze and trend readmission data and look for root causes to: (8)



Q98. Does your organization currently conduct a systematic screening to determine the risk of hospital readmission for admitted patients? (8)



Q99. If Yes to the question above, which screening tool(s) do you use? (8)

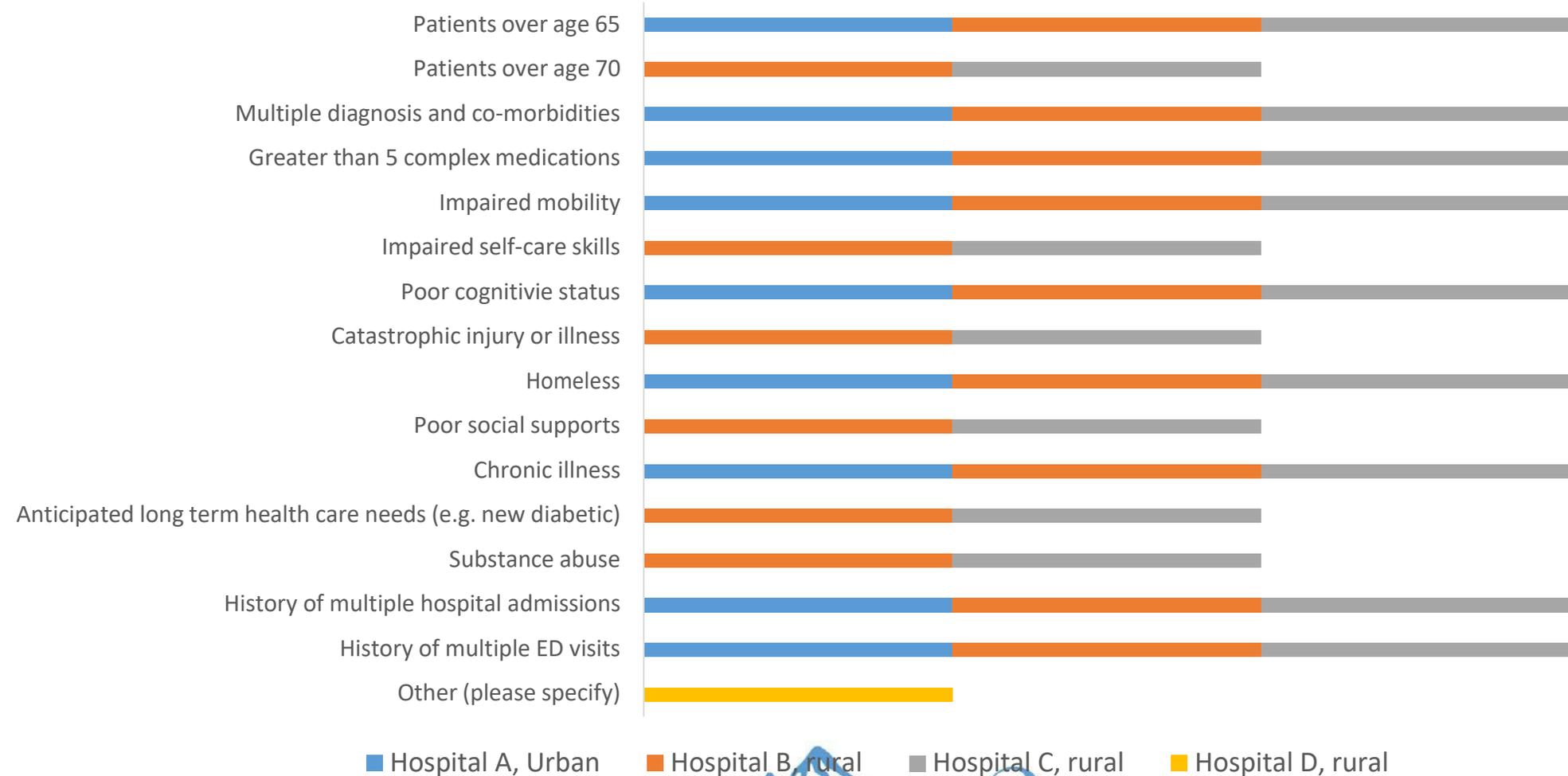


Other

- Corporate screening tool
- Actually, we are forced to regularly discharge patients with what we know is a high risk for readmission because of a lack of sufficient community services. Insurers only allow for brief acute hospitalizations when it is not possible to address everything. A formalized screening tool would have no impact on this care system reality.
- Customized tool
- Combination of tools
- The hospital developed screening tool which uses several evidence-based tools to identify high risk patients along with a simple developed screening which IHI and Kaiser helped to develop

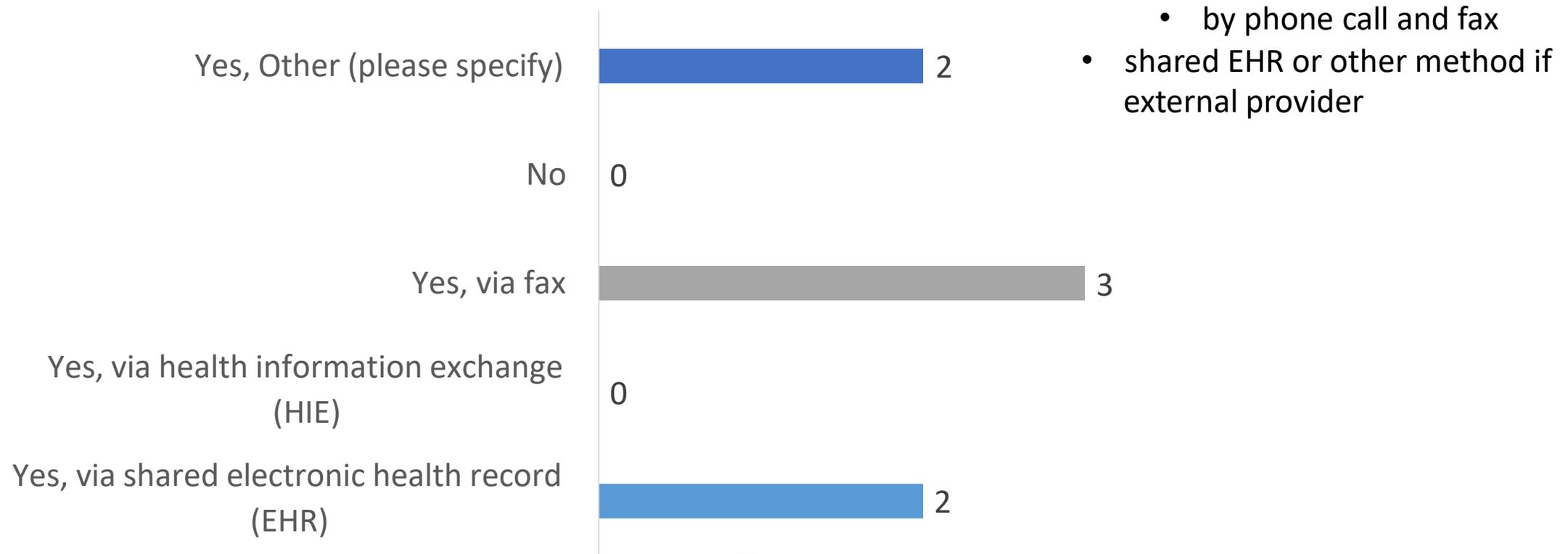


Q100. If only screening some patients, which patients receive screening? (4)

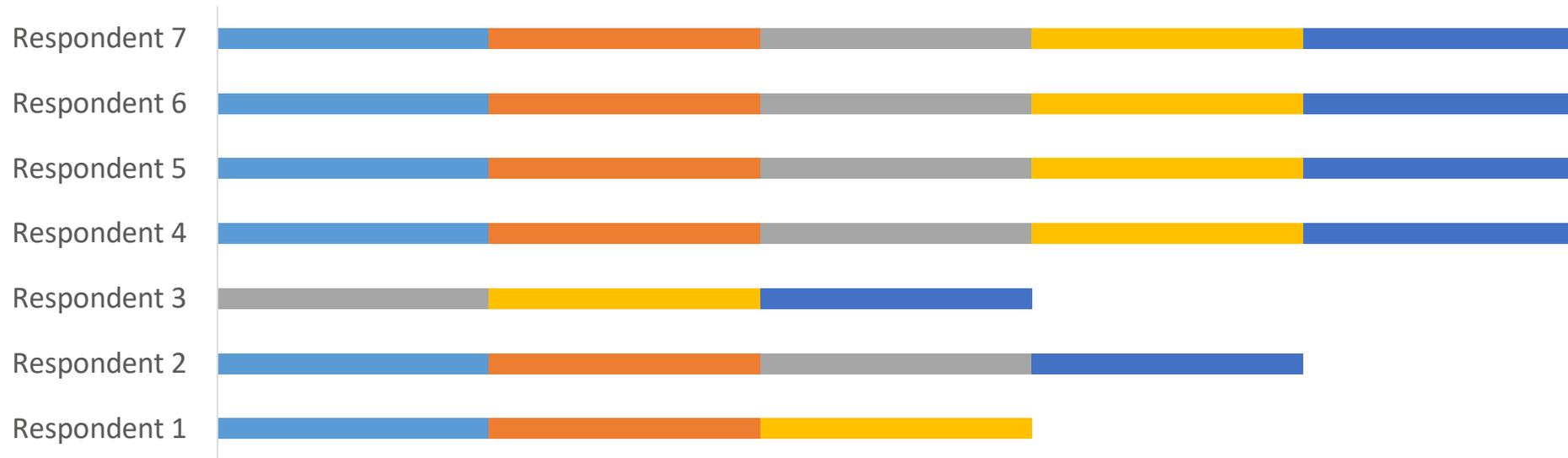




Q101. Does your organization notify primary care providers (and other involved services such as in-home and skilled nursing facilities) of their patient's emergency department visit and/or hospital admission?(7)

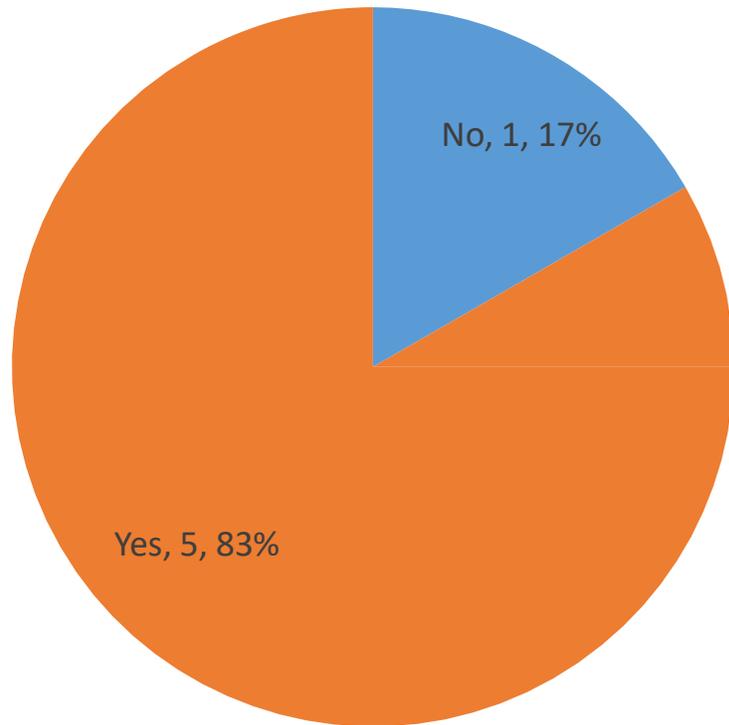


Q102. What barriers do you face when coordinating transitional care? (7)



- Access to transitional facilities (long term care, skilled nursing, etc.)
- Access to follow-up appointments (primary care physician, physical therapy)
- Transportation
- Stable housing
- Poor communication with family or caregiver

Q103. Does your organization want to implement or expand transitional care evidence-based methods? (6)



If Yes, which model? How can CPAA assist?

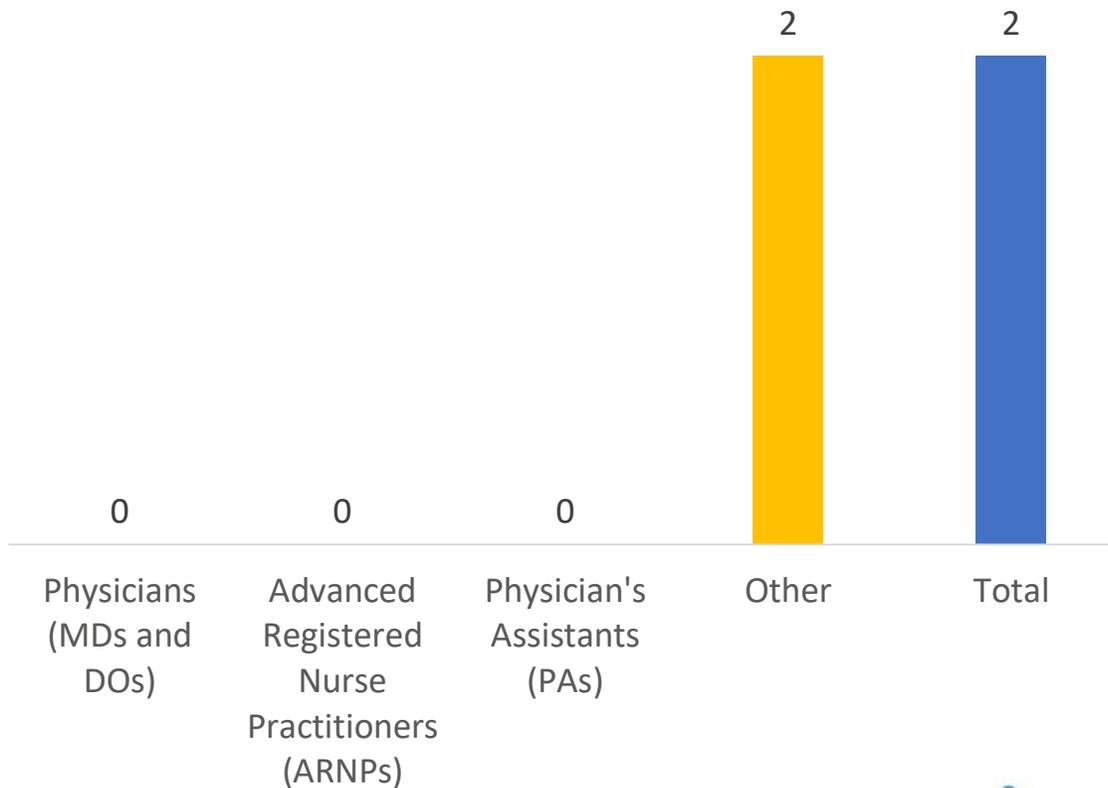
- Need assistance sourcing candidates
- education, staffing, development of sustainable reimbursement models

Do you provide syringe
exchange services? (22)

No: 21, Yes: 1

Q105. How many providers work at your practice? Include MD, DO, PA, ARNP in your count. (1)

Only one respondent, a County Public Health & Social Services



Q106. How many syringes did your program distribute in calendar year 2017?

1,112,089

Q107. How many syringes were returned/collected in calendar year 2017?

1,179,241

Q108. Are your services co-located with another agency?

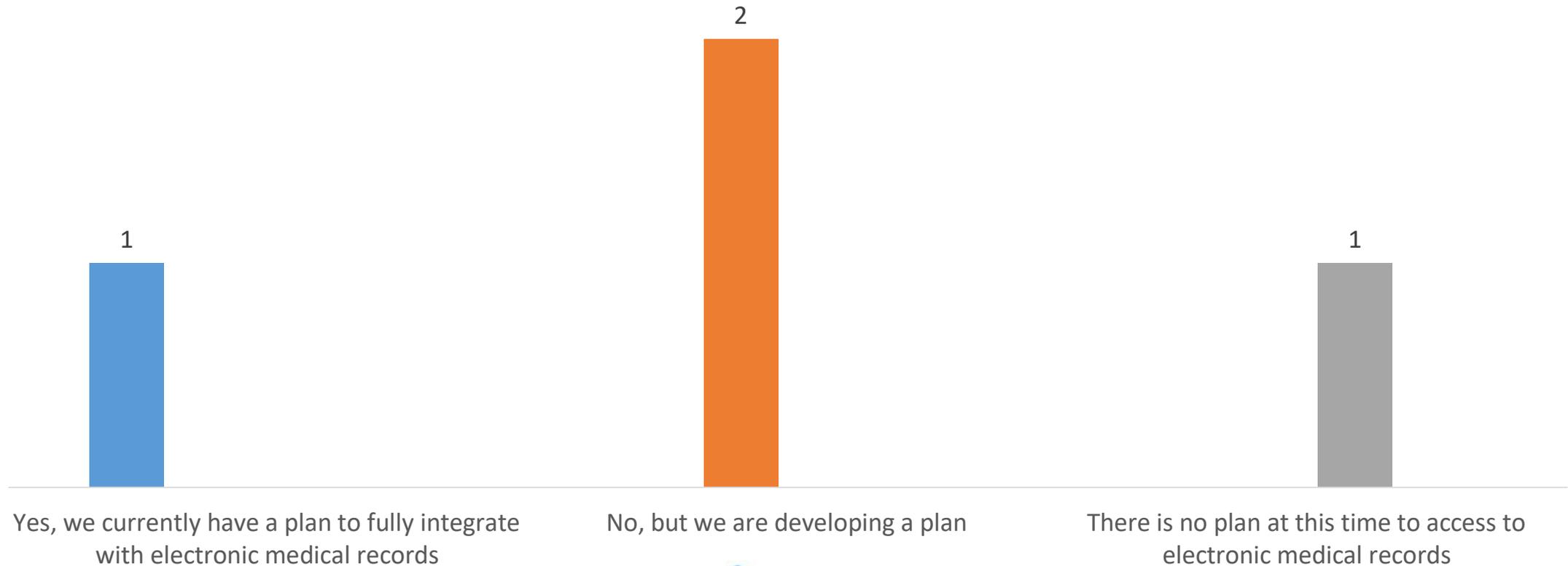
NO

Community Paramedicine

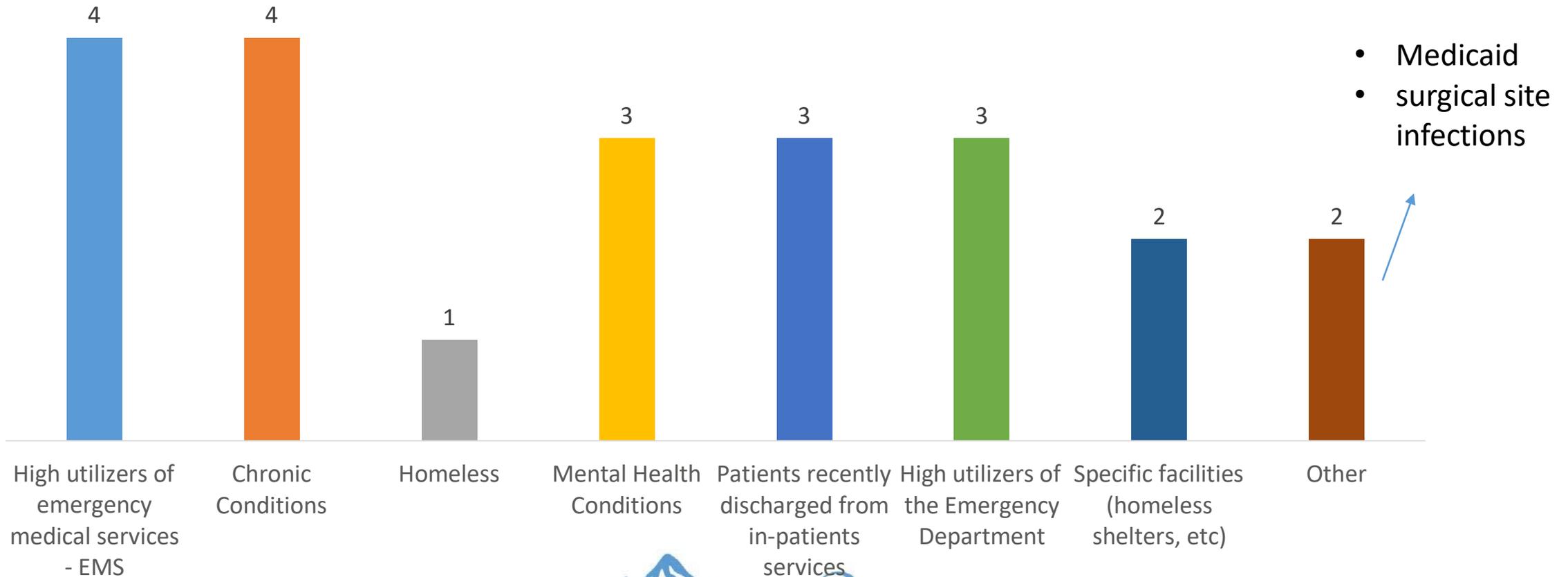
Q128. Do you plan to provide community paramedicine services? (22)

Yes: 4, No: 18

Q129. Do you have access to an electronic medical record or other electronic documentation of patient / client contacts with the community paramedicine program plan? (4)

