



Medicaid Transformation Project

Semi-Annual Report 2

July 1, 2018 – December 31, 2018



January 31, 2019

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

RE: CPAA Semi-Annual Report 2

Dear Semi-Annual Report Review Team:

Please find attached a copy of Cascade Pacific Action Alliance's (CPAA) second semi-annual report for the Medicaid Transformation Project (MTP). This report summarizes CPAA's work from July 1, 2018, through December 31, 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 continued to make progress advancing MTP objectives and achieving health care delivery system transformation through cross-sector collaboration. Key accomplishments during the reporting period include, but are not limited to, selecting Medicaid Transformation Implementation Partners, finalizing interim measures, Change Plan development and approval, finalizing projects and interventions, executing contracts, and developing the DY2 Funds Flow. During the reporting period, we also rounded out our staff to ensure a capable team and a solid organizational infrastructure are in place to support our partners during implementation of MTP projects.

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,

Jean Clark, CEO
Cascade Pacific Action Alliance

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**CPAA Excel Workbook and Project Work Plan are Separate Documents*

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 (CPAA)
Primary contact name	Jean Clark
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Secondary contact name	Christina Mitchell
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Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- 1. Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

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 informing

providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

Not applicable.

3. In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
Providers with low VBP knowledge	Email (Appendix A and B)	12/3/2018; 12/12/2018	<ul style="list-style-type: none"> • VBP Roadmap • VBP for Pediatric Providers • Defining a Strategy for Value-Based Contracting • VBP Practice Transformation Planning Guide
Small volume providers	Email (Appendix A and B)	12/3/2018; 12/12/2018	<ul style="list-style-type: none"> • VBP Roadmap • VBP for Pediatric Providers • Defining a Strategy for Value-Based Contracting • VBP Practice Transformation Planning Guide
Behavioral health providers	Email (Appendix A and B)	12/3/2018; 12/12/2018	<ul style="list-style-type: none"> • VBP Roadmap • VBP for Pediatric Providers

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
			<ul style="list-style-type: none"> Defining a Strategy for Value-Based Contracting VBP Practice Transformation Planning Guide

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

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

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response:

Not applicable.

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
Behavioral Health Agencies	Lack of practical knowledge needed to establish VBP contracts with MCOs	Behavioral Health Agency Transformation Intensive: Value Based Payment Preparations. November 14, 2018, presented by Qualis Health
All providers	Lack of knowledge on VBP	Healthier Washington Paying for Value Webinar Series
Behavioral Health Providers	Lack of knowledge on VBP	VBP Practice Transformation Academy

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH’s efforts to support completion of the state’s 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
Announcements in project workgroups, Clinical Advisory Committee, and CPAA Council	No	No
Post survey link on CPAA website and CPAA newsletter that includes a broad distribution list (Appendix C)	No	No
Individual communication with providers (Appendix D)	No	No

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
Provider with low VBP knowledge	Investment and infrastructure	Develop action plan to incentivize VBP survey	Target resources and investments based on completion and VBP survey results	Encourage partnering providers to increase VBP survey completion and VBP arrangements beginning in 2019
Small provider	Education	Individual meeting to explain VBP goals, changes in payment methodology, and VBP survey	N/A	Encourage partnering provider to engage with MCOs about VBP
Behavioral health provider	Education	Promoted the VBP Practice Transformation Academy	N/A	Encourage partnering providers to engage in the VBP Practice Transformation Academy

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. 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 “No” in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response:

Not applicable.

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. 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 “No” in item A.2, provide the rationale for having not

developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response:

During this reporting period, Cascade Pacific Action Alliance (CPAA), county commissioners, tribal governments, managed care organizations (MCOs), behavioral health and primary care providers, and other critical partners moved towards developing a plan and description of steps that need to occur for regional transitions to integrated managed care (IMC). While the MCOs have provided a general timeline that lays out transition milestones and stakeholder expectations, one challenge to fully completing this milestone is that CPAA has two behavioral health organizations (BHOs) in the region, Great Rivers BHO and Thurston-Mason BHO. Each BHO has different stakeholders and different internal timelines to transition to IMC.

The Great Rivers region has begun moving toward IMC through the development of the Leadership and Oversight Committee, which is described below. Through leadership from the public health departments, a committee was formed to monitor and report on implementation of IMC for the Great Rivers regional service area.

CPAA continues to engage with interested leaders from the Thurston-Mason regional service area. CPAA is in discussions with the Thurston-Mason BHO, public health departments, MCOs, and BHAs to develop a course of action moving forward. County administrators will continue to be engaged to determine how they would like to move forward with the interlocal leadership structure.

