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

Medicaid Transformation
Accountable Communities of Health
Demonstration Year 6 (DY6) Pay-for-Reporting (P4R) Report Guidance

DY6 P4R 2 Report

Updated Template Release Date:

August 1, 2022

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Semi-annual report information and submission instructions

Purpose and objectives of ACH DY6 P4R report

As required by the Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit reports on project activities and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period.

The purpose of the reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state's contracted Independent Assessor (IA) will review report submissions.

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

Achievement values

The amount of incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given reporting period.

AVs associated with Project Incentives for this reporting period are identified in the table below.

Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for DY6 P4R 2 report

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Completion of semi-annual report	4	6	4	4	4	6	8	6	4
Completion/maintenance of partnering provider roster	4	6	4	4	4	6	8	6	4
Engagement/support of Independent External Evaluator (IEE) activities	4	6	4	4	4	6	8	6	4
Collection and reporting of provider-level P4R metrics. This includes any current MeHAF assessments and CIAT support to providers.	2	2	2	2	2	2	2	2	2
Total AVs Available	14	20	14	14	14	20	26	20	14

Table 2. Potential P4R AVs for Project Incentives for DY6 P4R 2 report

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	4	3	-	-	4	-	-	3	14
Cascade Pacific Action Alliance	4	3	3	-	4	3	-	3	20
Elevate Health	4	3	-	-	4	-	-	3	14
Greater Columbia ACH	4	-	3	-	4	-	-	3	14
HealthierHere	4	-	3	-	4	-	-	3	14
North Central ACH	4	3	3	3	4	-	-	3	20
North Sound ACH	4	3	3	3	4	3	3	3	26
Olympic Community of Health	4	-	-	3	4	3	3	3	20
SWACH	4	3	-	-	4	-	-	3	14

Reporting requirements

This report includes the sections outlined below.

DY6 P4R 2 report requirements		
Section	**Item num**	**Sub-section components**
Section 1. Project implementation status update	1	Attachments - Partnering provider roster
	2 - 3	Narrative responses - Challenges and mitigation activities - Scale and sustain update - WA-ICA support update
	4 - 6	Attestations

There is no set template for the DY6 P4R 2 report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA's webpage. See instructions for how to format the report below.

File format

ACHs are to submit all required elements as a single searchable PDF, with the exception of the partnering provider roster and the P4R metrics, which are to be submitted as separate Microsoft Excel files or PDFs. Below are examples of the file naming conventions ACHs should use:

- *Main Report or Full PDF:* ACH Name.DY6 P4R 2 Report.10.07.22

- *Partnering provider roster:* ACH Name. DY6 P4R 2.Provider roster.10.07.22

Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA's Medicaid Transformation resources webpage.[1]

DY6 P4R 2 report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than October 7, 2022 at 3:00p.m. PST.**

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

ACHs must submit semi-annual reports through the WA CPAS: https://cpaswa.mslc.com/.

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "DY6 P4R Report 2."

The folder path in the ACH's directory is:

P4R Reports → DY 6 P4R Report 2.

See WA CPAS User Guide available in each ACH's directory on the CPAS website for further detail on document submission

DY6 P4R report submission and assessment timeline

Below is a high-level timeline for assessment of the DY6 P4R reports.

ACH submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute DY6 P4R report instructions to ACHs	IA	August 1, 2022
2.	Submit DY6 P4R report	ACHs	October 7, 2022
3.	Begin assessment of reports	IA	October 8, 2022
4.	If needed, issue information request to ACHs within 10 calendar days of report due date	IA	October 17, 2022
5.	If needed, respond to information request within 7 calendar days of receipt	ACHs	October 24, 2022
6.	If needed, review additional information within 7 calendar days of receipt	IA	October 31, 2022
7.	Issue findings to HCA for approval	IA	November 5, 2022

Contact information

[1] https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents

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

ACH contact information

Include in the DY6 P4R report the contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's DY6 P4R report. If secondary contacts should be included in communications, also include their information.

ACH name:	Better Health Together
Primary contact name **Phone number** **E-mail address**	Alison Poulsen 509.499.0482 alison@betterhealthtogether.org
Secondary contact name **Phone number** **E-mail address**	Charisse Pope 509.340.9010 charisse@betterhealthtogether.org

Section 1. Status update

The following sub-sections are required components of the ACH's DY6 P4R report unless otherwise noted. ACHs may report in the format of their choosing, as long as all required elements are addressed.