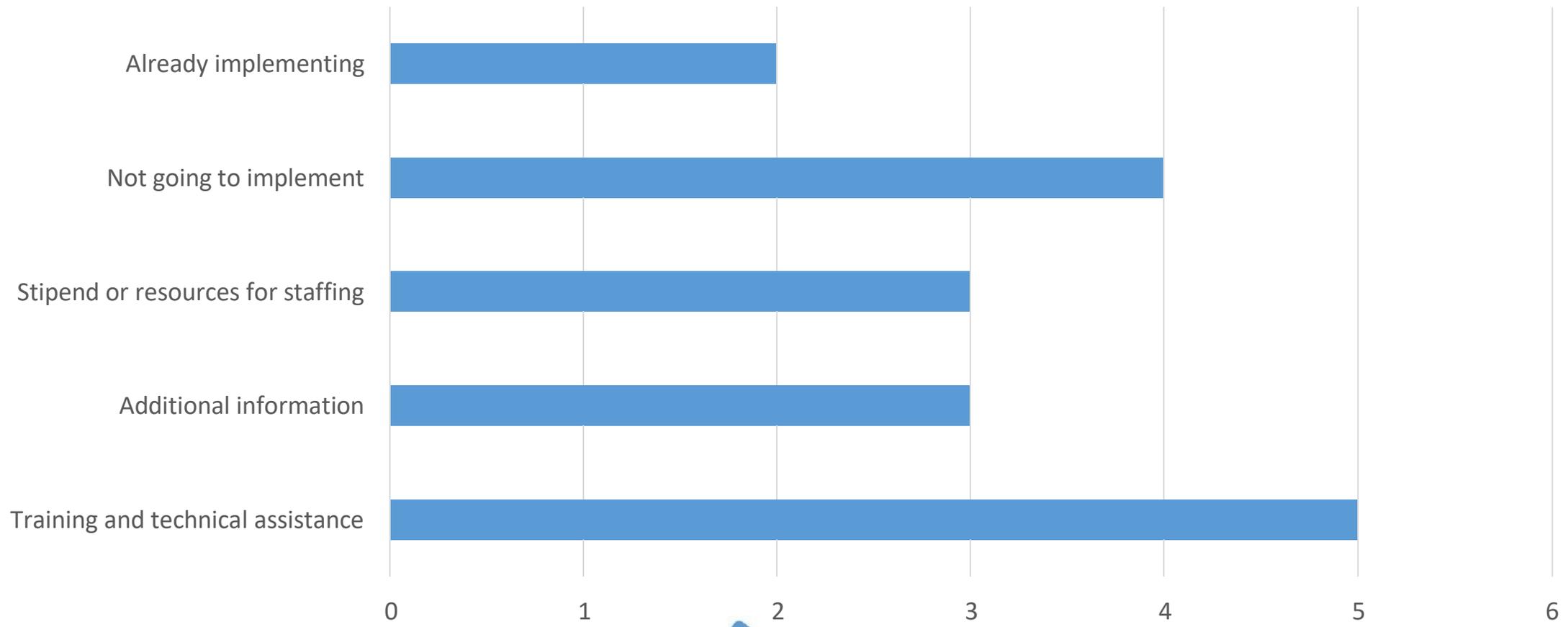


Q130. What are the priority of patients you plan to focus on with the community paramedicine program? (4)

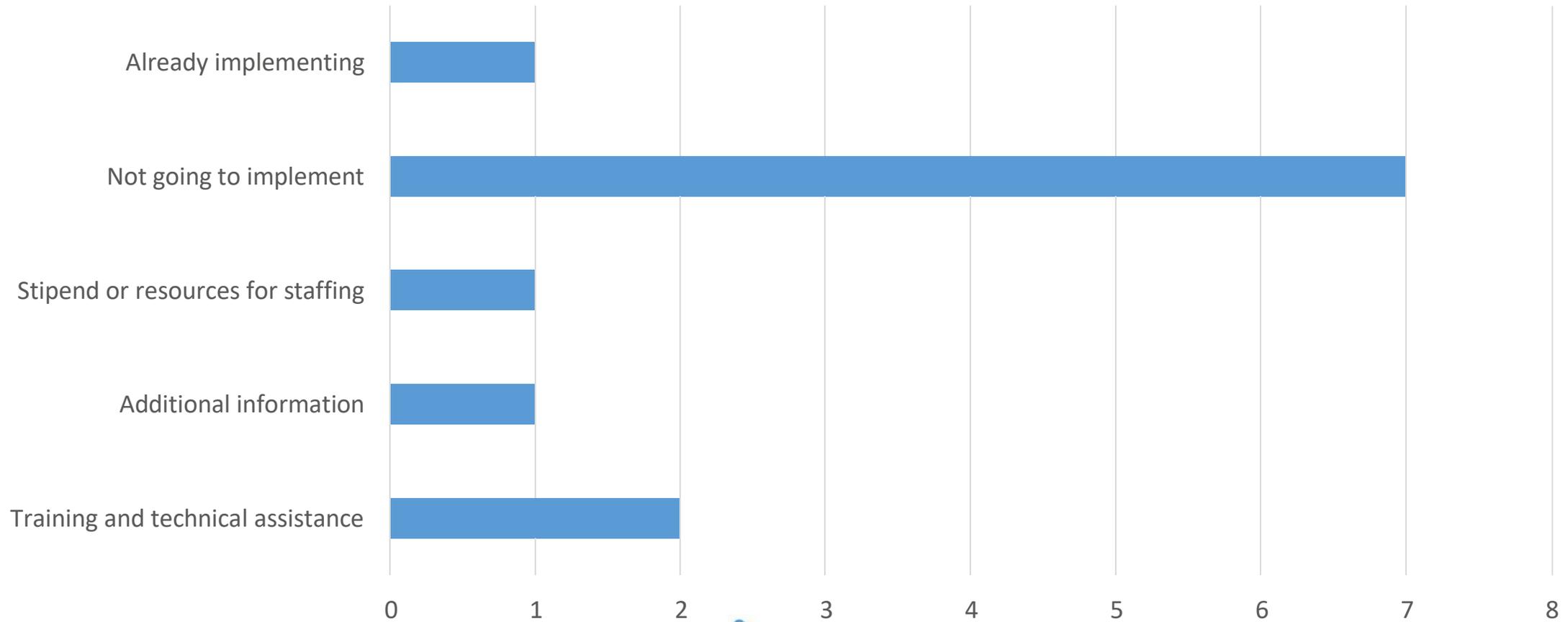


Community Based Organizations

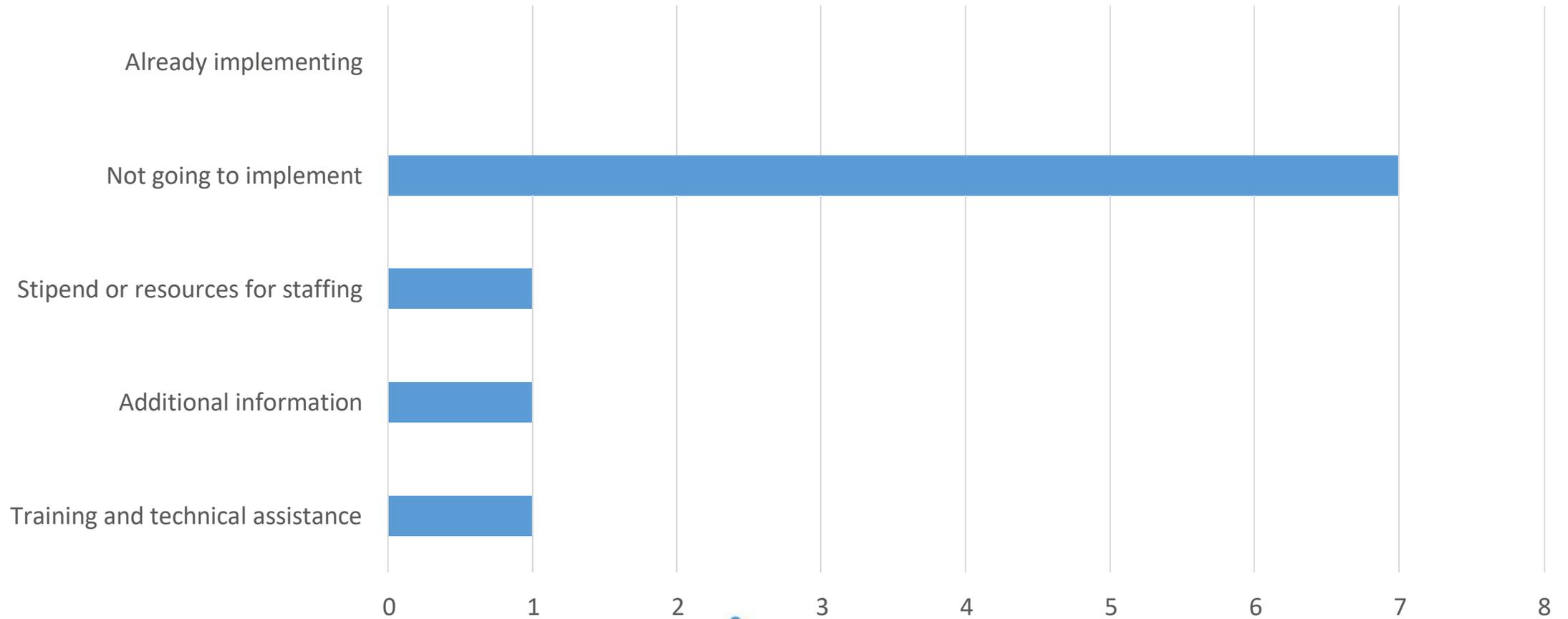
Q133. What kind of support is needed to enhance Nurse Family Participation? (10)



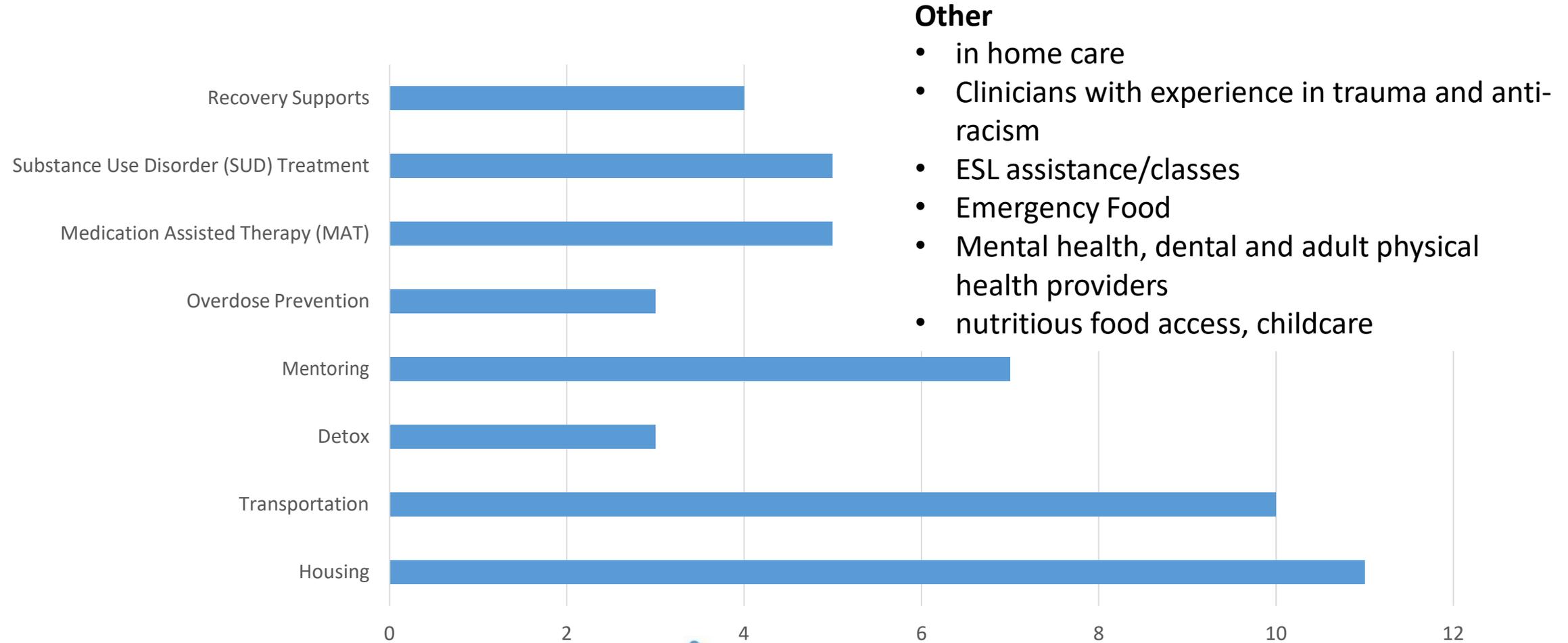
Q 134. What kind of support is needed to enhance Parents as Teachers? (10)



Q 135. What kind of support is needed to enhance Family Spirit? (10)



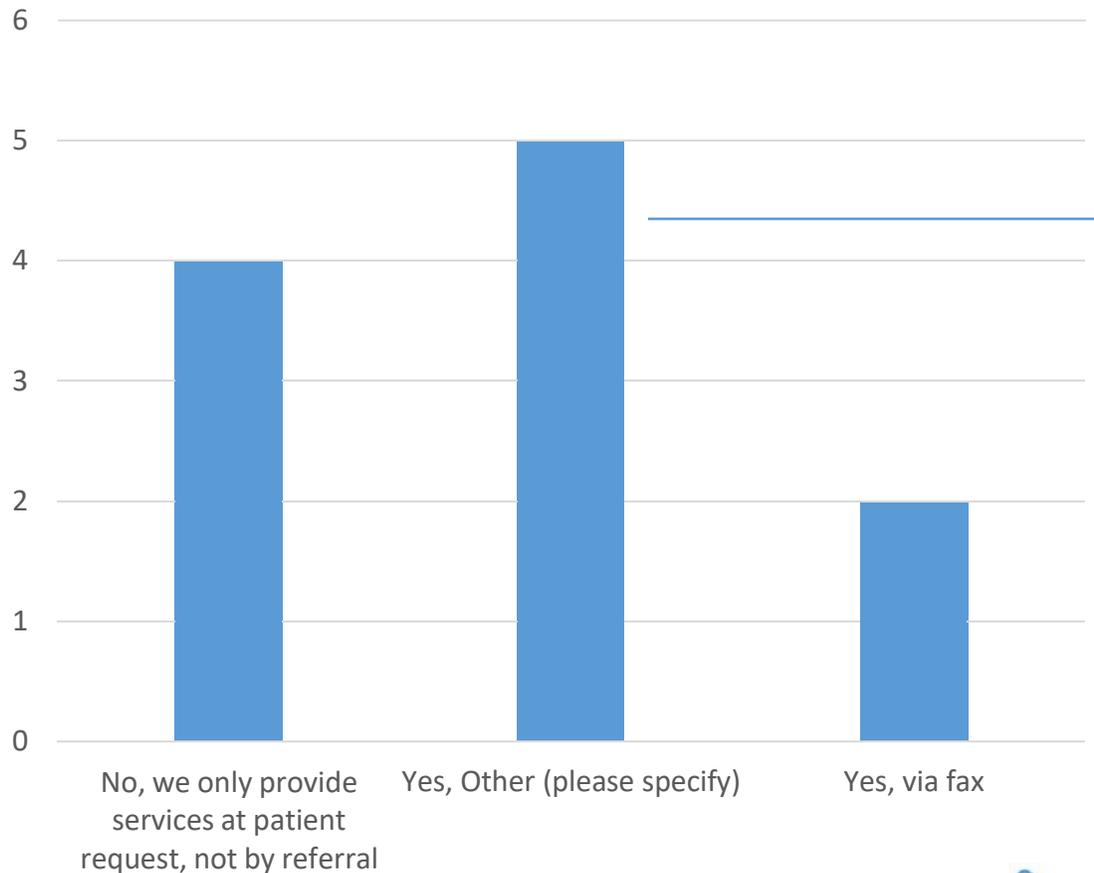
Q 136. Related to social determinants of health, which of the following services do your patients or clients need most? (12)



Other

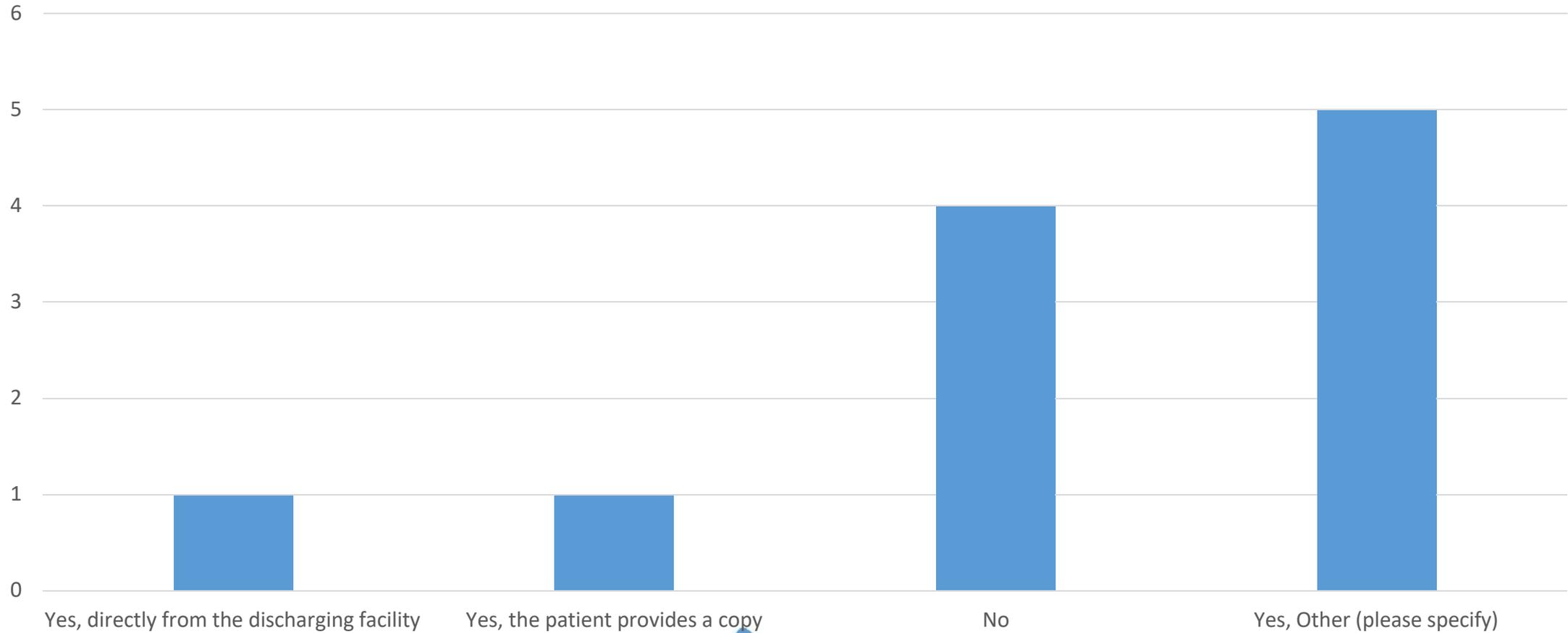
- in home care
- Clinicians with experience in trauma and anti-racism
- ESL assistance/classes
- Emergency Food
- Mental health, dental and adult physical health providers
- nutritious food access, childcare

Q137. Does your organization routinely receive referrals from patients being discharged from in-patient services?(11)

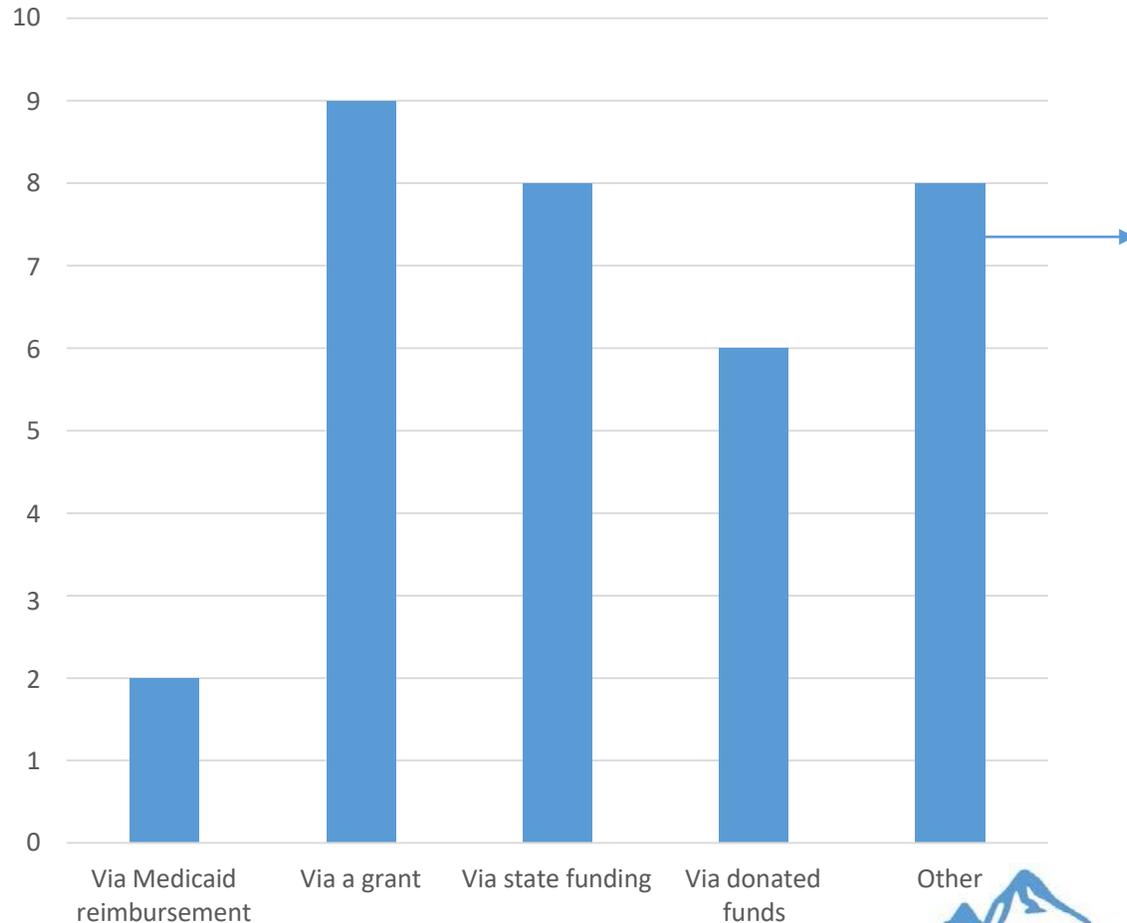


- This department is working towards becoming the Community Health Strategist, we do not provide direct services
- occasionally, rather than routinely, by phone and fax
- Via Secure Email (WA State)
- Sent from hospital to our Center
- Yes but not at large scale as this is new for us. Examples include patients discharged from joint replacement or cardiac surgery. Many of our evidence based models support safe recovery and improvement related to balance, strength, cardiovascular rehab, etc. We can receive EHR-based referrals and are in discussions with some state players to enter state run HIE.

Q138. Do you receive a discharge summary or treatment plan? (11)

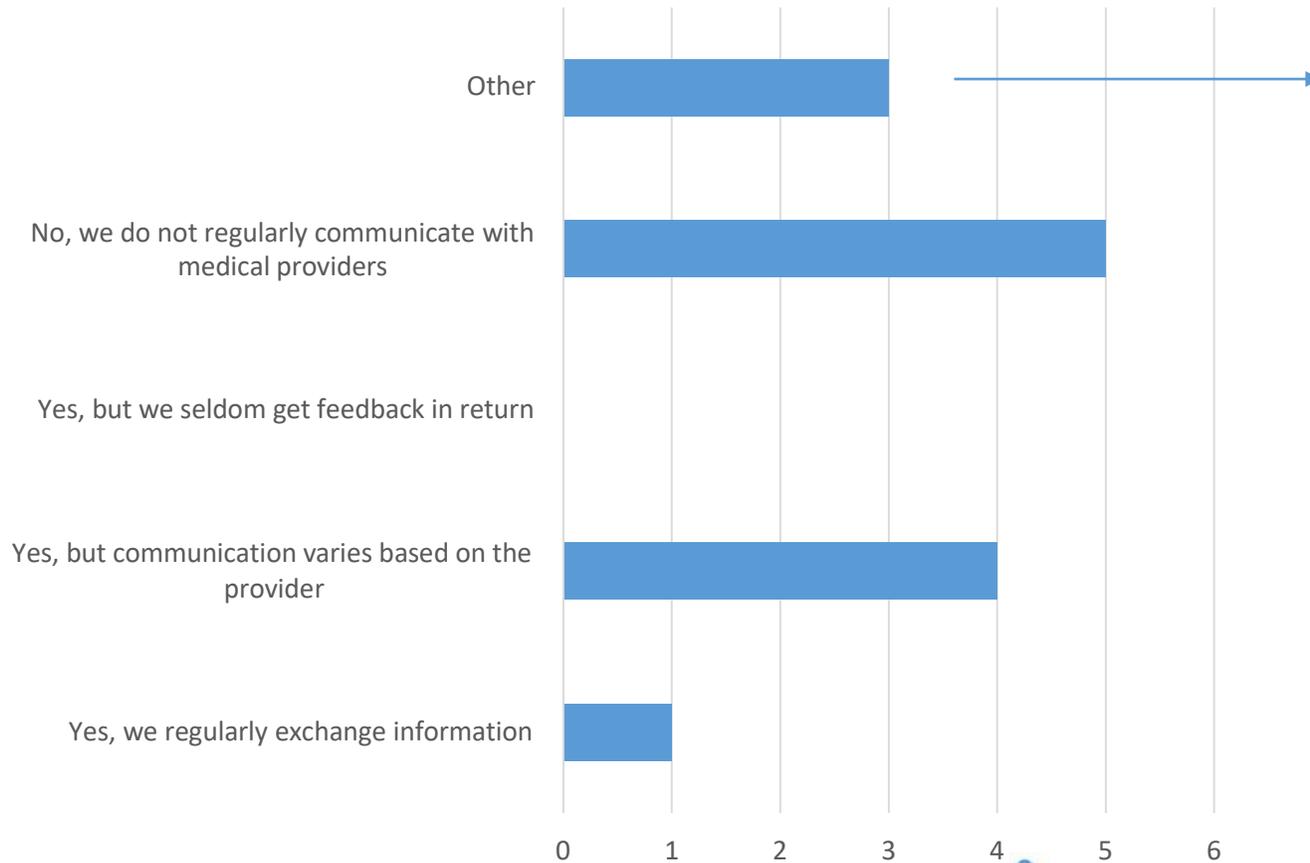


Q139. How do you receive reimbursement for your services? (11)



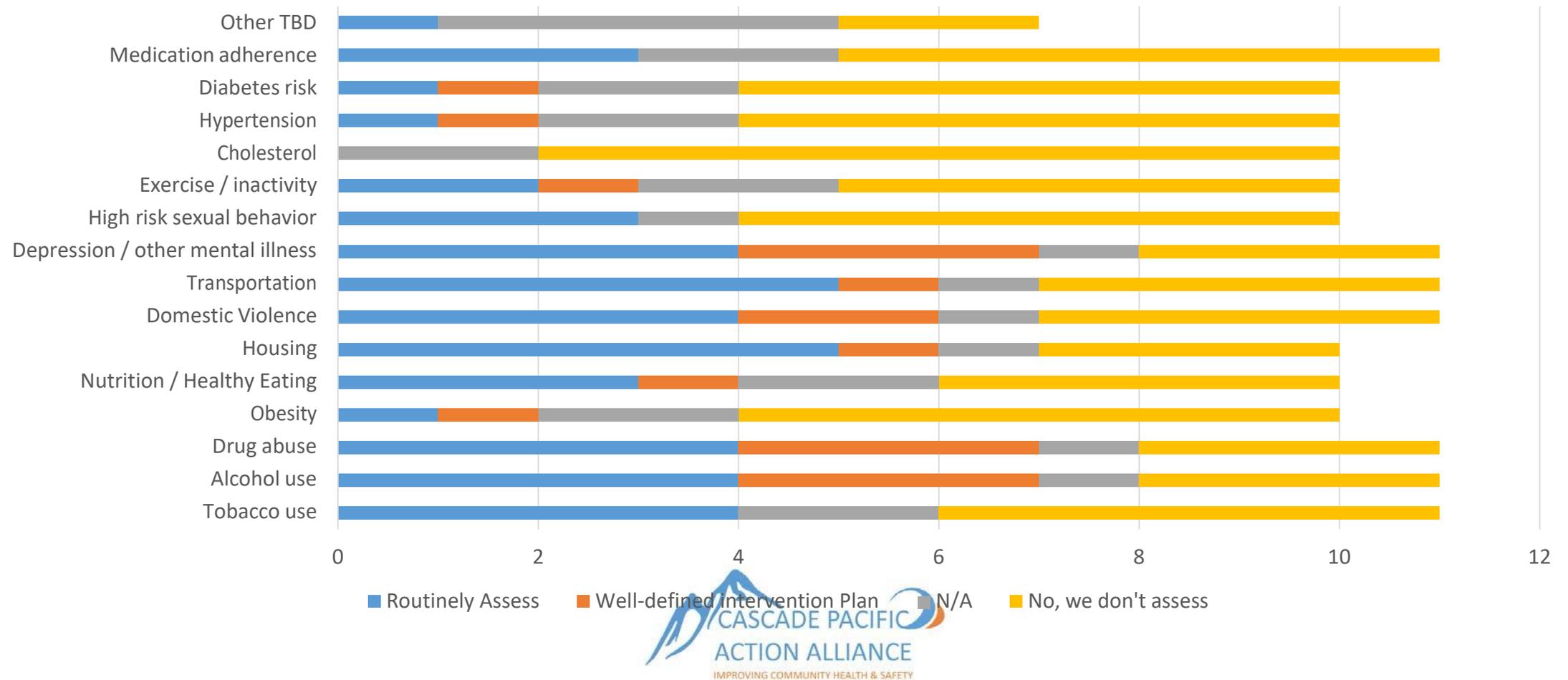
- Depends on the program, some grants, some state funding, no direct services that have been listed so far in this survey
- We dont receive reimbursement for our services.
- federal
- We are being reimbursed for service currently
 - Fees
- Federal/County
- We receive Medicaid administrative match for our services (which I considered "Medicaid reimbursement" above.
- Medicare, commercial plans, employers

Q140. Do you contact the discharging hospital or primary care physician with any discharge concerns? (13)

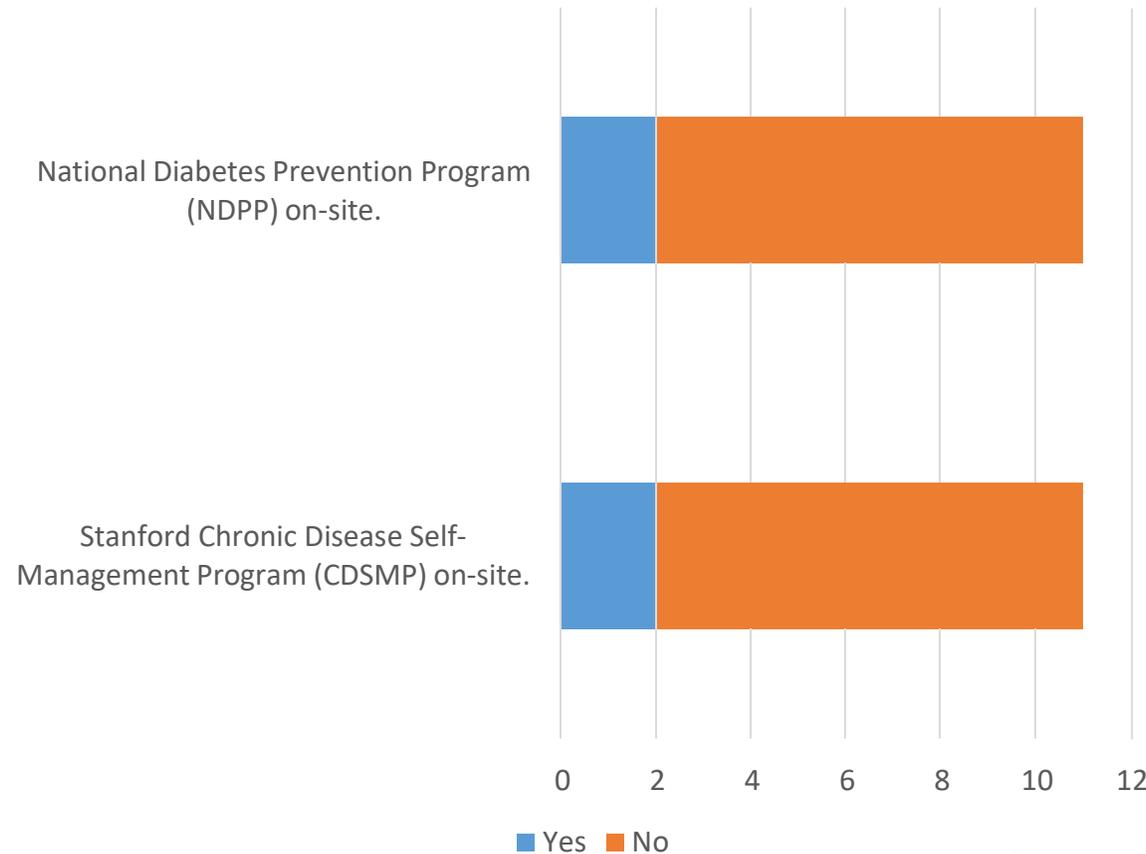


- Regularly communicate with medical providers around other programs like communicable disease rather than services listed in this survey
- connect with PED's at Mason General and Occupational Family Practice
- We have a central POC for concerns that also networks with providers

Q141. Does your organization routinely assess and document patients for the following risk factors? Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors? (11)



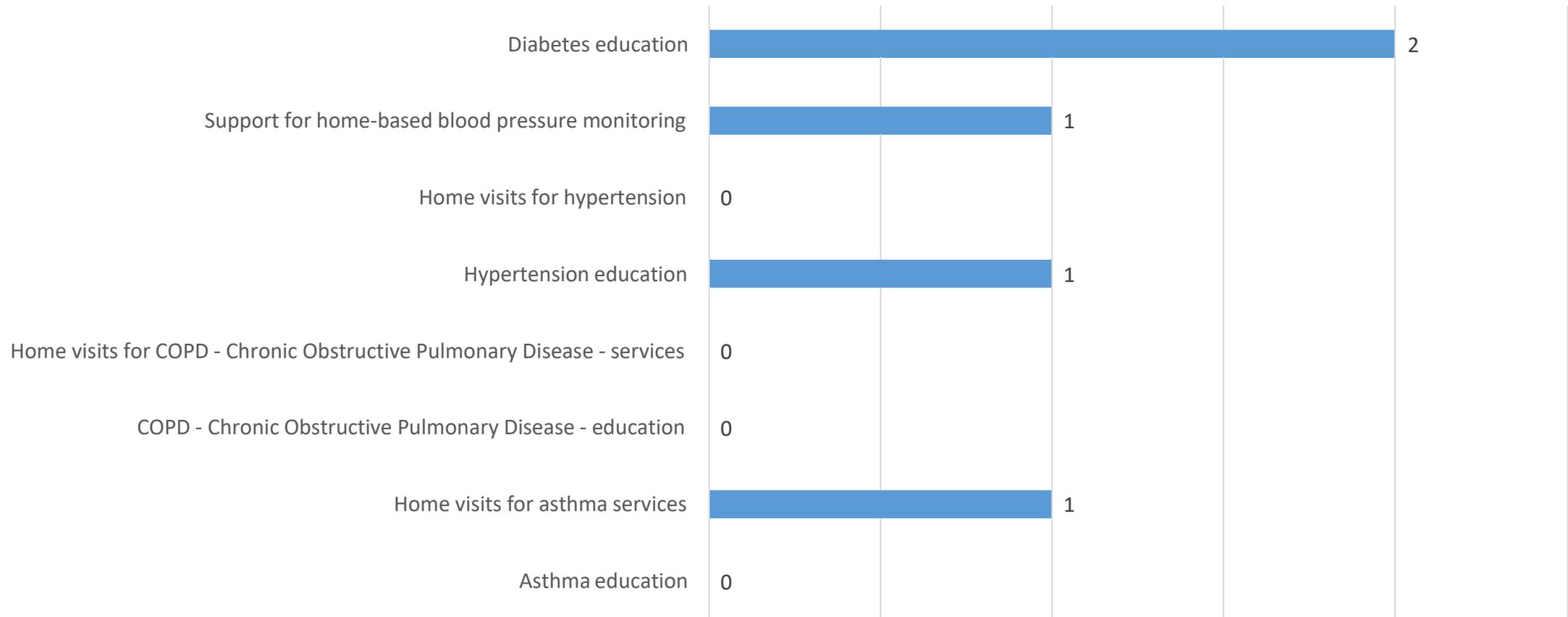
Q142. Do you offer chronic disease self-management or educational classes? (11)



We are interested in licensing and training for:

- Both, if can be administered by non-clinical personnel, e.g. our housing stability case managers who are cross-trained as CHWs.
- We provide through a sub-contractor who works in the community.
- Chronic Disease Self-Management Program
- we used to do CDSMP and DSME in many WA YMCAs

Q143. Our organization currently offers the following (3)



Q144. Does your organization maintain a chronic disease registry or registries? (11)



Q145. Do you have access to patient's treatment or care plans? (10)

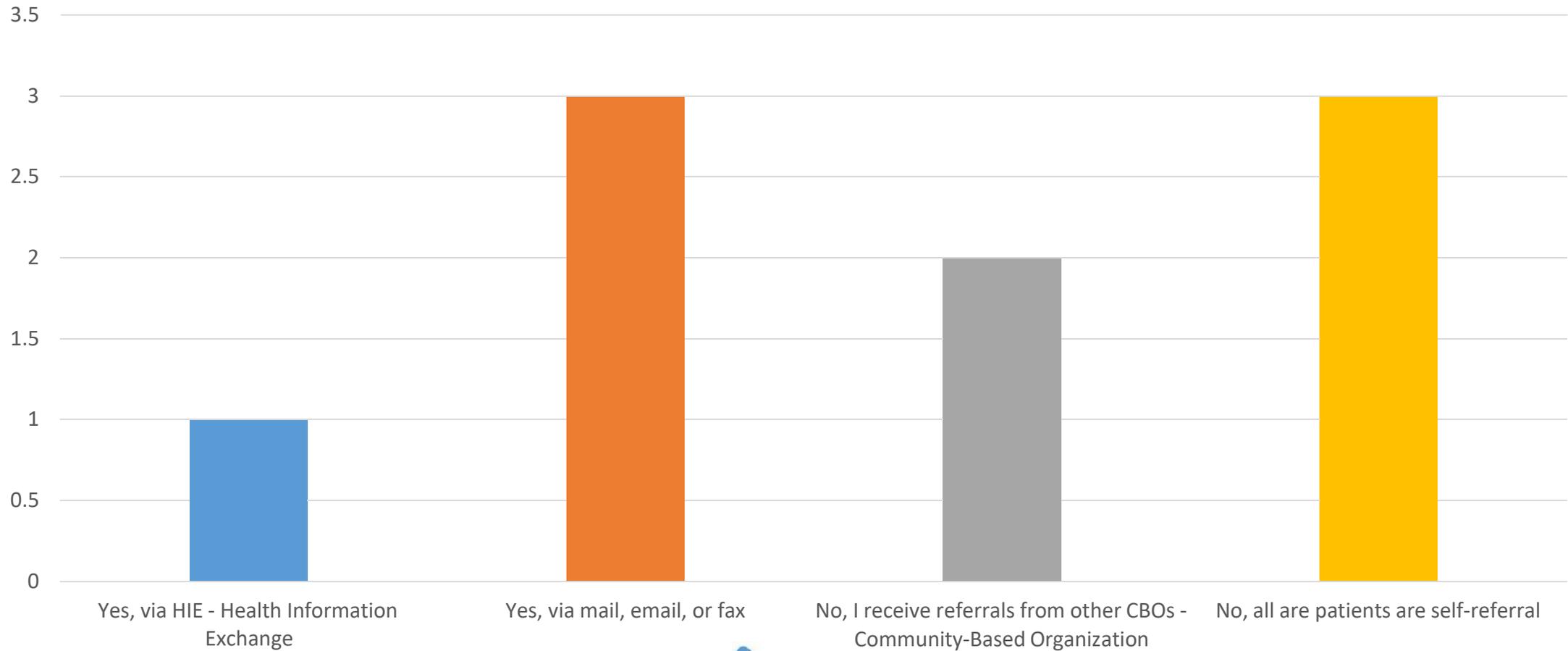


- Client may share pre and post natal care information
- Case-by-case basis, with client permission
- Yes - Dr. Rachel Wood (Health Officer - can access treatment or care plans through HER at Providence
- the ability to engage in bidirectional communication between our EHR and other providers' EHRs is not to this level of sophistication yet

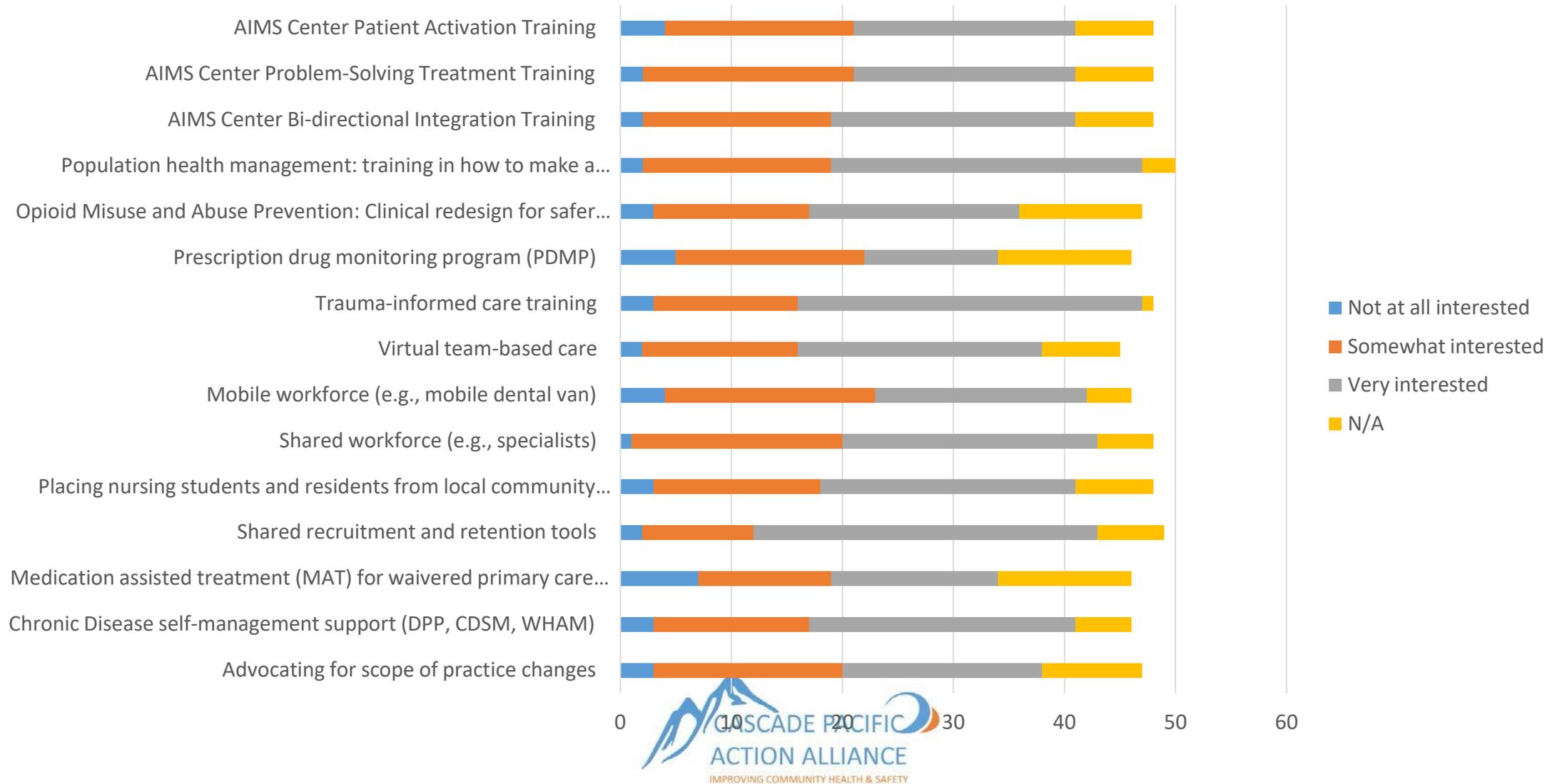
Q146. Which clinical and community partners do you routinely work with? [3413] (8)

- Hospitals, physicians, SUD Treatment providers, Housing providers, MH providers, BHO, United Way, Free clinic
- Peacehealth and Kaiser
- Kaiser, Peacehealth, Home Health, Great Rivers Behavioral Health, Cowlitz Tribe, Wahkiakum Health and Human Services
- Catholic Community Services, Community Youth Services, Juvenile Probation, Commerce Community Jobs, DSHS
- Mason County General Hospital; DSHS WIC; and Mason County Dept. of Health
- Columbia Wellness, Pathways, A First Place, Awakenings, CORE Health, Kaiser, Family Health Center, Peace Health, WIC
- Providence Behavioral Health, SeaMar, Behavioral Health Resources, Thurston Mason Behavioral Health Organization, Interfaith Works, Family Support Center, Community Youth Services, Partners in Prevention, SafePlace, Olympia Free Clinic, Lacey Veteran Services Hub, Olympia Community Court,
- Food lifeline, public housing, schools, faith based institutions, other