Attachments

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

1. **Partnering provider roster.**

To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that reflect **all partnering providers** that are participating in efforts through the ACH under Medicaid Transformation.[2] Please use the attached provider template.

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should use the template provided by the IA to indicate:

   i. Whether the partnering provider site is pursing tactics or strategies in support of

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

specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.

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

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

Submit updated partnering provider roster.

BHT does not have any updates to the partnering provider roster from what was provided for SAR 8.0. We have included that document again.

Narrative responses

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

2. Challenges and mitigation activities

a) Please describe ACH activities that emerged or evolved since (APRIL – AUGUST) quarter 2 of 2022 (e.g., project management, communication and engagement, coordination of funding, etc.).

During this reporting period, BHT has been continuing and evolving the ACH activities that were started in 2021. Additionally, BHT has made efforts to evolve the workgroups and systems created during the Waiver period to more sustainable structures moving forward. Lastly, we have also pursued opportunities to sustain our funding post-waiver.

Community Resiliency Fund

In 2021, BHT formally adopted an organizational policy acknowledging racism as a public health crisis and deepening our commitment to equity and anti-racist work. To support this, we released $1.5 million of our Community Resiliency Fund in a Request For Proposal (RFP) process to address racism and prioritize awarding dollars to organizations led by and serving Black, Indigenous, and people of color.

This fall, we are requesting the Board approve an additional allocation of $2 million to support two years of contracts.

Behavioral Health Workgroup

In April 2022, the workgroup approved a Charter and Membership Agreement for the Behavioral Health Forum, which transitioned the workgroup from a BHT advisory group to and a self-governing body with BHT continuing to provide administrative support. In May, the group adopted a set of Guiding Principles that intentionally use equity values to inform collective decision-making. The group then allocated $1.2 million into four categories, using a participatory budgeting process:

1. Workforce Retention & Expansion - $540,000
2. Training & Education – Evidence-Based Practices - $310,000
3. Peers & CHWs - $230,000

4. Emerging Opportunities - $123,906

After making these allocations, the group held a brainstorming session in June to discuss options in each funding category and then built a menu of items in each funding category, which was presented to the Forum in September 2022 to continue participatory decision-making. Possible funding categories include supervision support, scholarships, and trainings for Peers and CHWs. The Forum will continue to identify specific funding opportunities through this process and distribute dollars in 2023, focused on supporting the behavioral health workforce.

Tribal Partners

In 2022 BHT facilitated a participatory design process regarding the structure and governance of the Tribal Partners Leadership Council. From that process, it was determined that they would be a self-governing Collaborative with a paid network administrator to facilitate meetings, and a chairperson to work directly with them. The Tribal Partners Collaborative (TPC) released an RFP to fill the role of network administrator and has contracted with Jenny Slagle of Tmíyu Consulting, who has previously worked at Better Health Together as Director of Tribal Relations. In September 2022, they elected Tamika LaMere to serve as the TPC Chairperson through 2023.

It was also determined this year that the Tribal Partners Collaborative would be open to Native-led organizations that may not be clinical but are working in our communities supporting Native population health. The Collective will allocate funds to offer culturally specific, sacred care within their organizations, and equal opportunity, access, and care for the Native community within dominantly white systems of care.

Tribal Carve Out

The following organizations have used their Tribal Carve Out dollars for a range of activities:

- Lake Roosevelt Community Health Center has provided social/emotional learning curriculum and supplies for Inchelium and Keller School Districts, has funded a GONA (Gathering of Native Americans - teachings of belonging, mastery, interdependence, and generosity) for each grade level at Inchelium School, and are hosting a community gathering in Inchelium focused on Indigenous Medicines and Foods.
- Colville HHS funding supported the opening of the SanPoil Treatment Center in Keller, WA.
- Spokane Tribe HHS funding supported staffing capacity by hiring a psychiatrist.
- American Indian Community Center supported their Goodheart SUD program.

Organizational Equity Assessments

In 2019, BHT developed an Organizational Equity Assessment and administered it to contracted partners, which developed a baseline for participating organizations. BHT had planned to administer the assessment every two years but delayed the process due to COVID.