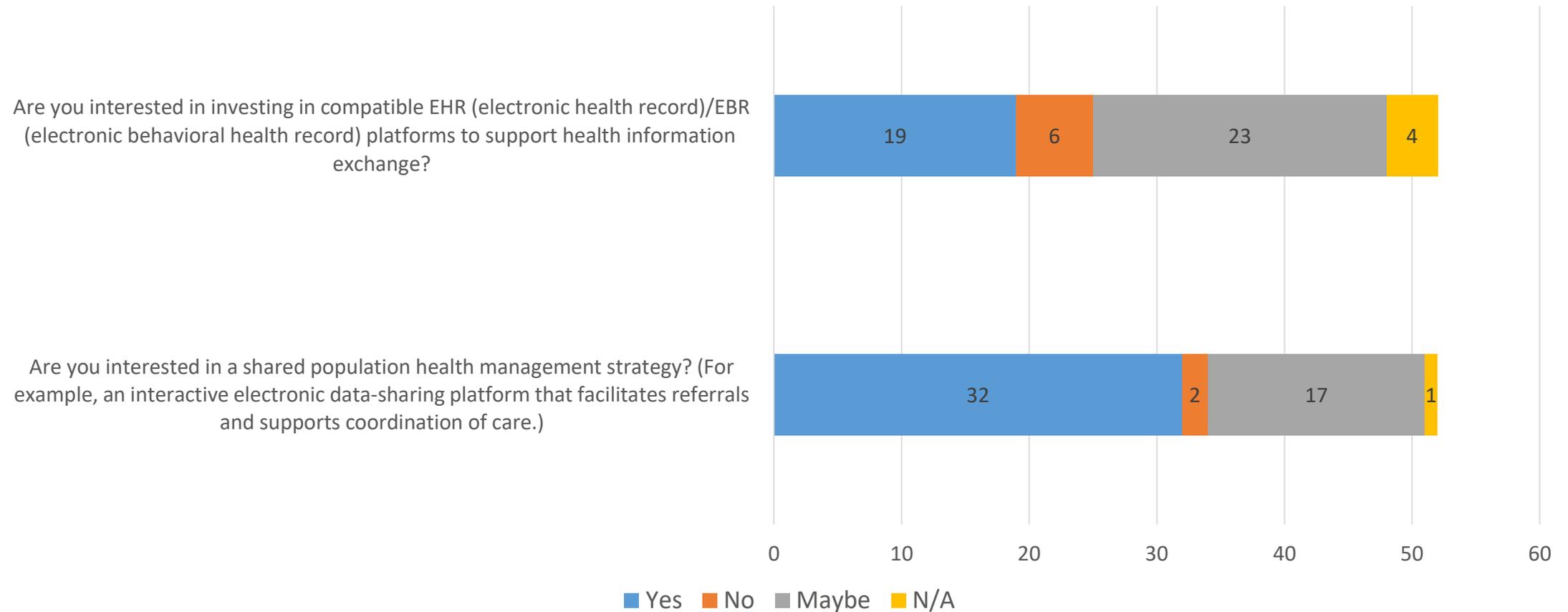
Q147. Do you routinely receive referrals from medical or behavioral health providers? [3414] (9)



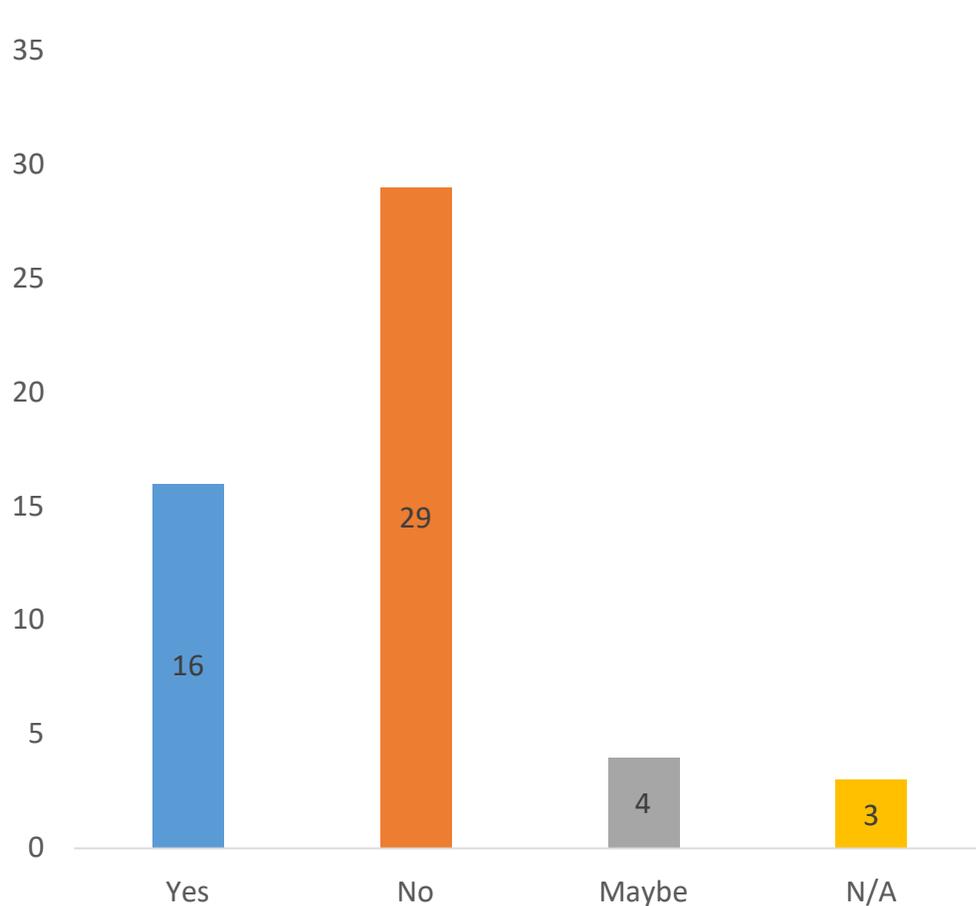
Q148. How interested is your organization in the following investment opportunities? [9001] (51)



Q149. Please answer the following regarding population health management: [9003] (52)



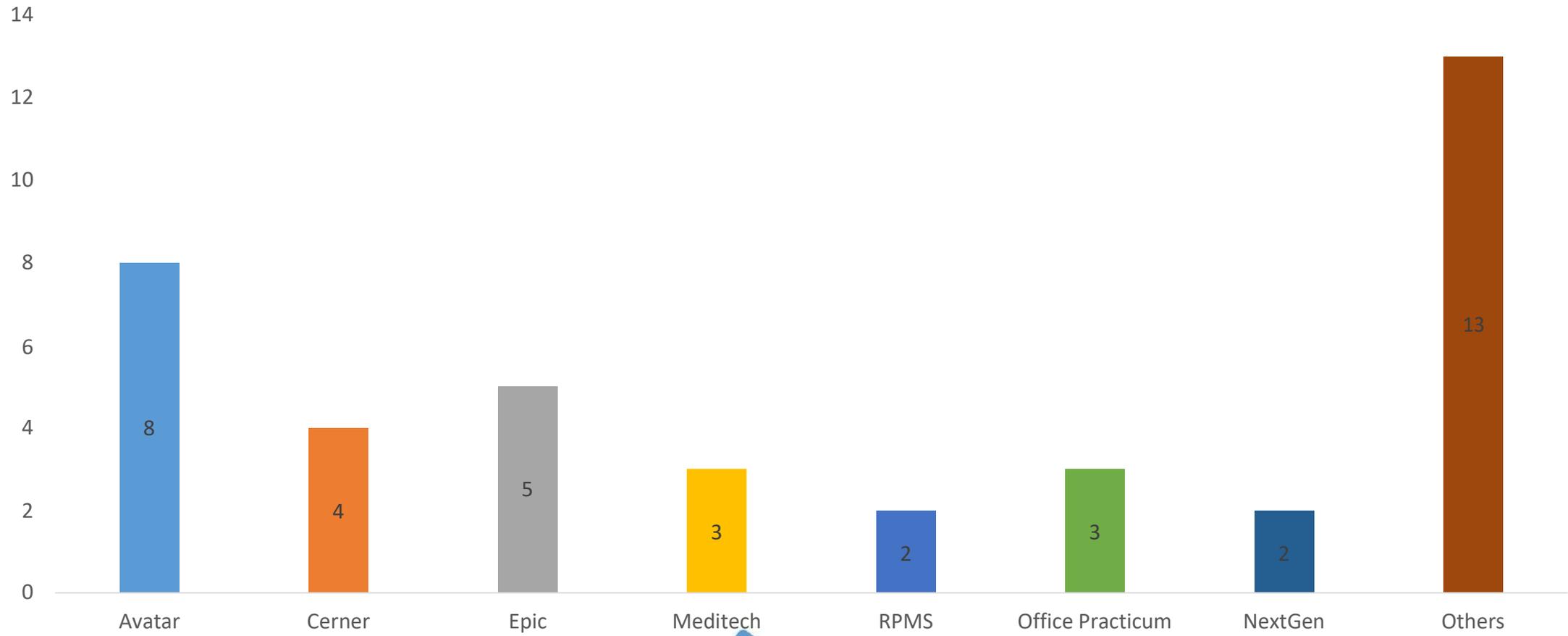
Q150. Does your organization currently operate one or more registries? [9005] (52)



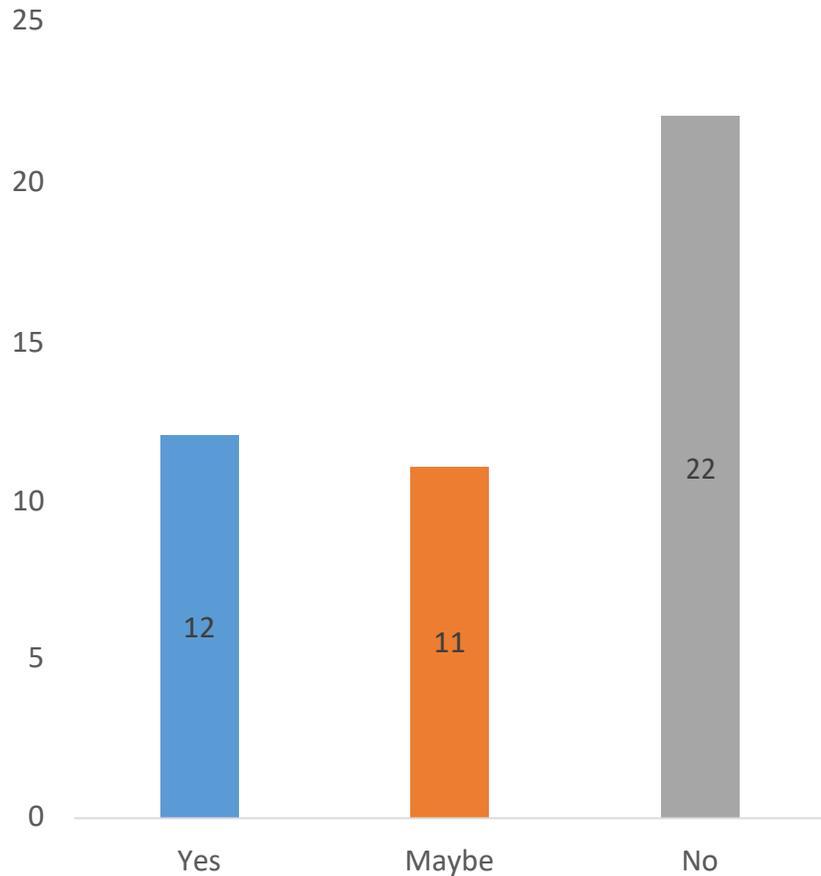
If you answered "yes" above, please describe your registry or registries.

- Arcadia
- as stated previously, we have paid for a child mental health adaptation of the CMTS software from AIMS. We also operate an extensive database software for PAL consultation program statewide.
- some basic excel registries used at a couple sites
- ESO, Image Trend and others
- Chronic disease
- within our EHR
- EMR registries for chronic pediatric conditions
- immunization registry, diabetic registry
- eClinicalWorks allows us to select patients by a range of criteria
- COPD, CHF, Diabetes, Opioid, possible others
- currently a spread sheet as well as one specifically for family planning and participate in the State immunization registry
- Homeless Management Information System (HMIS for WA State); CAP 60 case management software; BEST spreadsheet for FCS Supported Employment
- Chronic disease management,
- Participate in Immunization Information System, DOH STI Reporting
- Diabetes
- registries for chronic disease in health planet, disease registry, others, developing additional registries to assist with population health strategies
- unsure
- Immunizations, STD's
- Diabetes

Q151. What is your current EHR (electronic health record)/EBR (electronic behavioral health record)? (40)



Q152. Would you like to change or upgrade this system? [9008] (45)



Yes

- HIE is imperative to the role we serve
- We would upgrade to a product/system that is more user-friendly.
- current platform recently assumed by different company; active RFP currently evaluating new alternatives
- Would like better integration with other systems including hospitals and PMP.

Maybe

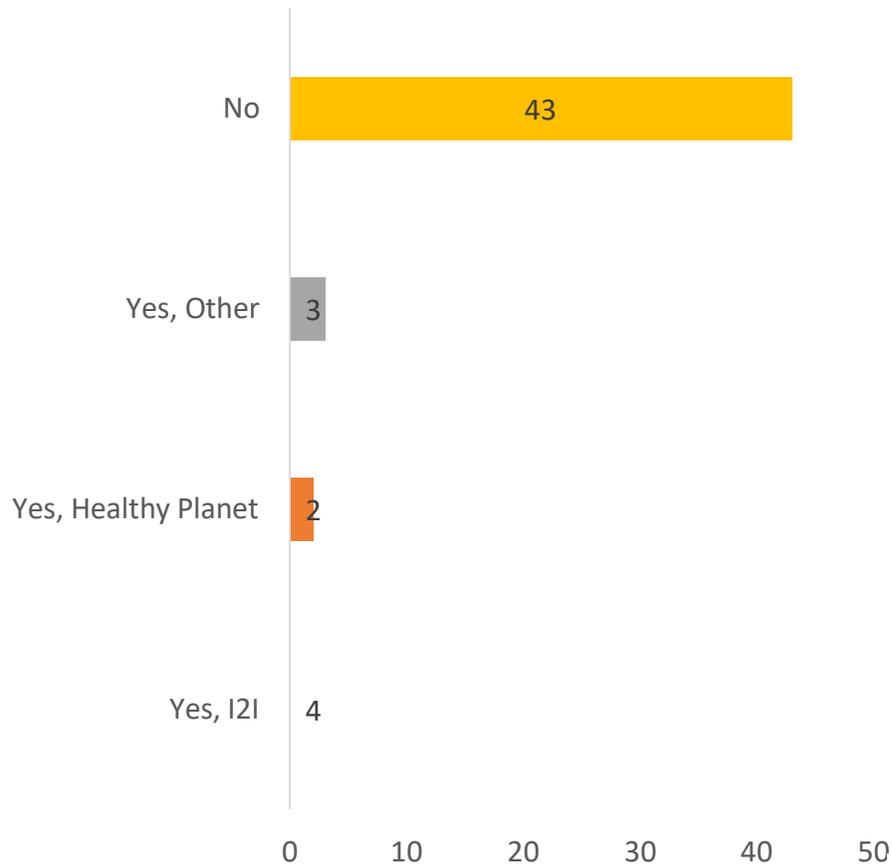
- We can't influence the decision of what EHR system Seattle Children's uses
- We would want to be able to interface with other providers

No

- I love this EHR!!!!

across our agency in our other 20+ programs

Q153. Do you currently have a population health management system? [9009] (52)



Yes, I2I

- EMR Office Practicum provides registry function.
- IHS
- Disease registry starting

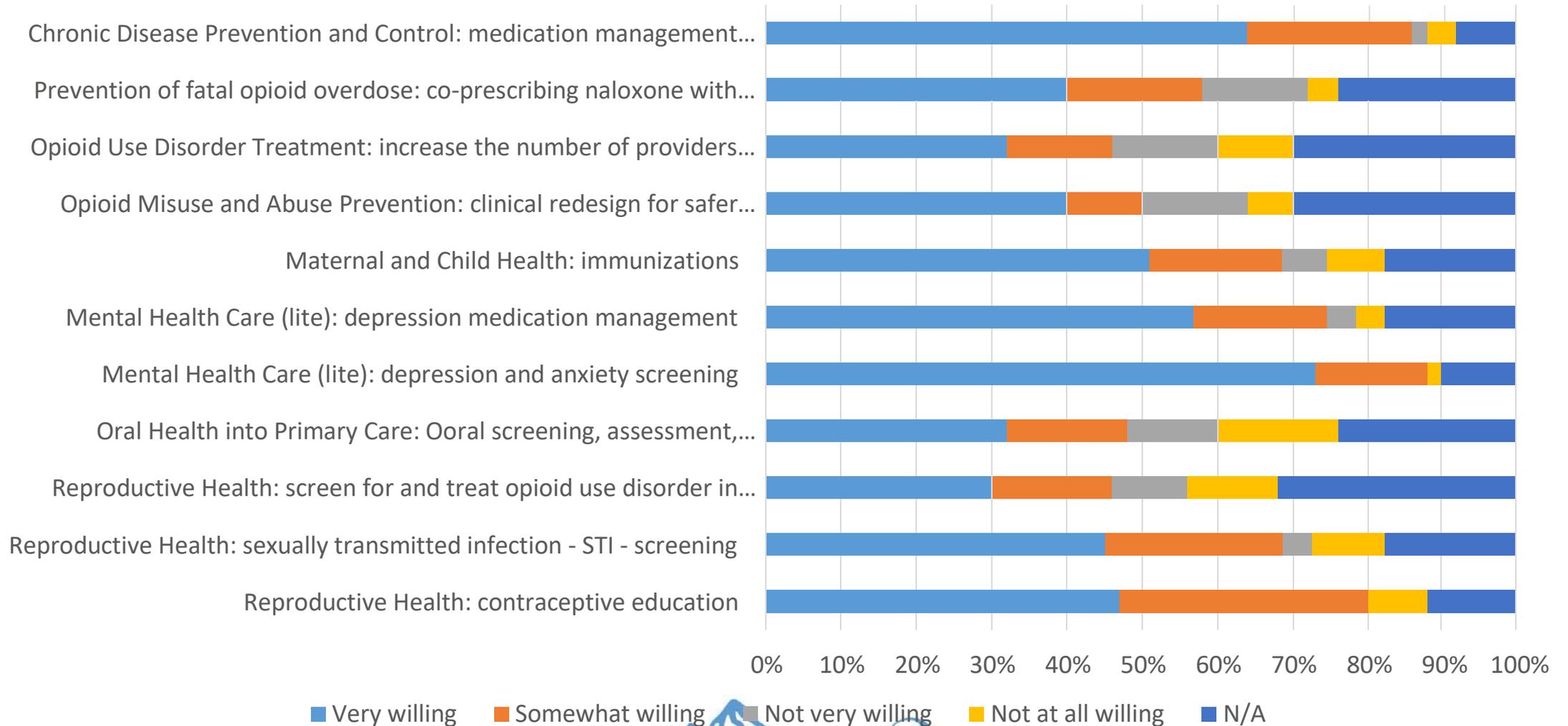
Yes, Other

- EHR
- Lightbeam
- NextGen product

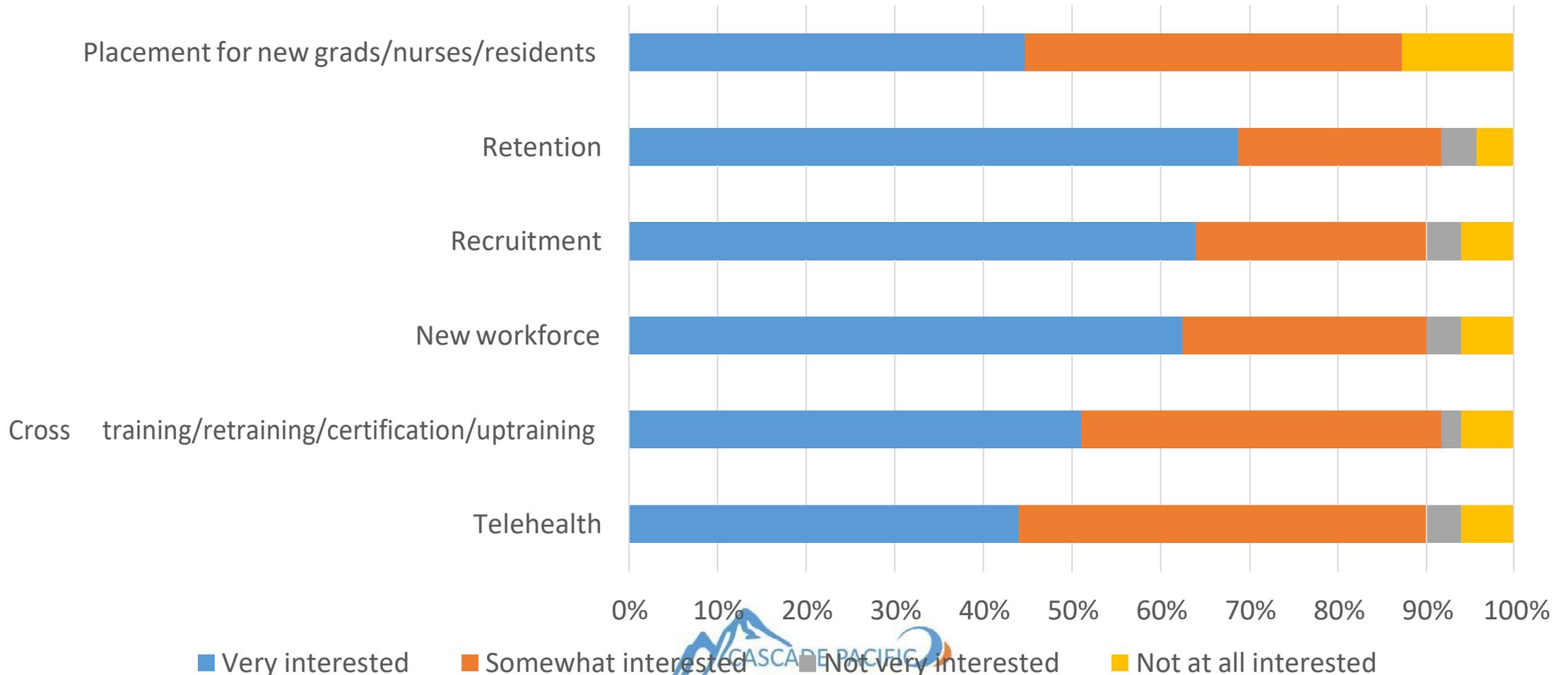
No

- We rely on data from DOH and other County sources currently-
- I don't know enough to answer.
- We aren't
- PH developed tool & EPIC
- currently not looking
- None at present
- None at this time
- RPMS has capacity, just not currently utilized
- Need more info about what this is. We have recently purchased a data analytics system (KPI) which pulls data directly out of our EHR and allows management to if it in terms of CQI, outcomes, utilization, population

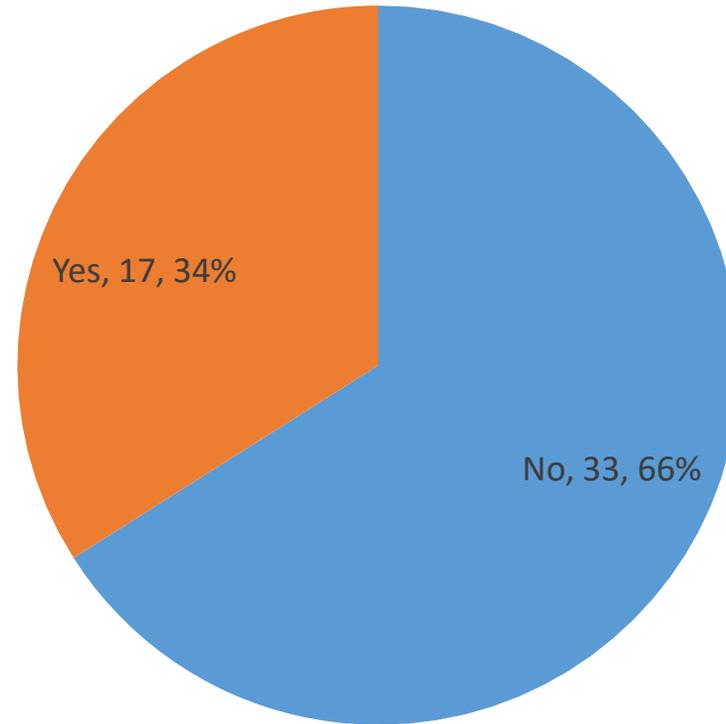
Q154. Willingness to perform (52)



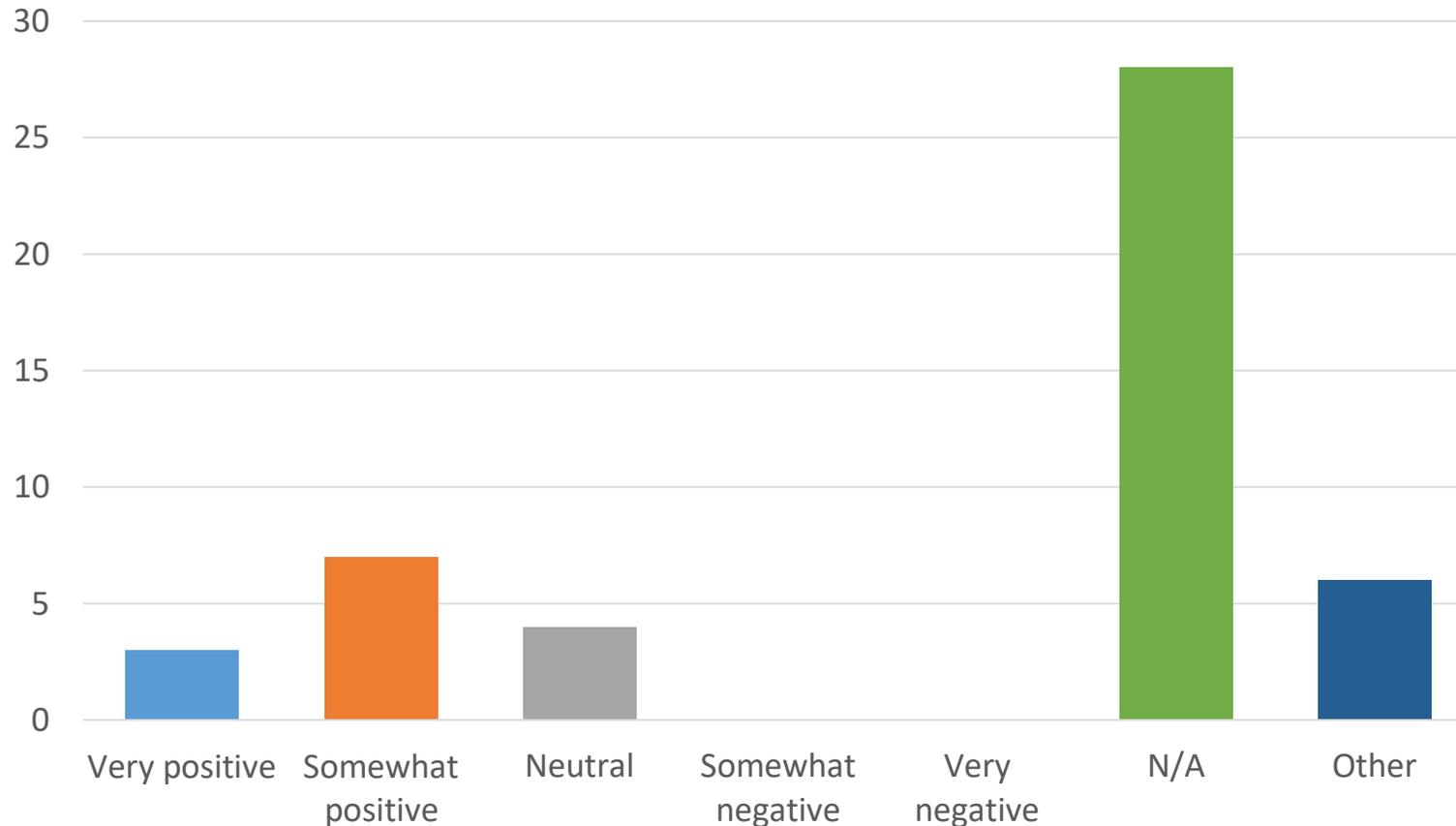
Q155. How interested is your organization in the following investment opportunities



Q156. Do you currently have value-based purchasing (VBP) contracts of any kind? (50)



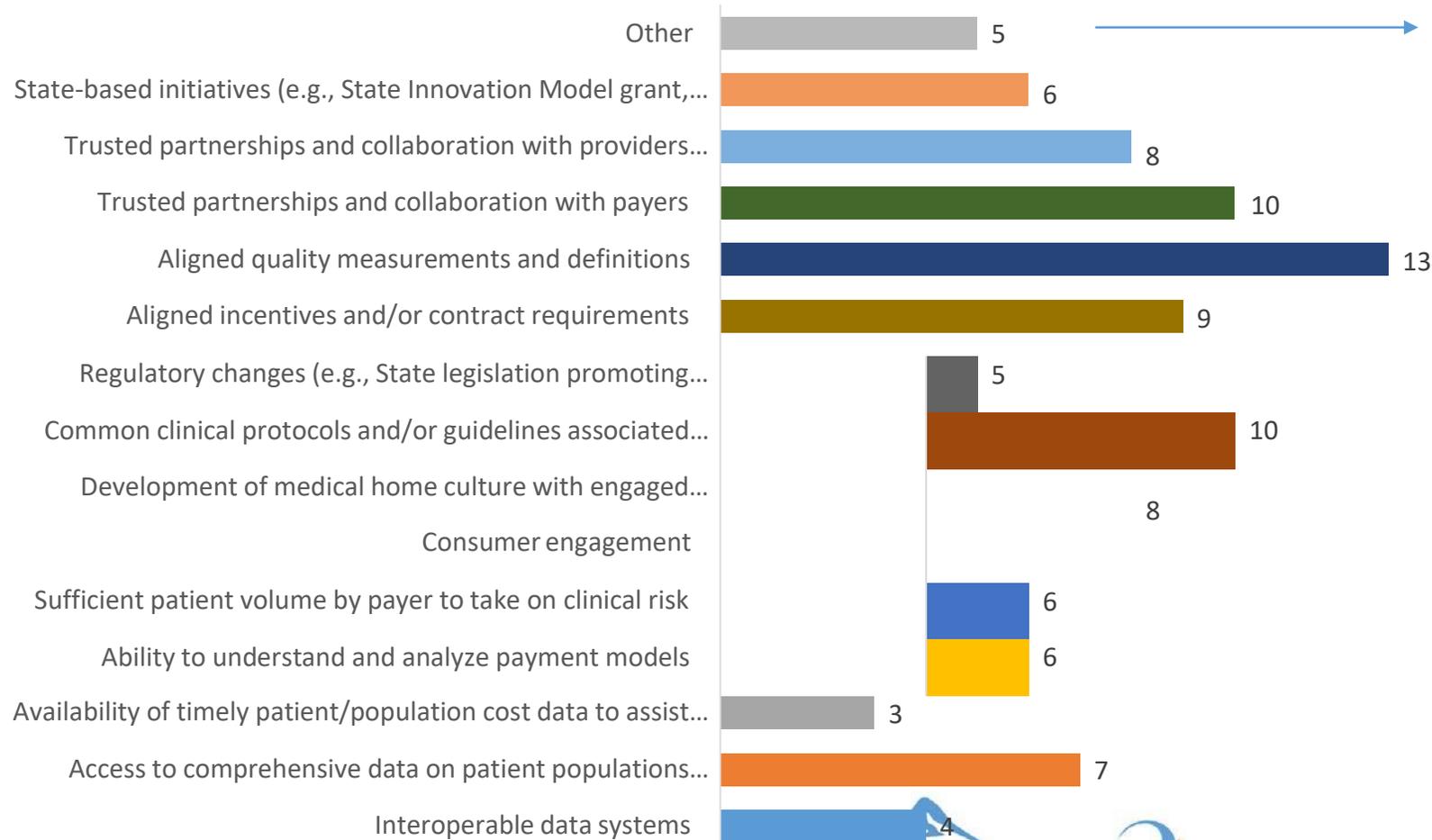
Q157. If you are receiving VBP from a health insurance company, please describe your overall experience with VBP: (48)



Other:

- not involved with these contracts
- We are a rural health clinic
- We are not yet sure this is providing us better reimbursement for the high quality medical care we believe we are already providing
- Just beginning this with FCS for Permanent Supportive Housing & Supported Employment
- just started....no experience yet
- BHO -Very Positive

158. If you are receiving VBP from any payer, what has enabled your participation in VBP? (48)

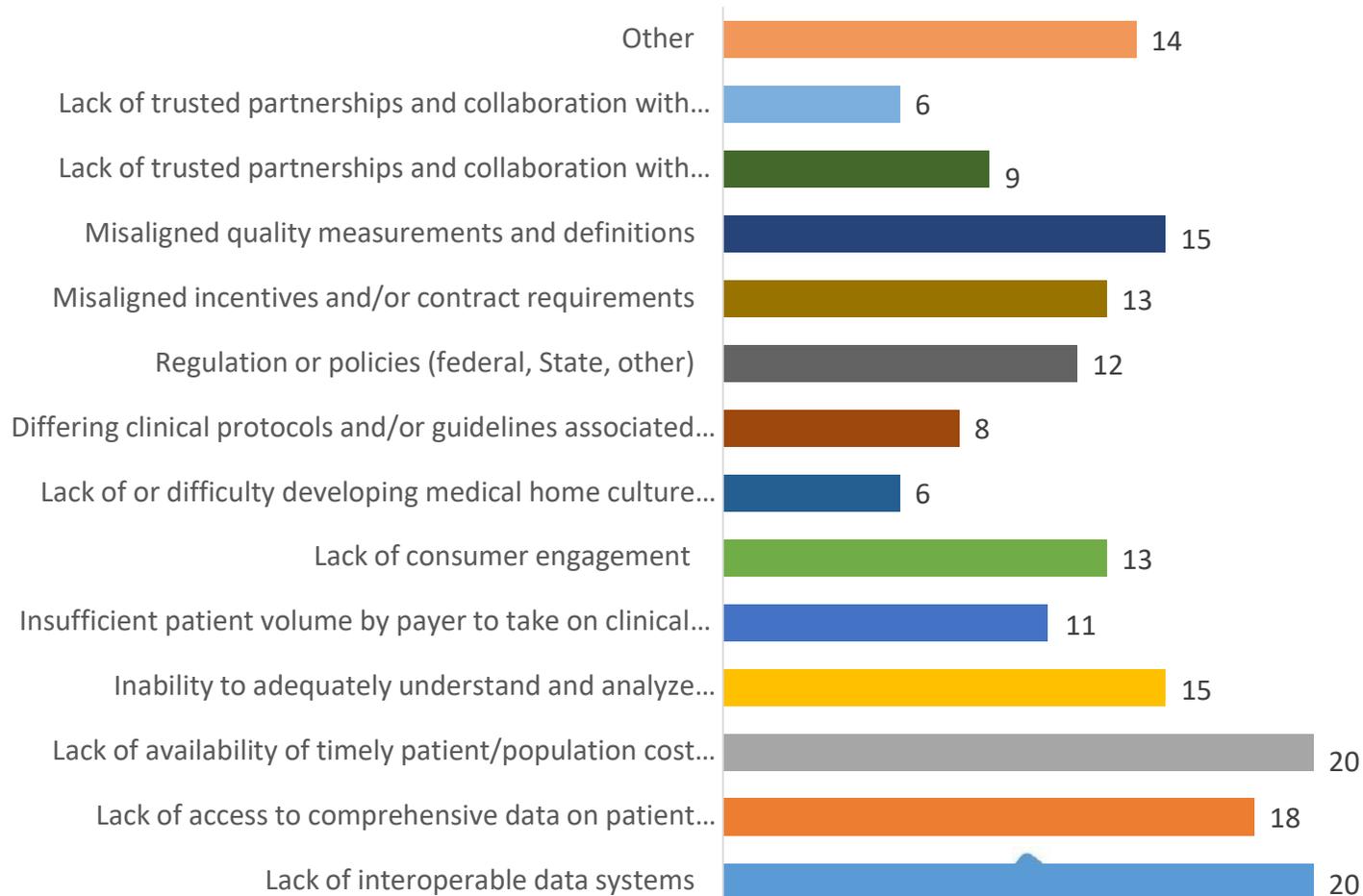


Other:

- Seattle Children's Care Network and TCPI
- not involved in VBP contracts
- Data mining by Physicians of SW Washington, saving us the expensive administrative burden
- Our VBP is a JV with Morton General Hospital and Snoqualmie Valley with Amerigroup (upside only Quality/Indicator based)!
- We are in learning mode in preparation for ACO participation

N/A: 31 Respondents

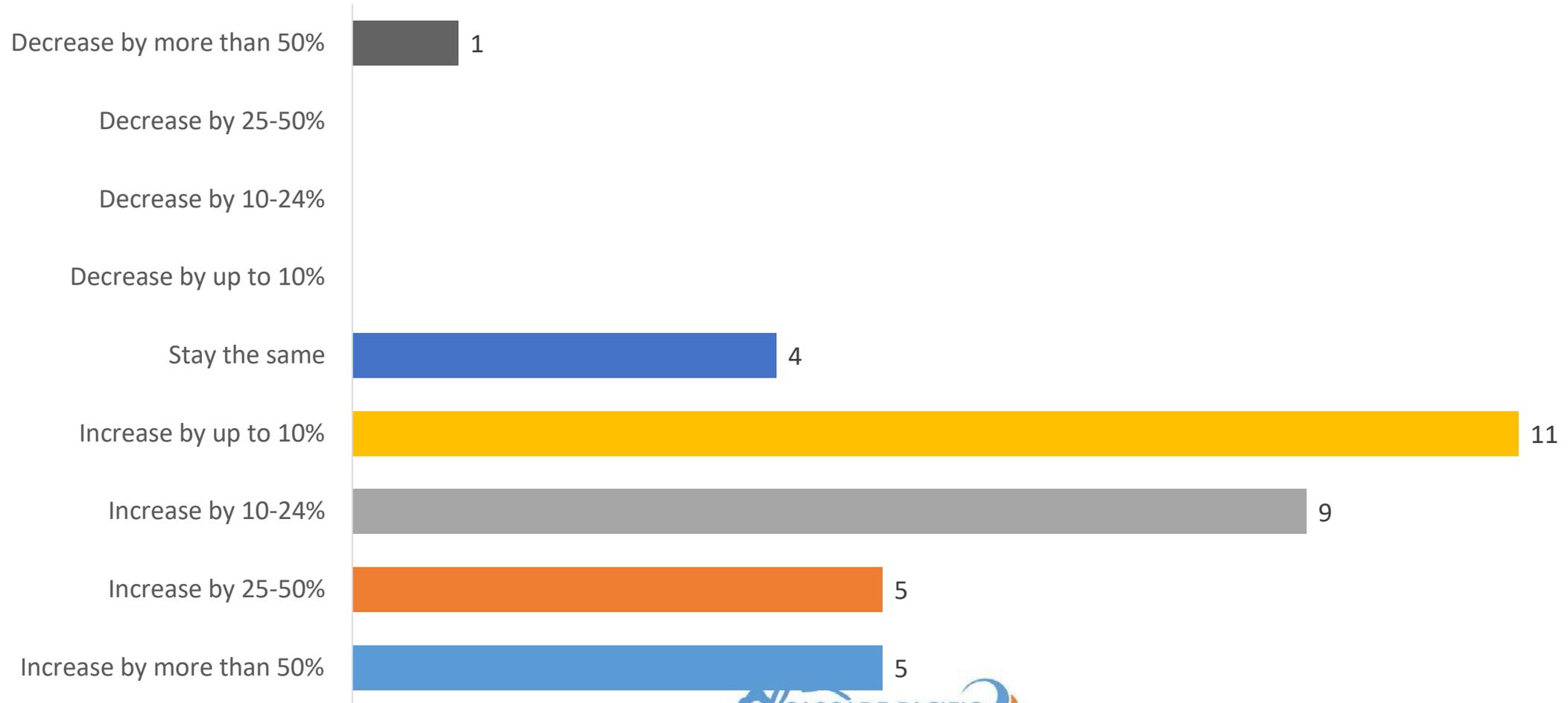
Q159. What are the greatest barriers for engaging in value-based purchasing?(Check all that apply) (41)



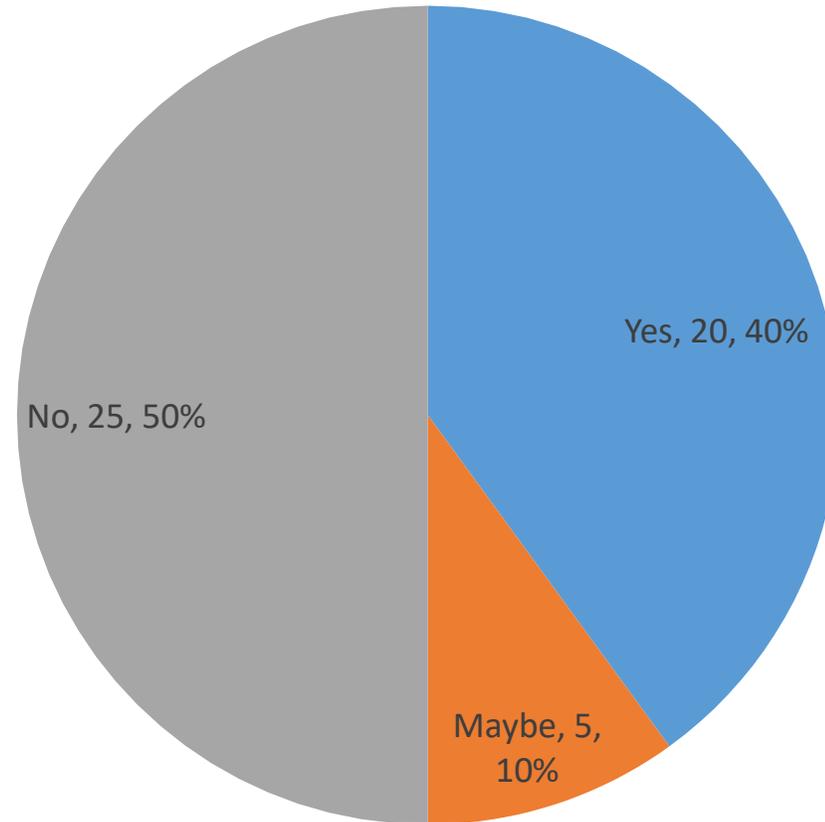
Other (please specify)

- inaccurate patient panels, lack of staff time to manage panels, multiple payors with different payment models work of negotiating with each payor
- not involved with VBP contracts
- lack of provider understanding
- We are a rural health clinic
- I don't understand it fully, but have had a conversation with a MCO rep that said it could increase access to our services for people covered by insurance from MCO's
- Not connected to our services
- We receive Federal Encounter rate for Medicaid patients.
- Inadequate benefits to justify burdensome reporting requirement. For independent providers, incentives are not obviously matched with our perception of high-quality low-cost care.
- physician reluctance/perception of more work, additional documentation, not trusting data from the health plans, inaccurate attribution of patients, wrong claims data, inability to engage/influence patient compliance
- Unsure
- All the MCO's that have approached us have wanted to start with Fee-for-Service which moves us backwards from our current VBP contracts
- Different target population

Q160. Realistically, how do you expect your participation in value-based purchasing (VBP) to change over the next 12 months? (48)



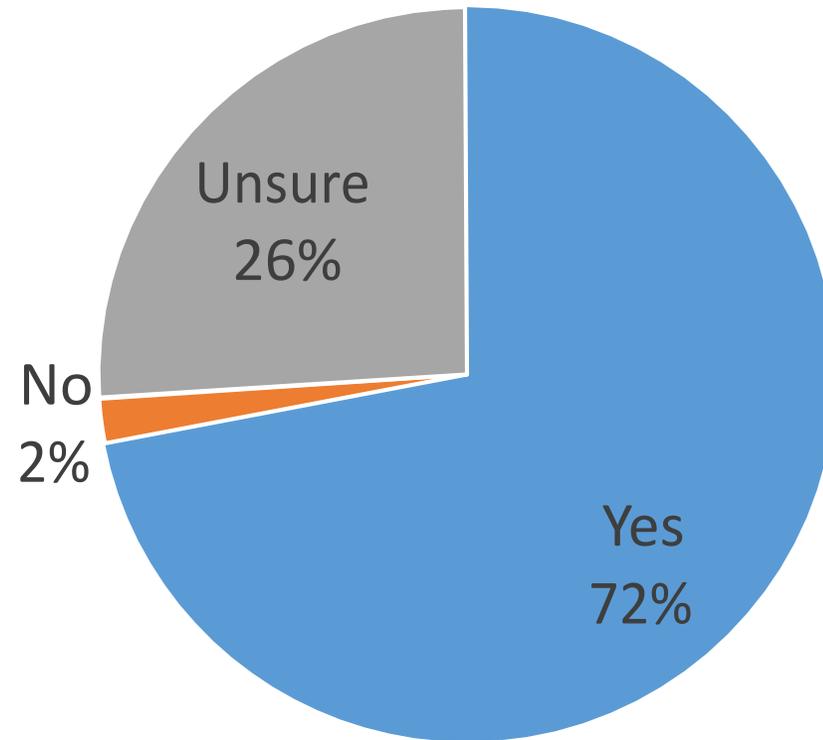
Q161. Is your organization currently reporting through a portal for grants, contracts, or initiatives? (50)



Q162. Is there a portal or platform that you like? (11)

- Avatar through the BHO's, iGrants through Office of Superintendent of Public Instruction for some grants
- It meets agency needs but could be updated (SAW)
- CSI
- CSI
- CSI
- For Parents As Teachers it's PENELOPE
- Smartsheets, SFTP, myFileGateway.
- we use grants.gov
- Interoperability with Netsmart
- QBS (WSHA)
- No, we would like a seamless reporting system that receives our data. We currently have several different portals to access and it's a waste of our resources.