BHT is offering this Organizational Equity Assessment again to each of our partners as a tool to help inform the next steps at their organization and on our region-wide equity journey. The assessment launched on September 12 and will close on October 28. We are asking as many staff members as possible to participate to have a robust set of results to share. The assessment

is largely the same as in 2019, with minor language changes for clarity and a more robust demographics section. The assessment delves into many aspects of equity, including gender, race, disability, sexuality, language, and lived experience. Additionally, for this round, we are offering the survey and other materials in English, Russian, Spanish, and Marshallese (English only in 2019). BHT will send individual results reports to partners in early 2023 and develop a regional report in collaboration with Providence CORE.

Youth Advisory Board (YAB)

In August of 2022, BHT took over facilitating the local Youth Advisory Board (YAB). YAB is part of the planning and implementation of YHDP (Youth Homelessness Demonstration Project) with community providers that administers $2.7M in federal HUD funding. YAB is actively recruiting additional members to ensure representation from the QTBIPOC community.

AHEC (Area Health Education Centers)

BHT has been working with AHEC on developing some collaborative opportunities for workforce development. BHT's Assistant Directors of Rural Programs and Behavioral Health Integration meets monthly with AHEC representation to discuss opportunities for BH workforce expansion and potential overlap & outreach to rural youth for career paths in medicine.

Rural Capacity Building

BHT continued to support our rural partners by helping them to scale and spread. This has included providing grant writing support. BHT paid a grant writer to support Steven's County with applying for a WA State Department of Commerce block grant to build a new library. BHT also paid a grant writer to assist Pend Oreille County in applying for a trauma-informed training for firefighters. Both of the applications were funded.

Landscape Analysis of Community-based Care Coordination

BHT contracted with Mathematica and Comagine to conduct a landscape analysis of community-based care coordination in Eastern Washington (BHT's six-county region). The final report was informed by three sources: a web-based survey of staff at organizations that provide care coordination services (209 responses – 152 complete and 57 partial); interviews and focus groups with community-based service providers, clinical providers, and adult and youth consumers (12 interviews, 4 focus groups); and an iterative review of publicly available sources. Additionally, a Survey and Data Advisor Group of representatives from BHT partner organizations helped inform the process. In selecting Data and Survey Advisors and participants for interviews and focus groups, BHT intentionally engaged youth and young adults, BIPOC individuals, community members with lived experience, and people working in social determinants of health organizations in rural and urban settings. BHT's total survey response number was higher than the number collected by Healthier Here in the King County landscape analysis, also done by Mathematica

The final report outlines identified four themes:

1. There are diverse needs and considerations for providing whole-person care in Eastern Washington, and providers lack sufficient resources to support and facilitate effective care coordination.

2. Organizations are already connected and collaborating but lack the systems, tools, and processes to effectively coordinate care.
3. The bidirectional information sharing foundational to coordinating care doesn't occur consistently, due in part to limits in technology and infrastructure constraints.
4. Strong relationships, along with self-reflection, are critical elements in providing whole-person-centered care.

b) Describe specific risks/issues, challenges, or other setbacks that emerged or persisted since quarter 2 of 2022 (e.g., workforce, information exchange, access). Please include any notable impacts to specific providers or communities. Also highlight any mitigation strategies or activities that shifted as a result of these challenges, if applicable.

Workforce

Workforce shortages continue to be a huge challenge for our counties, sectors, and organizations. Employees continue to experience burnout and hiring is challenging.

Specifically, Lincoln Alcohol and Drug saw the departure of their Executive Director as well as two of their four waivered providers for MAT. This has left the SUD treatment services in that region inadequate to address the need. In general, where NE Washington Alliances Counseling Services serves, their total staff is down by 50%. An emerging challenge we see is the lack of SDOH services and resources within our rural counties. Providers have begun hiring Community Health Workers, but the areas haven't built up the SDoH systems to provide the resources this workforce will seek.

There are several mitigation strategies in the works to help address these issues. The Collaboratives in these settings are focusing their equity projects on issues such as childcare and housing. The BH Forum is allocating the remainder of our IMC mid-adopter incentive dollars (approx. $1.2m) toward workforce retention and expansion efforts across our region. We are also working with our local AHEC to specifically collaborate on opportunities in rural areas.

Equity work

Being at the forefront of equity and diversity work in our region has led to some pushback, especially in our rural communities. We're highly aware of where different parts of our community are on their equity journey and BHT anticipated challenges as we continue to promote a culture of belonging. We also are working to create environments where it is safe to address counter-beliefs. Part of our mitigation strategy is the reissuing of the Organizational Equity Assessment. This tool is a safe way for agency staff to voice their experiences to help drive change from within. On the upside, we continue to experience demand for our Equity 101 training series, with more than 1,000 community members completing the training since it was launched.