Q163. Do you anticipate submitting a response to CPAA's Request for Proposals (RFP)?



Preliminary Survey Findings

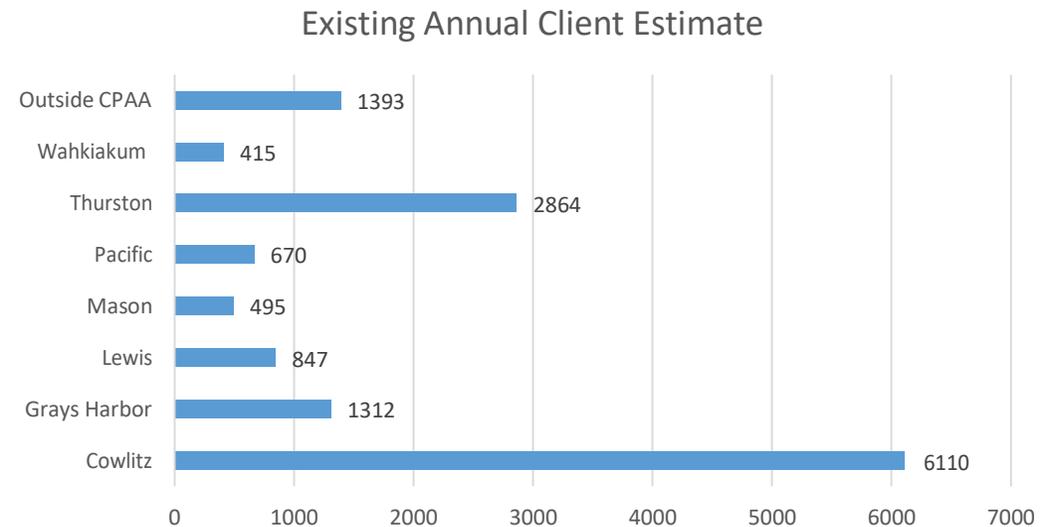
ENVIRONMENTAL SCAN OF CARE COORDINATION IN THE CPAA
REGION

Environmental Scan (1)

- 22 Agency responses
- 14 Clinical, 8 Community Based Organizations, 4 are Health Homes Providers
- 5 answered they had no care coordination services or did not complete the survey
- Only 5 are new to care coordination, providing services for less than 5 years
- Most agencies (10) have care coordination integrated into all other services
- Most common care coordination services:
 - Case management (17)
 - Outreach & Education (16)
 - Wrap-around case conferencing (13)
 - Patient advocacy (12)

Environmental Scan (2)

- Most (10) receive less than half of their care coordination clients from referrals
- 5 receive more than 75% of clients from another agency referral
- 40+ referral sources identified
- Over 14,500 clients annually



Environmental Scan (3)

- Nurses (13) and Social Workers (12) are the most commonly employed coordinators
- 11 employ coordinators with lower credentials than Nurse or Social Worker
- About 320 care coordinators
 - 9 Community Health Workers
 - 28 Peer Counselors
 - 146 Social Workers
 - 68 Nurses
 - 69 Other
- Almost all employees are full time
- Large variability in case loads, 15-200+ (average 65)
- All but one agency have less than 20 open slots

Environmental Scan (4)

- 10 have an integrated electronic client records system
- 6 use multiple electronic records
- 1 uses mostly physical chart notes
- All track care coordinator activities, client outputs, and client outcomes
- 11 have extensive reporting requirements

- 11 said “Yes” they are interested in becoming a CCA to implement Pathways
- 10 asked for additional information
- 0 said “No”

From: [Laura Spoor](#)
Subject: CPAA RFP Release
Date: Wednesday, May 30, 2018 2:10:38 PM

Dear Partners,

Cascade Pacific Action Alliance (CPAA) released a Request for Proposals (RFP) to determine Medicaid Transformation Project (MTP) implementation partners. You can access the RFP here: <https://fs28.formsite.com/MkccCHK/form1/index.html>. Please forward the RFP to organizations in the region that might be interested in participating in the MTP.

CPAA will select up to 45 partnering providers across the continuum of care, including social supports. **The RFP is open to any organization that provides direct services to the Medicaid population or to individuals below 310% of the federal poverty level within CPAA's 7-county region:** Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum. This includes, but is not limited to, both non-profit and for-profit organizations that provide clinical and behavioral health services, Public Health Departments, Educational Service Districts, and community-based organizations that assist with care coordination, housing, transportation, food, and recovery supports.

Independent assessors will score the responses to the RFP to identify the strongest possible project designs that will move MTP outcome metrics. The independent assessors' scoring is intended for CPAA internal use to help determine MTP implementation partners. **RFP responses and scores will not be made public.** Completing the RFP and selection as an implementation partner within the CPAA MTP partner network will trigger payment from CPAA. CPAA is making a four-year funding commitment to successful partnering providers, with payments dependent upon milestones and performance outcome goals.

You can view an offline version of the RFP here: http://cpaawa.org/rfp/RFP_WordVerison.docx. Please note that the RFP incorporates skip-logic, so you might not be required to answer every question. There is a supplemental reference guide, which includes important project area information. You may view the reference guide here: <http://www.cpaawa.org/wp-content/uploads/2018/05/RFP-Supplemental-Document.pdf>. The introduction to the RFP contains additional information and instructions and may be viewed here: http://cpaawa.org/rfp/CPAA_MTP_RFP_Instructions.pdf.

Please direct RFP questions to: rfp@cpaawa.org. Please reference the number in brackets at the end of each question when asking about a specific question in the RFP. CPAA will answer questions and post them to our website. Additionally, CPAA is hosting a **virtual town hall meeting on Friday, June 8, from 1:00-2:00 pm**, to answer RFP related questions. Join the webinar by clicking the link and following the instructions: <https://zoom.us/j/847516252>. Please send your questions prior to the event to help inform the discussion: rfp@cpaawa.org. You may also ask questions during the event.

-
The **RFP will close at 5:00 p.m. on Monday, July 16**, and partner selection will be finalized by mid-August.

Sincerely,

Winfried Danke

Winfried Danke

Chief Executive Officer

Cascade Pacific Action Alliance

CONFIDENTIALITY NOTICE: This e-mail (including any documents accompanying it) may contain confidential information belonging to the sender. The information is intended only for the use of individuals or entities named above. If you are not an intended recipient, you are prohibited from disclosing, copying, or distributing this information or taking any action in reliance on the contents. If you have received this email in error, please immediately notify me by telephone.



Dear Partners,

Cascade Pacific Action Alliance (CPAA) released a Request for Proposals (RFP) on Wednesday, May 30, to determine Medicaid Transformation Project (MTP) implementation partners. Independent assessors will score the responses to the RFP to identify the strongest possible project designs that will move MTP outcome metrics. For more information, please reference the MTP Toolkit: <https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf>. CPAA will select up to 45 partnering providers, being mindful of strategic considerations and broad representation of counties and different provider types.

RFP Eligibility

CPAA is looking for implementation partners across the continuum of care, including social supports. **The RFP is open to any organization that provides direct services to the Medicaid population or to individuals below 310% of the federal poverty level within CPAA's 7-county region:** Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum. This includes, but is not limited to, both non-profit and for-profit organizations that provide clinical and behavioral health services, Public Health Departments, Educational Service Districts, and community-based organizations that assist with care coordination, housing, transportation, food, and recovery supports.

Letter of Intent

CPAA is requesting a brief, one-page Letter of Intent from all partners interested in submitting a RFP response, **due by 5:00 p.m. on Thursday, June 14**. Please send your Letter of Intent to: rfp@cpaawa.org and include:

1. Your organization's name
2. Confirmation that you plan to submit a RFP response
3. Which project areas you plan to address

Partnering Providers

While we encourage applicants to list project partners in their application, we ask that each partner organization apply separately. **Funding awards will be made to individual organizations as defined by their EIN number**, not groups of organizations that come together for a specific project. This allows organizations that are working together to each earn their own funding and then decide how best to align and combine their MTP project resources in pursuit of project outcomes.

Completing the RFP and selection as an implementation partner within the CPAA MTP partner network will trigger payment from CPAA. CPAA is making a four-year funding commitment to successful partnering providers, with payments dependent upon milestones and performance outcome goals.

Medicaid Transformation Project

For the past year, CPAA has been preparing the region for implementation of the MTP. As part of that preparation, CPAA released a Request for Qualifications last year and a Current State Capacity Assessment earlier this spring, to which your organization may have responded. Building on the information gathered from both processes, and with the state having released more information about

the Implementation Plan that our region needs to complete by this fall, we are **requesting more detailed proposals** across six project areas: bi-directional care integration; care coordination; transitional care; opioid response; reproductive, maternal and child health; and chronic disease prevention and control. **MTP investments made in these project areas must improve the health care delivery system overall and foster new ways of working together to improve health in our region, benefitting everyone in our communities.** Equity considerations should be an underlying component of all transformation activities, and key deliverables/outcomes should reflect or be informed by health equity considerations. MTP implementation must be evidence-based, and funding will be milestones-driven, rewarding performance and patient and broader health outcomes.

Scoring the RFP

The independent assessors’ scoring is intended for CPAA internal use to help determine MTP implementation partners. **Responses to the RFP and RFP scores will not be made public.**

CPAA’s RFP is divided into four sections:

Section	Subject	Scoring Weight
Section 1	Applicant Information	Required for eligibility, not scored
Section 2	Individuals Served	Required for calculating bonus payments, not scored
Section 3	Projects & Interventions	
	Bi-Directional Care Integration	20 Points
	Care Coordination (Pathways)	20 Points
	Chronic Disease Prevention and Control	20 Points (+ 10 pt bonus for >1 intervention)
	Maternal and Child Health	20 Points (+ 10 pt bonus for >1 intervention)
	Opioid Use Public Health Crisis	20 Points (+ 10 pt bonus for >1 intervention)
	Transitional Care	20 Points (+ 10 pt bonus for >1 intervention)
Section 4	Readiness to Succeed	20 Points

At the start of Section 3, you will be asked to identify the projects in which you plan to engage. The RFP incorporates skip-logic, so your answers will dictate which sub-sections appear. **Please address multiple project areas in one application by checking the corresponding project boxes and explain how the proposed activities are mutually reinforcing.** Each project is worth up to 20 points. If you undertake more than one intervention for a given project, you are eligible to receive up to 10 bonus points with the exceptions of Bi-Directional Care Integration and the Care Coordination (Pathways) projects.

MTP Funding

A total of \$4.55 million in funding is available for CPAA MTP implementation partners through this RFP in 2018. Additionally, implementation partners selected through this RFP will benefit from \$3.28 million in

region-wide investments by CPAA this year in health information technology and health information exchange, workforce development, and value-based care transition supports. In addition to these first-year funds, CPAA anticipates releasing tens of millions of dollars to partnering providers selected through this RFP over the next three years. Exact funding amounts depend on our region's implementation success, i.e., on the degree to which our implementation partners are able to meet performance milestones and outcome goals.

Implementation partners selected through this RFP will have access to two main funding pools for first-year funds: base funding and bonus funding.

First-Year Base Funding: The total amount of base funding per implementation partner for 2018 will vary based on the number of awards made. CPAA has set aside \$1.58 million for first-year base funding. CPAA will select up to 45 implementation partners. Total first-year base funding per implementation partner will depend on the number of partners selected. First-year base funding is based on MTP participation, not on number or type of interventions selected by the implementation partner.

First-Year Bonus Pools: Implementation partners can qualify for up to three bonus funding pools: equity, rural, and Medicaid lives served. Depending on the number/percentage of Medicaid beneficiaries served and/or the degree to which the implementation partner serves individuals who experience health disparities and/or live in rural areas, partners can access a total of \$1.23 million. Awards per implementation partner depend on the number of partners who qualify for the three bonus pools. The fewer partners qualify, the greater the funding amounts per eligible partner.

Additionally, implementation partners will have access to the following funding pools:

Multi-Project Incentive: Implementation partners who commit to working in four or more project areas will be eligible to receive payment from CPAA's \$520,000 first-year multi-project incentive pool. Awards per eligible implementation partner will depend on the number of partners who qualify. Please note that in subsequent years, implementation partners will receive payment based on the number of project areas in which they participate and the degree of implementation success. Partners who commit to working in multiple project areas will qualify for more funding.

Capacity Development Fund: In addition to the above funding pools, CPAA is setting aside \$335,179 for partners who respond to the RFP but are not selected as implementation partners. As with implementation partners who are selected through the RFP, access to this funding pool is based on how well an organization scores through the RFP process, as well as strategic considerations. CPAA intends to use these funds to support promising projects and keep partners engaged who might join CPAA's network of implementation partners in the future.

Implementation Plan Performance Payment: CPAA is setting aside \$940,715 for successful submission of the region's implementation plan. This funding will be distributed to implementation partners who are selected through the RFP process and participate in the region's implementation plan development.

RFP Application Form Instructions

When using the RFP application form, your answers will be saved when you advance to the next page. You can save your form and return to it later; however, to do so, you must first create an account by following the link on the first page. **CPAA strongly encourages all applicants to create an account.**

Please note: If you close your browser before saving or before moving to another page, your input will be lost. If you choose to not create an account, you cannot return to your answers later.

To directly log into your own form, use this link:

https://fs28.formsite.com/MkccHK/form1/form_login.html

If you prefer to prepare your answers offline and enter them when you are ready to submit, you can view an offline Word version of the RFP here: http://cpaawa.org/rfp/RFP_WordVerison.docx. Please note that the RFP incorporates skip-logic, so you might not be required to answer every question.

Additionally, there is a supplemental reference guide you may view here: <http://www.cpaawa.org/wp-content/uploads/2018/05/RFP-Supplemental-Document.pdf>.

The RFP includes pop-up text for individual questions that offers more detailed instructions. Hover over the question mark to access that question-specific information.

The narrative portions of the RFP have 1,500 word count limits. Please answer thoroughly, but CPAA and the independent assessors appreciate and encourage brevity.

RFP Questions

CPAA's RFP was sent to partners who have worked with us, is posted on our website:

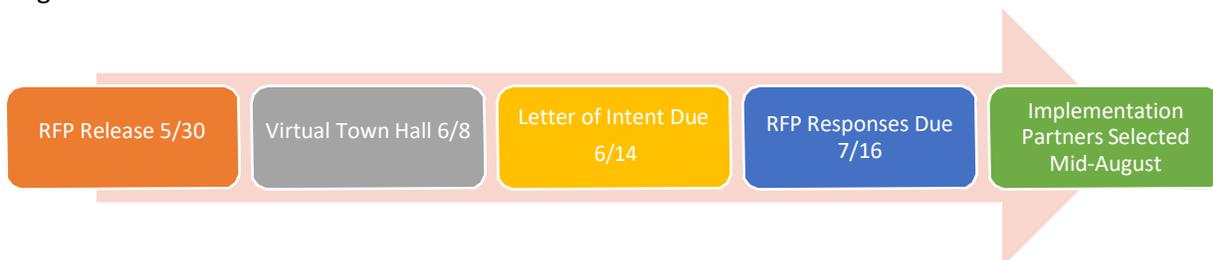
<https://www.cpaawa.org>, and has been promoted through social and traditional media. Please forward the RFP to organizations in the region that might be interested in participating in the MTP.

Please direct RFP questions to: rfp@cpaawa.org. Please reference the number in brackets at the end of each question when asking about a specific question in the RFP; this will help us identify your query. CPAA will answer questions and post them to our website.

Additionally, CPAA is hosting a **virtual town hall meeting** on **Friday, June 8, from 1:00-2:00 pm**, to answer RFP related questions. Join the webinar by clicking the link and following the instructions: <https://zoom.us/j/847516252>. Please send your questions prior to the event to help inform the discussion: rfp@cpaawa.org. You may also ask questions during the event.

RFP Timeline

The **RFP will close at 5:00 p.m. on Monday, July 16**, and partner selection will be finalized by mid-August.



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

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE.	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings.
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole-person care and value-based payment.	Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs	ACHs would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state’s ongoing role in the Practice Transformation Support Hub, the P-TCPI Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the Value-based Payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program.
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives.	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.
In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers, and allowing for reimbursement on additional codes	Support from the state on VBP, specifically understanding how we can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other technical assistance from the state.	ACHs wants to ensure that information held in these data repositories (<i>All-Payers Claims Database and Clinical Data Repository</i>) is accurate, accessible, timely, and useful to our transformation work and to our partners.
Systems for Population Health Management support for: <ul style="list-style-type: none"> •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries 	Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists).	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid.
Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing, and licensed social workers	Training and TA for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, trauma-informed practices, and cultural sensitivity.	Establishing a career path for rural nursing and workforce needs, from high school, through 4-year programs.
Support for Dental Health Aide Therapists and other dental professions that expand scope of practice to improve dental access	Increased capacity for practice transformation support directly to participating providers-i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training, and	Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.

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

	collaborative tools needed to work across ACH regions.	
	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models, how it will impact them, and what steps they should take to be prepared.	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care.
	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.



VIRTUAL TOWN HALL TO ANSWER RFP QUESTIONS

JUNE 8, 2018

Welcome and Introductions



WELCOME

Procedure for Asking Questions

- ✓ If you already emailed your question to rfp@cpaawa.org, thank you!
- ✓ If you are joining us and have a question, please:
 - Utilize the Zoom chat box feature and type your question.
- ✓ If we are not able to answer your questions today, we will respond promptly at cpaawa.org.



How to Access Answers to RFP Questions



Who We Are ▾

How We Work ▾

What We Do ▾

Resources ▾

Consumers ▾

Calendar

Feedback



- Calendar
- CPAA Documents
- Opportunities
- CPAA News**
- Articles & Updates
- Frequently Asked ACH Questions

WELCOME

CPAA is improving community health and safety while advancing the *Triple Aim*:

improving health equity, promoting whole person care, and reducing per-capita health care costs while improving the quality of care.

How to Access Answers to RFP Questions



Who We Are ▾ How We Work ▾ What We Do ▾ Resources ▾ Consumers ▾

Calendar

Feedback



CPAA News



May 30, 2018

ANSWERS TO RFP FREQUENTLY ASKED QUESTIONS

Q: Who is eligible to submit a RFP? The RFP is open to any

MEDICAID TRANSFORMATION



May 30, 2018

CPAA'S REQUEST FOR PROPOSALS

Dear Partners, Cascade Pacific Action Alliance (CPAA) released a Request for

MEDICAID TRANSFORMATION



May 21, 2018

REQUEST FOR PROPOSALS RELEASED WEDNESDAY, MAY 30

Dear Partners, Cascade

QUICK LINKS

[Home](#)

[Calendar](#)

[Contact Us](#)

[Opportunities](#)

[Frequently Asked ACH Questions](#)

SUBSCRIBE FOR NEWS UPDATES

Email Address

How to Access Answers to RFP Questions



Who We Are ▾ How We Work ▾ What We Do ▾ Resources ▾ Consumers ▾

Calendar

Feedback



Answers to RFP Frequently Asked Questions

By Carol Palay | May 30, 2018 | Medicaid Transformation

No Comments

0

Q: Who is eligible to submit a RFP?

The RFP is open to any organization that provides direct services to the Medicaid population or to individuals below 310% of the federal poverty level within CPAA's 7-county region: Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum. This includes, but is not limited to, both non-profit and for-profit organizations that provide clinical and behavioral health services, Public Health Departments, Educational Service Districts, and community-based organizations that assist with care coordination, housing, transportation, food, and recovery supports.

Q: I am working with partners on a MTP project. Do we each have to submit a RFP?

We ask that each partner organization apply separately. Funding awards will be made to individual organizations as defined by their EIN number, not groups of organizations that come together for a specific project. Please do list your MTP project partners in your response to the RFP.

Q: In reading through the RFP, it is not clear what the ask should be. Should we be asking for an FTE for each project? Can we ask for moneys for other uses?

It is entirely up to the applicant to determine what is needed in order to make the project/s work. CPAA will provide money to chosen implementation partners based on the needs that are articulated by our partners and available funding as determined by the available base

TOPICS

[Accountable Communities of Health](#)

[Behavioral Health](#)

[Care Coordination](#)

[Careers](#)

[Education & Prevention](#)

[Events](#)

[Medicaid Transformation](#)

[Opportunities](#)

How to Access the RFP

The screenshot shows the Cascade Pacific Action Alliance website. The logo is on the left, and the navigation menu includes 'Who We Are', 'How We Work', 'What We Do', 'Resources', and 'Consumers'. There are also buttons for 'Calendar' and 'Feedback'. A yellow arrow points from the 'Resources' menu item down to the 'CPAA News' section. In the news section, there are three articles. The first article is 'ANSWERS TO FREQUENTLY ASKED QUESTIONS' dated May 30, 2018. The second article is 'CPAA'S REQUEST FOR PROPOSALS' dated May 30, 2018, with a yellow arrow pointing to it. The third article is 'REQUEST FOR PROPOSALS RELEASED WEDNESDAY, MAY 30' dated May 21, 2018. On the right side, there is a 'QUICK LINKS' section with links to Home, Calendar, Contact Us, Opportunities, and Frequently Asked ACH Questions. Below that is a 'SUBSCRIBE FOR NEWS UPDATES' section with an 'Email Address' input field.

CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

Who We Are ▾ How We Work ▾ What We Do ▾ **Resources ▾** Consumers ▾

Calendar Feedback

↓

CPAA News

Q&A

May 30, 2018
ANSWERS TO FREQUENTLY ASKED QUESTIONS

Q: Who is eligible to submit a RFP? The RFP is open to any

MEDICAID TRANSFORMATION

RFP

May 30, 2018
CPAA'S REQUEST FOR PROPOSALS

Dear Partners, Cascade Pacific Action Alliance (CPAA) released a Request for

MEDICAID TRANSFORMATION

RFP

May 21, 2018
REQUEST FOR PROPOSALS RELEASED WEDNESDAY, MAY 30

Dear Partners, Cascade

QUICK LINKS

[Home](#)

[Calendar](#)

[Contact Us](#)

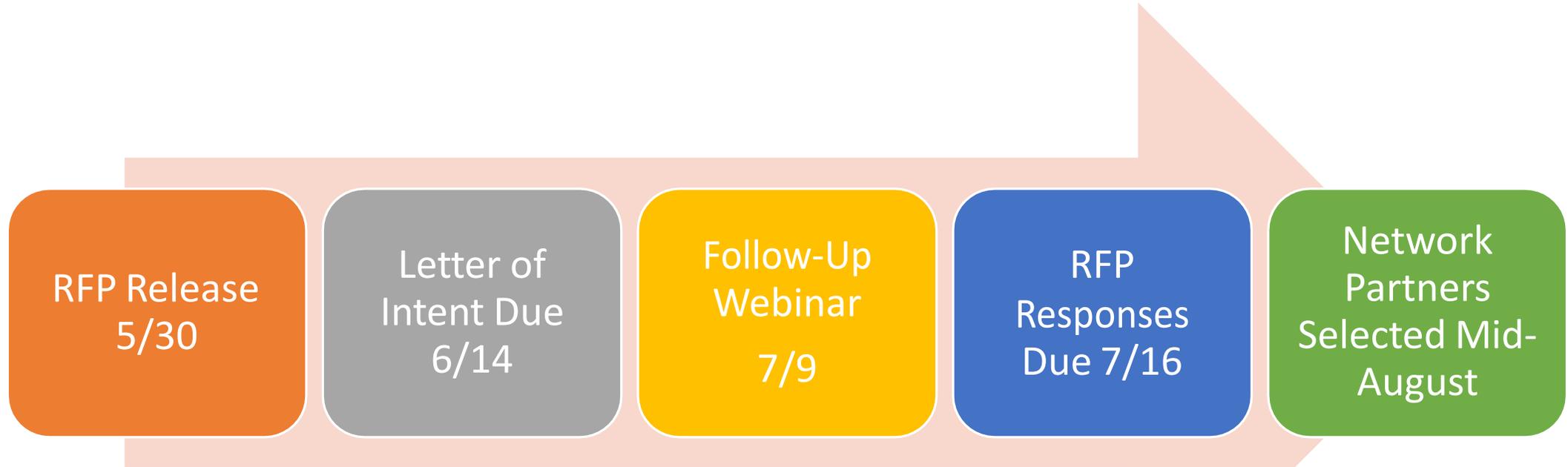
[Opportunities](#)

[Frequently Asked ACH Questions](#)

SUBSCRIBE FOR NEWS UPDATES

Email Address

RFP Timeline



What CPAA is Looking for in Medicaid Transformation Project RFP Responses

- Drive health system transformation; move outcome metrics
- Sustainability of the project
- Improve health equity/reduce health disparities
- Address social determinants of health to the greatest extent possible
- Investment in rural and urban areas
- Investment in all seven counties
- Truly transformative efforts, not marginal improvements
- Supplement, not substitute existing funding

RFP Scoring

Section	Subject	Scoring Weight
Section 1	Applicant Information	Required for eligibility, not scored
Section 2	Individuals Served	Required for calculating bonus payments, not scored
Section 3	Projects & Interventions	
	Bi-Directional Care Integration	20 Points
	Care Coordination (Pathways)	20 Points
	Chronic Disease Prevention and Control	20 Points (+ 10 pt bonus for >1 intervention)
	Maternal and Child Health	20 Points (+ 10 pt bonus for >1 intervention)
	Opioid Use Public Health Crisis	20 Points (+ 10 pt bonus for >1 intervention)
	Transitional Care	20 Points (+ 10 pt bonus for >1 intervention)
Section 4	Readiness to Succeed	20 Points



Implementation Partner Selection

ROUND ONE

The highest-scoring organizations within each major category

- Clinical Providers / Hospitals
- Community-Based Organizations
- Pathways partners

ROUND TWO

The remaining slots will be assigned based on strategic considerations

- Importance to project success
- Strength of partnering
- Strength of current or proposed investment in projects
- County representation

Brief Overview of Medicaid Transformation Project Funding

First-Year Base Funding (\$1.58 million): The total amount of base funding per implementation partner for 2018 will vary based on the number of awards made.

First-Year Bonus Pools (\$1.23 million): Implementation partners can qualify for up to three bonus funding pools: equity, rural, and Medicaid lives served.

Multi-Project Incentive (\$520,000): Implementation partners who commit to working in four or more project areas will be eligible to receive payment from CPAA's first-year multi-project incentive pool.

Capacity Development Fund (\$335,179): In addition to the above funding pools, partners who respond to the RFP, but are not selected as implementation partners, may qualify for this funding.

Implementation Plan Performance Payment (\$940,715): Implementation partners selected through the RFP qualify for this funding after submission of the region's implementation plan.



Bonus Pool Funding

1. Attribution

- **Clinical** - Number and percentage of Medicaid beneficiaries served
- **Non-Clinical** - Number and percentage of individuals who are at or below 310% of the federal poverty level

2. Rural and Equity

- Zip codes of residence for the individuals served and the number of individuals served in each zip code
- **Rural** designation based on National Center for Education Statistics
- **Equity** designation based on the Community Needs Inventory

Questions & Answers



Answers to RFP Questions

Q: Are MTP funds taxable?

A: It depends on your organization type. ACHs and Public Hospitals are exempt from B&O taxes. If you are not an ACH or Public Hospital, unfortunately, you are required to pay taxes on MTP funding.

Q: If I'm chosen as an implementation partner, what can I use MTP funds for?

A: It is entirely up to the applicant to determine what is needed in order to make their project/s work.

Answers to RFP Questions

Q: Who is eligible to submit a response to CPAA's RFP?

A: The RFP is open to any organization that provides direct services to the Medicaid population or to individuals below 310% of the federal poverty level within CPAA's 7-county region: Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum.

Q: I'm working with partners on a MTP project. Do we each need to submit a response?

A: We ask that each partner organization submit a response to the RFP separately. Funding awards will be made to individual organizations as defined by their EIN number, not groups of organizations that come together for a specific project.

Q: My organization is doing multiple projects. Do we submit more than one response?

A: One response to the RFP and one LOI per organization.



Answers to RFP Questions

Q: If an organization has a proposal specific to Domain 1 investments, such as providing training and workforce development essential for MTP success (Certified Peer Counselor or Community Health Worker training, for example), but does not provide direct services, are they still eligible?

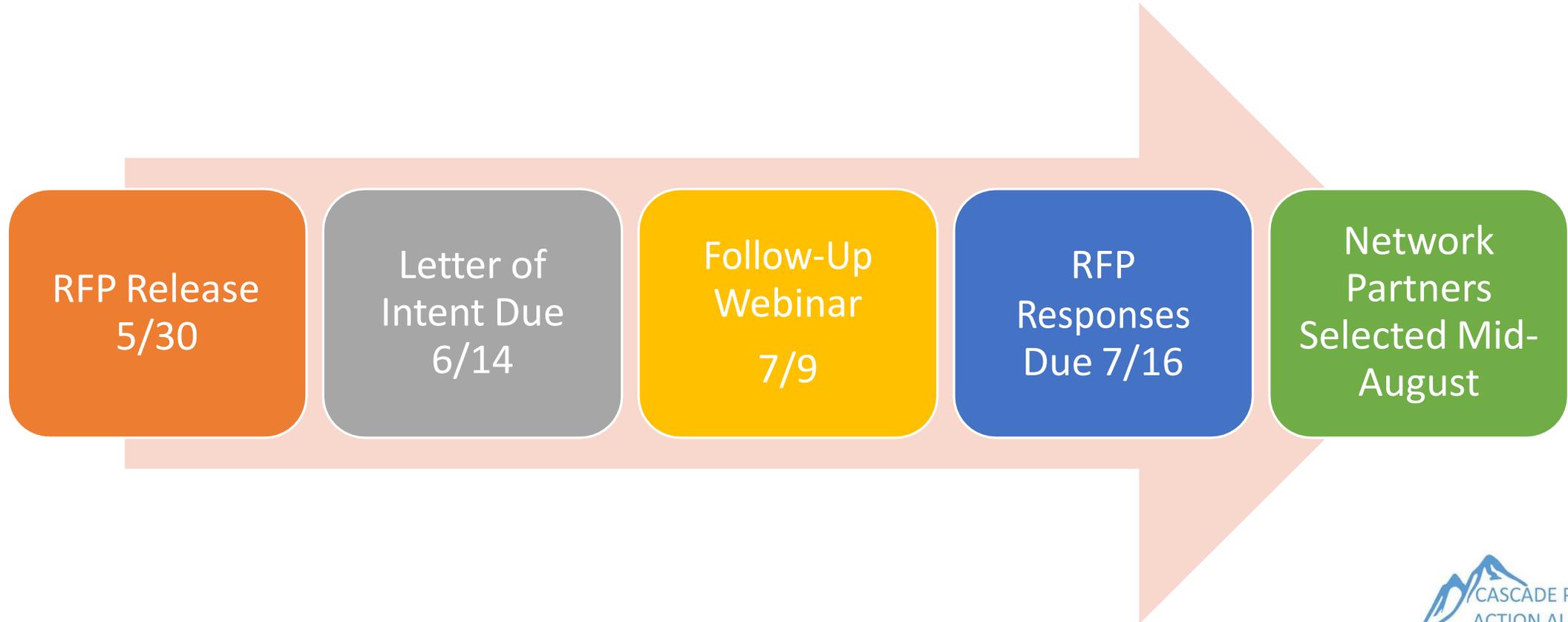
A: The RFP targets providers providing direct services. If you feel you can meaningfully contribute to the region's workforce development, HIT/HIE improvements, and/or value-based purchasing, you may send us a Letter of Interest outlining your qualifications and intended contribution to the region's MTP project areas.

Answers to RFP Questions

Q: Is there an opportunity for RFP early review or a preliminary review, just to make sure I'm on the right track?

A: Unfortunately, CPAA does not have the capacity to conduct preliminary reviews on all RFPs. CPAA is happy to answer specific questions that are submitted to rfp@cpaawa.org. In the interest of fairness and transparency, all questions will be anonymized, and the answers posted here: <http://www.cpaawa.org/2018/05/30/answers-to-rfp-frequently-asked-questions/>. An independent assessor will review and score all responses to the RFPs.

Next Steps



Questions?

- Send RFP questions to rfp@cpaawa.org
- Visit cpaawa.org for answers to your questions
- Letter of Interest is due by COB Thursday, June 14
- RFP due by COB Monday, July 16
- Follow-Up Town Hall Meeting:

Monday, July 9, 3-4pm



CPAA LOI RFP Submissions

	Organization	Location	2A	2B	2C	3A	3B	3D
1	Assured Independence	Thurston	X	X	X			X
2	Consejo Counseling	Mason		X	X	X		X
3	CORE Health	Lewis, Cowlitz	X	X	X			
4	Noble Foundation	Cowlitz		X				
5	Peninsula Community HS	Mason	X	X	X	X	X	X
6	Planned Parenthood	Thurston	X	X		X	X	
7	Willapa BH (1)	Pacific	X	X				
8	Willapa BH (2)	Pacific		X	X	X		X
9	Child Care Action Council	Mason					X	
10	PeaceHealth	Cowlitz	X	X	X	X	X	X
11	Summit Pacific	GH	X	X	X	X	X	X
12	AAADSW	Cowlitz, Wahkiakum		X	X			X
13	ESD 113	Thurston	X	X			X	X
14	Department of Corrections	Thurston		X	X	X		X
15	SeaMar CAC	Cowlitz, Grays Harbor, Thurston	X	X	X	X	X	X
16	Youth & Family LINK	Cowlitz					X	
17	Crisis Clinic	Thurston, Mason		X	X	X		X
18	Pacific County Health and Human Services Depart	Pacific				X		
19	Morton General Hospital	Lewis	X					
20	Lewis County Sheriff's Office	Lewis		X	X	X		X
21	Great Rivers Behavioral Health	Cowlitz, Grays Harbor, Lewis, Pacific	X	X				
22	Pioneer Family Practice	Thurston		X	X	X		X
23	Lacey Fire Department	Thurston	X		X			X
24	Wahkiakum County Health and Human Services	Wahkiakum		X	X	X		X
25	Lifeline Connections	Grays Harbor, Lewis, Pacific				X		
26	South Sound Pediatrics PLLC (DBA Pediatric Asso	Thurston	X	X	X	X	X	X
27	Olympia Pediatrics	Thurston	X	X			X	
28	Valley View Health Center	Lewis	X		X	X	X	X
29	Child and Adolescent Clinic	Cowlitz	X	X	X	X	X	
30	Capital Recovery Center	Thurston		X	X	X		X
31	Cowlitz Family Health Center	Cowlitz	X		X	X	X	X
32	Behavioral Health Resources	Thurston	X		X	X	X	
33	Thurston County Sheriff's Office	Thurston		X	X	X		X

34	Gather Church	Lewis		X	X	X		
35	HeartStrides Therapeutic Riding & Horsemanship	Thurston	X	X		X		
36	Grays Harbor County Sheriff's Department	Grays Harbor		X	X	X		X
37	Evergreen Treatment Services	Thurston, Grays Harbor		X	X	X		X
38	Cowlitz County Corrections Department	Cowlitz		X	X	X		X
39	Catholic Community	Lewis, Mason, Thurston	X			X		
40	Kaiser Permanente Health Plan of NW	Cowlitz	X			X		X
41	Ramona Leber	Training, Consulting						
42	North Mason Regional Fire Authority	Mason		X		X		X
43	TOGETHER	Thurston		X		X	X	
44	WSU, Vancouver	Peer Counselor Training						
45	Family Education and Support Services FESS	Thurston	X	X		X	X	X
46	Mason General Hospital and Family Clinics	Mason	X	X	X	X	X	X
47	Northwest Pediatric Center	Lewis	X				X	
48	Thurston County Public Health Dept	Thurston		X		X	X	X
49	PacMtn Workforce Development	Work force						
50	Columbia Wellness	Cowlitz	X	X	X	X	X	X
51	Physicians of SW Wa (PSW)	Thurston		X	X			
52	YWCA	Thurston					X	
53	Lewic Public Health Department	Lewis		X	X			X
54	Lewis County Community Health Partnership	Lewis		X	X			X
55	Lower Columbia CAP	Cowlitz		X	X	X	X	X
56	Community Youth Services CYS	Thurston	X	X	X	X		
57	Wahkiakum Heath and Human Services	Wahkiakum			X		X	X
58	Northwest Resources II	Thurston, Lewis		X	X	X		X
59	Montesana Internal Medicine	GH		X	X	X		X
60	Ocean Beach Hospital and Clinics	Pacific						X
61	Grays Harbor Community Hosital	GH			X	X	X	X
62	Sidewalk	Thurston				X		
63	NAMI Southeast Washington	Cowlitz, Wahkiakum	X	X				
64	Wahkiakum School District	Wahkiakum					X	
65	Eelochoman Valley Partners, LLC	Wahkiakum			X		X	
		Total	26	42	36	38	23	35

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration</p> <p>delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways)</p> <p>brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care</p> <p>coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response</p> <p>applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health</p> <p>supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control</p> <p>supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Bi-Directional Care Integration

Project Purpose

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.

CPAA's Evidence-Based Approaches

The Medicaid Transformation is built on implementing evidence-based approaches in each project area. CPAA is focused on working with partners to create or further develop integrated care programs, both in primary care and behavioral health settings. With partners at different readiness levels, we are stressing the importance of flexibility in planning when implementing collaborative care principles.

Implement Core Principles of Collaborative Care				
Patient-centered team care	Population-based care	Measurement-based treatment to target	Evidence-based care	Accountable care

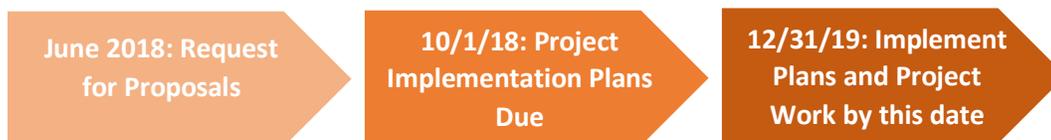
Visit these links to learn more about evidence-based approaches for this project:

Collaborative Care Model: <https://aims.uw.edu/collaborative-care>

Bree Collaborative BHI Recommendations: <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>

Milbank Report (Integrating Primary Care into Behavioral Health Setting): <https://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf>

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration</p> <p>delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways)</p> <p>brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care</p> <p>coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response</p> <p>applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health</p> <p>supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control</p> <p>supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Care Coordination

Project Purpose

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. This project area focuses on working with care coordinators to identify high-risk individuals, complete a comprehensive health assessment, identify risk factors, and determine what standardized “pathways” a care coordinator should employ with that individual. The Pathways model emphasizes empowered patients who set their own goals with the support of their care coordinator.

CPAA’s Evidence-Based Approaches

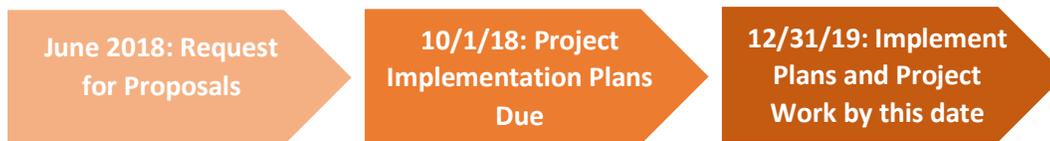
The Medicaid Transformation is built on implementing evidence-based approaches in each project area. A “pathway” is a standardized process that represents one issue with a measurable outcome that is tracked through to completion. **The Pathways HUB model is a community-wide, evidence-based approach that ensures those patients at greatest risk are identified, and that individual’s medical, behavioral health, and social risk factors are addressed.**

Implement Core Principles of Care Coordination				
Collaboration across organizations	Standardized care coordination services	Equitable distribution of patients	Centralized data mapping patterns of need	One care coordinator per patient

Visit this link to learn more about the evidence-based approach for this project:

PathwaysHUB: <https://pchcp.rockvilleinstitute.org/hub-model/>

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

For more information or to get involved, contact Michael O’Neill, Care Coordination Program Manager, at oneillm@crhn.org or visit www.cpaawa.org

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration</p> <p>delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways)</p> <p>brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care</p> <p>coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response</p> <p>applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health</p> <p>supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control</p> <p>supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Transitional Care

Project Purpose

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 to reduce avoidable hospital utilization**. 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.

CPAA's Evidence-Based Approaches

CPAA aims to transform transitional care practices through the implementation and expansion of evidence-based approaches, such as the Transitional Care Model. Through the Medicaid Transformation's integrated health system improvement and whole-person approach to care, providers have a unique opportunity to focus on mitigating health complications and avoidable hospital readmissions.

Implement Core Principles of Transitional Care				
Increase access to care	Population-based care	Decrease hospital readmissions	Evidence-based, accountable care	Whole-person care

Visit these links to learn more about evidence-based approaches for this project:

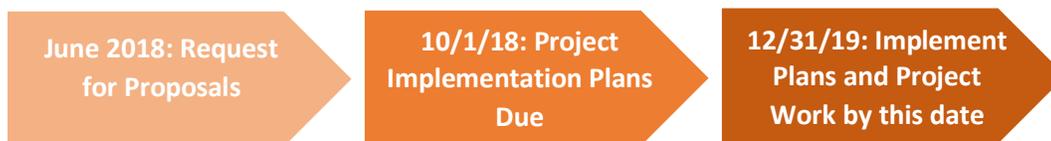
Transitional Care Model: www.nursing.upenn.edu/ncth/transitional-care-model/

Care Transitions Interventions: <http://caretransitions.org/>

Bridge Model: <https://transitionalcare.org/the-bridge-model/>

Community Paramedicine Model: www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

For more information or to get involved, contact Alexandra Toney, Transitional Care Program Manager, at toneya@crhn.org or visit www.cpaawa.org

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration</p> <p>delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways)</p> <p>brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care</p> <p>coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response</p> <p>applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health</p> <p>supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control</p> <p>supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Opioid Response

Project Purpose

The Opioid Response Project leverages the Medicaid Transformation to address the opioid epidemic in our region and reduce 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).**

CPAA's Evidence-Based Approaches

The Medicaid Transformation is built on implementing evidence-based approaches in each project area. **CPAA is working with partners to increase access to evidence-based therapies delivered in a cohesive system by providers who understand the role of trauma in substance use disorder.** With partners at different readiness levels, we are stressing the importance of flexibility in planning when implementing harm reduction principles.