MCO contracting?

We asked partners to share wins, challenges, and insights from working the MCOs in a recent round of MTP contract reporting. Many reported challenges with MCOs, and interestingly, several expressed that it has been more challenging than working with the BHO.

Provider comments:

- The introduction of the MCO system has created unique challenges with clients receiving adequate services. Prior authorizations and continued authorizations for residential treatment continue to be an issue that did not exist in the BHO System. This has included individuals not receiving services after a month amount of time.
- The MCOs do not consider homelessness or lack of housing as a reason for continued services. Housing is not a Medicaid-fundable service.
- I do not believe the MCO system is a win over the BHO systems. The BHO system and the individuals you worked with were members of your community and we tended to have a more personal relationship with the individuals at the BHO. If we had a choice between the BHO and MCO systems, we would choose the BHO system.
- After 3 years of contracting with the MCOs, it has become apparent the small, specialized behavioral health agency is a low priority. We have immense workforce challenges and large waitlists for service and profit-driven funders that are unresponsive to our needs. Spokane County was historically very supportive of the behavioral health providers and worked with us to keep wages somewhat competitive and waitlists low.

The ACH has limited mitigation opportunities in the realm of MCO contracting. Contracting with multiple MCOs with limited local relationships is difficult compared to contracting with a single local entity. We are hoping for the HCA's attention to this, particularly during re-procurement, especially if there are opportunities to streamline the contracting process.

c) Please describe any anticipated or upcoming challenges and/or opportunities related to the transition from the extension to the renewal period.

Care Connect HUB

BHT has found a lot of success with the Hub structure that we launch with the COVID work as a way to link together community efforts and resources. We have been successful in finding other contracts to support this work. We see that the Health Care Authority co-investing with DOH on this allows the infrastructure to be more robust, allowing us to support a community-based workforce. We continue to work through contracting and fiscal infrastructure to be able to better support our partners and bring other organizations on who may need some additional support/TA. We are working on building out support for the workforce, including offering population health trainings across HUB projects and SDoH partners. BHT also utilizes our Eastern Washington CHW Network to help inform gaps and provide feedback.

Continuous Coverage for Kids

BHT feels excited about this opportunity as it links to our ongoing work with the Health Benefit Exchange Navigator program as well as our targeted work with the COFA Islander community in Spokane. Additionally, our primary care, behavioral health, and MCOs partners have expressed

interest in having more opportunities to provide access to care through the school setting. As part of this work, we funded a school-based clinic partnership in Newport, WA with Newport School District and Newport Public Hospital Clinic and a Telehealth pilot with CHAS, Unify, and Spokane Public Schools.

Equity Fund

BHT sees the inclusion of an Equity Fund in the Waiver Renewal as an important and exciting step toward putting equity values into action on a state-wide scope. We hope that this will be flexible funding and focused on local needs. We see lots of opportunities to focus on systemic racism and structural issues related to poverty. We would encourage HCA to look at the way several of the ACHS have structured their Community Resiliency Funds as an example of how to execute this.

With our Community Resiliency Fund, BHT has funded projects focused on Racism as a Public Health Crisis and prioritized funding to Black, Indigenous, and People of Color led organizations. This invited 20 new relationships into our work which have transitioned into partners working in our Hub and SDoH delivery systems and have allowed BHT to widen our reach and deepen our connections to the community.

Foundational Community Supports and Long-term Care

BHT sees an exciting opportunity for the ACHs to sit in the center, connecting things together, and further deepen the partnerships and support to expand the reach of these programs.

3. Scale and sustain update

a) Briefly describe the ACH's approach and activities related to sustainability of DSRIP investments, programs, projects, and any other planning taking place in this area.

BHT has been working on a sustainability planning process since 2020 and continues to make strides toward sustaining and expanding the work we do.

At the beginning of this process, our Board members discussed gaps in the region and identified opportunities to build on and expand current work. At the end of 2021, the Board moved its discussions into action, which started with a restructuring of our Board as described in our last P4R. This new Board has been hard at work developing a strategic plan for 2023-2025 with a focus on 3 key initiatives:

1. COMMUNITY HUB Strategic Initiative. Linking health care and social determinant of health services through a community-based workforce
2. WHOLE PERSON CARE INTEGRATION Strategic Initiative: Investing in primary care, behavioral health, and oral health to ensure access and culturally relevant care for all (Health System Transformation)
3. CONVENING & EQUITY MOVEMENT BUILDING Strategic Initiative. Organizing our power collectively to solve our most urgent and (sometimes) hidden equity needs

In addition to strategic planning, the organization continued to pursue funding and opportunities that aligned with our focus areas and allow us to expand our operations beyond Medicaid Waiver activities.