Implement Core Principles of Harm Reduction				
Result-based and cost effective	Safety for drug users and the community	Non-judgemental	Meeting people where they're at	Involvement of people who use drugs

Visit these links to learn more about evidence-based approaches for this project:

Harm Reduction: <https://www.dualdiagnosis.org/harm-reduction-guide/>

Medication Assisted Treatment (MAT):

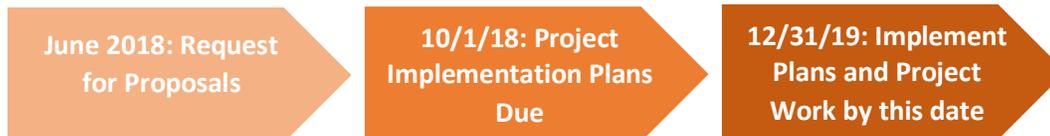
<https://www.hri.global/files/2010/05/31/HIVTop50Documents11.pdf>

Recovery Support Services: https://facesandvoicesofrecovery.org/file_download/68610d77-430f-4711-8032-f526f4c6cf94

Trauma-Informed Care:

http://m.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

For more information or to get involved, contact Malika Lamont, Opioid Response Program Manager, at lamontm@crhn.org or visit www.cpaawa.org

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration</p> <p>delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways)</p> <p>brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care</p> <p>coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response</p> <p>applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health</p> <p>supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control</p> <p>supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Reproductive, Maternal & Child Health

Project Purpose

Healthy families are the center of a healthy community. CPAA intends to support families by helping young men and women, mothers, and children access health services, mitigate the impact of adverse childhood experiences (ACEs), and build resilience in our region.

CPAA's Evidence-Based Approaches

The Medicaid Transformation is built on implementing evidence-based approaches in each project area. CPAA is focused on working with partners to increase trauma-informed care training and increase access to reproductive, maternal & child health programs, including health screenings, long acting reversible contraception, well-child visits and immunizations, prenatal care, and home visits. With partners at different readiness levels, we are stressing the importance of flexibility in planning and implementation.

Implement Principles of Trauma-Informed Care				
Ensuring physical and emotional safety	Building trust	Prioritizing patient choice and control	Maximizing collaboration	Skill-building and empowerment

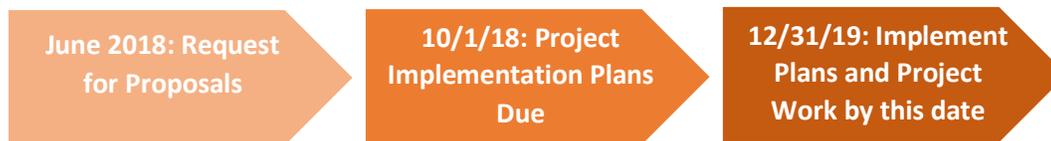
Visit these links to learn more about evidence-based approaches for this project:

One Key Question: <https://powertodecide.org/one-key-question>

Trauma-Informed Care: <http://traumainformedcareproject.org/>

Long Acting Reversible Contraceptive (LARC): www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways) brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Chronic Disease Prevention and Control

Project Purpose

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.

CPAA's Evidence-Based Approaches

CPAA aims to transform chronic disease prevention and control through the implementation and expansion of evidence-based approaches, such as the Chronic Care Model, to address chronic diseases like asthma, heart disease, and diabetes. Through the Medicaid Transformation's integrated health system improvement and whole-person approach to care, providers have a unique opportunity to reduce risk factors to prevent chronic disease, increase access to preventative health services, support patient self-management, and reduce costly, preventable complications.

Implement Core Principles of Chronic Care				
Improved patient self-management skills	Provide decision support	Population-based care	Informed, activated patients	Proactive health care team

Visit these links to learn more about evidence-based approaches for this project:

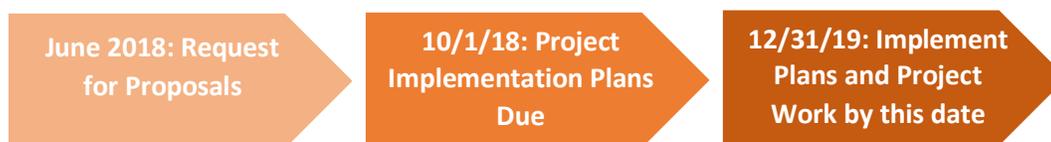
Chronic Care Model: www.improvingchroniccare.org

National Diabetes Prevention Program: www.cdc.gov/diabetes/prevention/index.html

Chronic Disease Self-Management Program:

www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management/

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

CPAA Medicaid Transformation Project Overview

CPAA's Purpose

Cascade Pacific Action Alliance (CPAA) is an original pilot Accountable Community of Health (ACH) in Washington.

ACHs are local partners with the state's Healthier Washington Initiative. ACHs aim to transform the health system statewide: **better health, better care, and lower costs**. ACHs are guided by the principle that **health is more than health care: it's the total well-being of individuals, families, and communities**.

CPAA brings together clinical care, community and social services, educational service districts, public health efforts, community members, experts, and organizations to address local health challenges and implement regionally appropriate strategies to achieve **improved health and safety for all residents**.



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

Medicaid Transformation Project Areas

<p>Bi-Directional Care Integration delivers whole-person care, addressing physical and behavioral health in an integrated system.</p>	<p>Care Coordination (Pathways) brings standardization and organization to care coordination services for individuals with complex needs.</p>	<p>Transitional Care coordinates services when a patient moves from one health care setting to another, improving patient safety and satisfaction.</p>
<p>Opioid Response applies practical, evidence-based approaches to both prevention and treatment services to address the opioid epidemic.</p>	<p>Reproductive, Maternal & Child Health supports healthy families by increasing access to health services and mitigating the impact of adverse childhood experiences (ACEs).</p>	<p>Chronic Disease Prevention and Control supports early detection and patient self-management to help reduce the impact of chronic disease.</p>

Background

The Medicaid Transformation is a 5-year agreement between Washington State and the Centers for Medicare and Medicaid Services (CMS). **It will provide up to \$1.5 billion to ACHs for regional projects and health improvement investments**. Investments made in these project areas will improve the delivery system overall and transform the way health care is provided in our region, **benefitting everyone in our communities**.

Our Region

Cowlitz, Grays Harbor, Lewis, Mason, Thurston, Pacific, and Wahkiakum counties.



Value-Based Care

CPAA aims to transform health care into a sustainable, value-based system. Value-based care is an **outcomes-focused approach that incentivizes high quality, whole-person care and reduces overall health care costs** by linking payments to patient health outcomes, rather than the current fee-for-service model.

Bi-Directional Care Integration

Project Purpose

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.

CPAA's Evidence-Based Approaches

The Medicaid Transformation is built on implementing evidence-based approaches in each project area. CPAA is focused on working with partners to create or further develop integrated care programs, both in primary care and behavioral health settings. With partners at different readiness levels, we are stressing the importance of flexibility in planning when implementing collaborative care principles.

Implement Core Principles of Collaborative Care				
Patient-centered team care	Population-based care	Measurement-based treatment to target	Evidence-based care	Accountable care

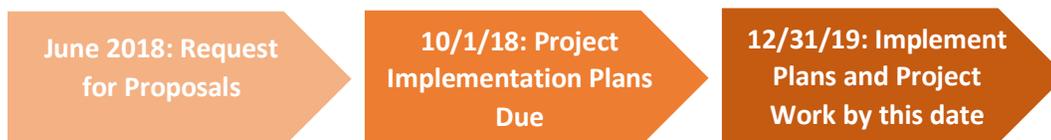
Visit these links to learn more about evidence-based approaches for this project:

Collaborative Care Model: <https://aims.uw.edu/collaborative-care>

Bree Collaborative BHI Recommendations: <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>

Milbank Report (Integrating Primary Care into Behavioral Health Setting): <https://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf>

Key Dates for CPAA and Partnering Organizations



How Does the Transformation Benefit Partnering Providers?

- Earn money by implementing evidence-based approaches
- Improve patient outcomes and satisfaction
- Access to technical assistance and workforce training
- Assistance moving towards value-based payment
- Connect with other partners and build relationships
- Add your voice to the conversation

How Does CPAA Operate?

A 19-member **Board of Directors** receives input from:

- **CPAA Council**
- Project **Work Groups**
- **Support Team** to ensure projects and strategies align
- **Finance Committee** to ensure transparency and ongoing stewardship
- **Consumer Advisory Committee** with community members and Medicaid beneficiaries to apply a health equity lens and balance clinical considerations
- **Clinical Provider Committee** with different provider types to ensure clinical oversight and assess project feasibility

Support Organization

CHOICE Regional Health Network is a nonprofit collaborative founded in 1995 with the mission to improve community health in Central Western Washington through collective planning and action of health care leaders. CHOICE serves as the administrative support organization for CPAA and provides logistical, administrative, and financial management services. For more information, visit crhn.org.

CHOICE
Regional Health Network

Medicaid Transformation Project Pathways HUB

Purpose of the Pathways HUB

The HUB is an evidence-based model to improving care coordination by working with care coordinators to identify high-risk individuals, complete a comprehensive health assessment, identify risk factors, and determine what standardized “pathways” a care coordinator should employ with the individual. By implementing this model and forming a HUB of providers, referral sources, and payers, the region can jointly prioritize the needs of specific populations.

Social Determinants of Health

The Pathways HUB model specifically assesses all aspects that contribute to wellness and provides standardized Pathways that help people access and obtain the help they need. Examples include education, employment, and housing. The Pathways model emphasizes that clients should set their own goals with the support of care coordinators.

Successful Care Coordination					
Collaboration across organizations	Standardized care coordination services	Equitable distribution of patients	Standardized & centralized data mapping patterns of need	One care coordinator per patient	Outcome based payment for services

Transformation Timeline and Milestones





Medicaid Transformation Project Opioid Response Project

Purpose

The Opioid Response Project is an opportunity to address the opioid crisis in our region by using practical, evidence-based approaches to prevent initiation of use by changing the way opioids are prescribed by doctors in the region, change the way providers engage with drug users with trainings and education, create protective factors for youth and families, prevent overdose deaths by expanding access to naloxone, increase access to medically assisted treatment (MAT), and increase recovery supports.

What is Harm Reduction?

Harm reduction is a public health policy designed to address the harmful consequences of drug use along with the drug use itself. Harm reduction is pragmatic, evidence-based, and cost-effective. It is a human rights focused model of care that calls for non-judgmental, non-coercive, dignity-based services that seeks to empower drug users. The goals of harm reduction include improving quality of life and public safety.

What is Medication Assisted Treatment (MAT)?

MAT combines behavioral therapy and medications to provide a “whole-patient” approach to treating substance use disorder. These medications relieve withdrawal symptoms that cause chemical imbalances and physical reactions in the body.

Goals

- Create coordinated and integrated systems of care that engage with people who have opioid use disorder (OUD) in a respectful way
- Provide people with OUD the tools they need to survive (i.e. information, education, naloxone, clean injection supplies, access to treatment for those who are ready)
- Facilitate a process for people who use drugs to move along a continuum of treatment to address acute health issues, access to MAT (if chosen by patient), supporting them in stabilizing other behavioral and physical health issues, and connecting people to resources to improve their lives and enhance their recovery

Recovery Support Services Include:

- Health – overcome or manage one’s disease(s) or symptoms
- Home – have a safe and stable place to live
- Purpose – conduct meaningful daily activities, and possess the independence, income, and resources to participate in society
- Community – have relationships that provide support, friendship, love, and hope



Medicaid Transformation Project: Transitional Care

Purpose

Costly, avoidable hospital readmissions, a common occurrence in our region, are a symptom of a larger problem in our health care system. Transitional Care happens when a patient moves from one health care setting to another or to home. Many patients are not fully recovered when they leave the hospital, and a poor transition can lead to longer recovery times and stress for both patients and their caregivers. Coordinating transitional care services prevents medication errors, emergency room visits, and hospital readmissions, which results in lower health care costs and healthier, more satisfied patients.

Goals

What is the Transitional Care Model and Care Transitions Intervention?

The Transitional Care Model aims to prevent health complications and readmissions of chronically ill, elderly hospital patients by providing them with comprehensive discharge planning and home follow-up care, coordinated by a “Transitional Care Nurse” who is trained to care for people with chronic conditions.

Care Transitions Intervention is a 4-week program for patients with complex care needs. The patient and family caregivers work with a Transitions Coach, through home-visits and phone calls, to learn self-management skills to ensure their needs are met during the transition from hospital to home.

CPAA will work directly with partnering providers to:

- Limit the time between patient discharge and follow-up appointments
- Reduce hospital readmissions
- Improve coordination between medical and community resources for high risk patients
- Expand admission screenings to identify high risk patients

How Patients Can Ensure a Smooth Transition

- Ask your doctor or nurse questions about your condition, medications, and the discharge plan
- Involve family members and ensure they know their role in your recovery
- Know who to call with concerns or questions about your recovery
- Schedule a follow-up appointment with your doctor and bring hospital paperwork with you



Medicaid Transformation Project Reproductive, Maternal & Child Health Project

Purpose

Healthy families are the center of a healthy community. By helping young men and women, mothers, and children access reproductive, maternal, and child health services, Cascade Pacific Action Alliance (CPAA) intends to support families, mitigate the impact of adverse childhood experiences (ACEs), and build resilience in our region.

What are Adverse Childhood Experiences (ACEs)?

ACEs are experiences that produce toxic levels of stress, resulting from situations like neglect, living with a parent with substance abuse or mental health disorders, racism, bullying, housing instability, witnessing violence, physical, emotional or sexual abuse, medical trauma, losing a parent to divorce, incarceration or deportation, and natural disasters.

What is Resilience?

A set of learnable skills that helps a person feel safe and able to cope with stress and adversity in their lives and which can even prevent new ACEs from occurring.

Goals

- Provide “trauma informed” training to members of the community and professionals such as teachers, nurses, doctors, hygienists, and dentists. Trauma informed care involves learning how to recognize, understand, and positively respond to the effects of trauma.
- Reduce the teen pregnancy rate.
- Increase the number of people using long acting reproductive contraceptives.
- Increase chlamydia screenings in women ages 16-24.
- Increase first trimester prenatal care.
- Increase the number of children seeing their doctor for regular well child check-ups and immunizations.

Strategies:

Reproductive Health Screenings, Home Visits, Well Child Visits & Immunizations

A planned pregnancy is a healthier pregnancy. Reproductive Health Screenings are simple questions asked during regular doctor visit to help families stay health and plan for when to have a baby. Home Visits would expand access to existing home visiting program so pregnant moms and families who need additional support could be eligible to receive in-home services. Regular Well Child Visits and Immunizations are crucial for health and prevention.



Medicaid Transformation Project: Chronic Disease Prevention and Control

Purpose

Managing chronic diseases places an overwhelming burden on our region's health system. Chronic diseases cause serious health issues and can negatively impact daily life. Cascade Pacific Action Alliance (CPAA) intends to prevent chronic disease, support patient self-management, and reduce costly health complications. This project includes increasing healthy lifestyle habits, regular check-ups with the doctor, preventative screenings, and educational and supportive classes.

Common Chronic Diseases

Arthritis
Asthma
COPD
Diabetes
Heart Disease
Obesity

What is the Chronic Care Model and Community Paramedicine?

Chronic Care Model cares for people with a chronic disease in primary care settings. It creates practical, supportive interactions between an informed patient and a proactive health care team. In **Community Paramedicine**, paramedics and EMTs have expanded roles to provide routine health care services and reduce unnecessary hospital admissions and readmissions.

Goals

- ✓ Raise awareness of chronic disease prevention through community outreach and education
- ✓ Educate doctors and nurses on chronic disease prevention and treatment
- ✓ Increase frequency of preventative screenings for common chronic diseases
- ✓ Expand community paramedicine resources (EMS)
- ✓ Improve coordination between medical and community resources for high risk patients

Social Determinants of Health and Chronic Disease Prevention and

Control Social determinants of health are the many social, economic, and behavioral factors that contribute to a person's health and well-being, things like education, income, housing, nutritious food, and access to health care. A healthy lifestyle is critical to the prevention and treatment of chronic disease, and it's a lot harder to be healthy if you don't have a job or a home or enough food. CPAA is committed to working with health care and other important services to address health inequities like stable housing, healthy food, health literacy, and reliable transportation to appointments.

CPAA ACH LLC
Preliminary Budget to Actuals October 1, 2017 - June 30, 2018
Operating

	YTD Actual		Total Budget	
Revenue				
Contributions	\$ 20,300		\$ -	\$ 20,300
Federal Grants & Contracts ¹	\$ 1,218,950		\$ 1,375,988	\$ (157,038)
State & Local Grants & Contracts	\$ 66,502		\$ -	\$ 66,502
Foundation Grants and Contracts	\$ -		\$ -	\$ -
Interest Income	\$ 4,049		\$ -	\$ 4,049
Total Revenue	\$ 1,309,801		\$ 1,375,988	\$ (66,187)
Expenses (a)				
Salary & Wages ²	\$ 538,501		\$ 659,267	\$ 120,766
Employer's FICA Expense	\$ 38,965		\$ 51,270	\$ 12,305
Unemployment Insurance	\$ 6,204		\$ 14,074	\$ 7,870
Worker's Comp Insurance	\$ 2,695		\$ 6,702	\$ 4,007
Medical/Dental Insurance	\$ 73,132		\$ 118,303	\$ 45,171
Other Fringe Benefits	\$ 979		\$ 698	\$ (281)
Retirement Plan Contributions	\$ 12,591		\$ 26,808	\$ 14,217
Professional Fees (Legal)	\$ 1,482		\$ -	\$ (1,482)
Professional Fees (Other) ³	\$ 282,915		\$ 258,455	\$ (24,460)
Supplies (Office)	\$ 505		\$ 5,625	\$ 5,120
Supplies (Other)	\$ 790		\$ 2,292	\$ 1,502
Postage, Shipping & Courier	\$ 412		\$ 662	\$ 251
Rent ₃	\$ 31,374		\$ 32,653	\$ 1,279
Utilities	\$ 2,367		\$ 5,044	\$ 2,677
Telecommunications	\$ 3,737		\$ 4,349	\$ 612
Maintenance & Janitorial	\$ 1,448		\$ 3,344	\$ 1,896
Equipment	\$ 1,870		\$ 3,750	\$ 1,880
Printing & Photocopying	\$ 4,082		\$ 4,385	\$ 303
Advertising	\$ 1,000		\$ 8,250	\$ 7,250
Publications & Subscriptions	\$ 1,270		\$ 1,350	\$ 80
Local Travel - Mileage, Accom. & Other	\$ 13,138		\$ 8,887	\$ (4,251) Out-of-
Town Travel - Accom. & Other	\$ 4,114		\$ 2,102	\$ (2,012) Conference Fees
& Registration	\$ 1,984		\$ 3,750	\$ 1,766 Meeting Expense
	\$ 17,357		\$ 6,300	\$ (11,057)
Dues, Fees & Licenses	\$ 202		\$ 6,600	\$ 6,399
Subcontractor Expense ⁴	\$ 239,278		\$ 63,666	\$ (175,612)
B&O Taxes	\$ 3,061		\$ 75,000	\$ 71,939
Total Expenses	\$ 1,285,451		\$ 1,373,585	\$ 88,134
Net Income	\$ 24,349		\$ 2,403	\$ 21,946

KEY

Color

Residing with CPAA ACH LLC

Residing with CHOICE



August 27, 2018

Dear Ms. Mitchell:

Thank you for the submission of Cascade Pacific Action Alliance's semi-annual report for the period January 1 – June 30, 2018. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project DSRIP program, Myers and Stauffer LC (Myers and Stauffer) has assessed the report.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information. Please respond within the template provided. Updates to semi-annual reports are not required and will not be reviewed.

Please feel free to contact Myers and Stauffer at WADSRIP@mslc.com for additional information should you need clarification about the request. In your email, please specify your questions, or request a conference call if a discussion would be preferred. If requesting a conference call, please provide two or three available timeframes.

Please post your response in PDF or Word format to WA CPAS (<https://cpaswa.mslc.com/>) within the Request for Information folder (pathway is Semi-Annual Reports ➤ Semi-Annual Report 1 – ➤ July 31, 2018 Request for Information. **We ask for response no later than 5:00 p.m. PST, September 11, 2018.** Information received after this date will not be considered.

Thank you,
Myers and Stauffer LC



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report Template
Reporting Period: January 1, 2018 – June 30, 2018

Request for Supplemental Information

Upon review of the ACH's semi-annual report, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification. Please respond within this template. Updates to semi-annual reports are not required and will not be reviewed.

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

No requests for additional information.

Section 2: Standard Reporting Requirements

Item G.2, Workbook Table A. Provide total Design Fund expenditures as of June 30, 2018.

1. **Independent Assessor Question:** Per review of the Workbook G2, Design Funds tab, the following is noted:
 - Table A: No design funds are indicated as expended during the reporting period. However, Table C, indicates design fund expenditures totaling \$1,652,891.93. Please explain the difference.

ACH Response: ACH Response: The amount of design funds expended through June 30, 2018, is \$1,652,892, and is now documented on Tab G2, Table A as required. This was an oversight on our part.

Item G.2, Workbook Table B. If the ACH has not expended the full amount of earned design funds, describe the planned use for these funds.

2. **Independent Assessor Question:** The response is minimal, only stating that “design funds will support CPAA throughout the course of the MTP period.” Please provide further detail as to CPAA’s planned use for the funds.

ACH Response: Design funds have been budgeted to support MTP project administration over the 5-year project period. Utilizing these funds limits the need to draw DSRIP dollars for project administration, therefore maximizing the amount of funds



available to the CPAA region. Project management and administration includes funding for staff, consulting, staff training, legal, travel, and administrative fees. Health systems and capacity building including capability development, recruiting, training, retention, administrative systems, organizational HIT, and systems capacity. Engagement is for convening, education, training, and tribal consultation, marketing, outreach, and travel. Other expenses include facilities, rent, utilities, and operational expenses.

Planned expenditures include:

- Project management and administration: \$2,829,495
- Health Systems/Capacity \$1,165,354
- Engagement \$188,320
- Other \$163,938