For this reporting period this includes:

- **HRSA Community Health Worker Training Program.** This is a 3-year contract for a total of $3,000,000 to expand the public health workforce through the training of new Community Health Workers (CHWs) and health support workers and to extend the knowledge and skills of current CHWs and other health support workers.
- **Department of Commerce Digital Navigator Project.** This 9-month contract is for a total of $500,000. The Digital Navigator Program is meant to advance digital literacy skills, digital equity, and connectivity in Washington.
- **Department of Commerce BIPOC/Impacted Communities Outreach.** This grant is for $600,000. BHT will contract with BIPOC/Impacted community organizations as trusted messengers to support outreach and engagement with their community members. The goal is to have the clients they serve sign up for resources such as WIC/TANF, which they have always been eligible for but hadn't previously taken advantage of due to whom the message was coming from.

b) Briefly describe any changes to the funding and financing of partnering providers and community initiatives in DY6 (and beyond, if applicable), compared with DY1-5. This may include provider contracts and relationships, scope, project transitions/project sustainability, etc.

We have continued to use the same funding mechanism that we put in place at the start of the Waiver for DY6 funds. At our September Board meeting, we voted to treat our High-Performance Pool and Year 6 Pay for Reporting funds the way we have treated our other Pay for Reporting Funds allocating to 55% to Providers; 30% to Regional Infrastructure; 10% to Community Resiliency Fund and 5% to admin.

PC and BH providers will be wrapping up their Year 3 MTP contracts at the end of this year. We have financially incentivized the completion of the WA-ICA as part of Cohort 1 (Q3 2022) and upcoming Cohort 2 (Q1 2023). We do not anticipate designing additional integration/transformation contracts with PC & BH partners until we know more about the priorities & funding in the Waiver Renewal.

Over the last couple of years, BHT has seen a unique opportunity to integrate SDoH with health care settings and will continue to invest in these collaborations. BHT will continue to invest in the capacity of providers. However, with our investment of staff and resources into the Hub, BHT sees increasing opportunity for broadening of that work and provide the support for systems collaboration and care coordination.

BHT used the full $8M in funds we received for early adopter of IMC to support BH. We currently have $1.2M left to invest, which has been earmarked by the forum to support in behavioral health access and workforce development.

Lastly, BHT expects to allocate $3.6M for an SDoH RFP for the next two years as well as $2M to our Community Resiliency Fund, and $500k for a rural school-based health care RFP.

c) Briefly describe how the ACH is communicating with partnering providers related to the transition from the extension to the renewal period.

BHT intends to take a pause on contracting after Year 3 contracts wrap this year as we wait to know more about the specific priorities and funding for the Waiver Renewal. We have communicated this decision directed to currently contract primary care and behavioral health partners. We are also keeping the Board and Collaboratives in the loop as we watch the Renewal take shape and await the approval and specifics. BHT shared the Waiver Renewal application with our partners and hosted a webinar for BHT Board and regional partners with HCA presenting the renewal information. BHT coordinated public comment from our Board, BH Forum, and BHT Community Voices Council.

4. WA-ICA support update

a. Describe how the ACH is engaging and supporting primary care practices and out-patient BH practices in the WA-ICA Initiative, as agreed to through the WA-ICA Workgroup. Please provide an example.

BHT's Board approved a $10k incentive for organizations who submitted the WA-ICA during Cohort 1 or 2. We also offered facilitation support and technical assistance as providers completed the assessment. For example, we met with each organization's teams as they completed the ICA to answer questions and help clarify where their activities fell in the scoring. We used the communication language and schedule provided by HealthierHere, which was great for consistent messaging across the state. BHT had 52 sites across 25 organizations submit the ICA in Cohort 1, accounting for 25% of total statewide submissions. The submissions represent 74% of our Year 3 MTP contracted partners.

Attestations

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

	Yes	No
5. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation.	X	
6. The ACH supported WA-ICA implementation as outlined below:	X	

If the ACH checked "No" in item above, provide the ACH's rationale.