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?
 - a. If yes, describe the region’s plan to establish an EWS Workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type workgroup participants
 - b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response:

Despite challenges, including but not limited to two regional service areas in the region and being an on-time adopter with the transition timeline of 2020, CPAA has made progress during this reporting period to establish an early warning system (EWS). There are two regional service areas and corresponding behavioral health organizations in the CPAA region: Great Rivers and Thurston-Mason. The Great Rivers region established an Interlocal Leadership Committee in August 2018 to “collaboratively design and implement the fully integrated managed care model for this regional service area to assure clients are at the center of care delivery and support integrated delivery of physical and behavioral health care at the

provider level.” Local organizations involved in planning for IMC stressed the importance of this workgroup being led by a county government entity instead of the ACH. The Interlocal Leadership Structure represents a diverse body of stakeholders, including five county administrators, Washington State Health Care Authority (HCA), MCOs, tribal representatives, CPAA representative, and a BHO representative. The Interlocal Leadership Structure includes three workgroups: Provider Readiness Workgroup, EWS Workgroup, and the Communications Workgroup. The EWS Workgroup will begin in mid-2019, according to the draft charter. This workgroup is responsible for overseeing the development and operation of an EWS in the Great Rivers region, collaborating and coordinating with regional stakeholders to resolve issues that may arise from the transition to IMC, providing recommendations that will inform the development of EWS metrics, and developing long-term strategies for increasing uniform access to care.

The Thurston-Mason region has yet to establish an Interlocal Leadership Structure or EWS Workgroup. CPAA reached out to Thurston County Public Health and Social Services and Mason County Public Health Departments. CPAA has also worked closely with the Thurston-Mason BHO to determine how we can best support the transition to IMC and what role CPAA will play in the EWS. The workgroup will likely include two county administrators and one CPAA representative.

4. Describe the region’s efforts to establish a communications workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response:

The CPAA region, which consists of both Great Rivers and Thurston-Mason BHOs, has yet to establish an IMC Communications Workgroup due to the IMC transition timeline of January 2020. However, a Communications Workgroup is expected to be established in 2019. CPAA estimates there may be approximately 10-15 participants representing MCOs, BHOs, HCA, behavioral health agencies, CPAA, and a consumer representative.

5. Describe the region’s efforts to establish a provider readiness/technical assistance (TA) workgroup, including:
 - i. Which organization will lead the workgroup?
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response:

The CPAA region has yet to establish a TA Workgroup. Although a workgroup has not yet formed, our region is actively preparing for the IMC transition. Partners in the CPAA region have engaged in multiple TA opportunities to date. Great Rivers BHO hosted an IMC transition summit with behavioral health

providers and identified numerous areas of support needed. In the Thurston-Mason BHO region, the Thurston Asset Building Coalition hosted a behavioral health forum with all stakeholders to discuss IMC and the consumer populations affected by the transition. Qualis Health completed several individual IMC readiness assessments with behavioral health agencies and led an IMC learning summit. CPAA reached out to XPIO Health about contracting for TA starting in Q1, 2019. In addition to these preparations, CPAA plans to coordinate or lead a TA Workgroup that will be formed in Q1, 2019. There may be approximately 10 participants in the workgroup representing MCOs, BHOs, HCA, behavioral health agencies, and CPAA.

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response:

As an on-time adopter region, CPAA has compiled best practices, lessons learned, and TA needs from other ACH regions and BHO-hosted events for Medicaid behavioral health providers transitioning to IMC. Much of the provider readiness relates to business operations such as billing systems support, IT readiness, software/hardware capabilities, MCO credentialing, and EHR upgrades. Additionally, we identified MCO contracting training, engagement, and negotiation as a provider readiness support area.

In partnership with BHOs, MCOs, and external consultants, CPAA is planning to address these areas of support in 2019. Preliminary calls were conducted with both BHOs in our region to understand their IMC transition plans and strategies, as well as to establish areas of alignment for shared resources. Next steps include engaging XPIO Health about contracting in 2019 to provide on-the-ground business operations TA to behavioral health agencies in our region. CPAA also set a date in April 2019 to host an MCO contracting training event with an independent attorney, Adam Falcone.

7. What **non-financial technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?**

ACH response:

To help address provider readiness, CPAA has identified that HCA could, on a regular basis, share best practices and lessons learned from early and mid-adopter regions. HCA could also regularly check in with on-time adopters with elements of IMC to consider.

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response:

CPAA had multiple contacts with both BHOs around their preparations and planning for IMC. Preliminary calls were conducted with both BHOs in our region to understand their IMC transition plans and strategies, as well as to establish areas of alignment for shared resources. Additionally, both BHOs helped CPAA promote in-person IMC training events and helped share IMC education materials by sending emails to their partner networks.

Great Rivers BHO hosted an IMC transition summit with behavioral health providers and identified numerous areas of support needed. CPAA's Community and Tribal Liaison participated in this event as the ACH representative (Appendix E). In the Thurston-Mason BHO region, the Thurston Asset Building Coalition hosted a behavioral health forum organized by CPAA's Opioid Response Program Manager for all stakeholders to discuss IMC and the consumer populations affected by the transition (Appendix F). More than 60 people were in attendance from throughout the region, including representatives from HCA, MCOs, BHOs, NAMI, and social service organizations.

CPAA engaged the MCOs in our region on multiple occasions at the CPAA Council meetings during individual contacts with MCOs. Due to MCO IMC priorities in other regions, we are expecting a cascading level of engagement throughout Q1 and Q2 of 2019 as behavioral health agencies start to establish contracts with MCOs. Representatives from all the MCOs attended the IMC training hosted by Qualis Health and the Practice Transformation Support Hub and presented a timeline detailing major milestones and expectations for behavioral health agency attendees.

Lastly, CPAA's Community and Tribal Liaison attended an IMC Consumer Forum in Lewis County, which was specifically designed to educate consumers and receive feedback.

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond "Not applicable."

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity's qualifications. Include a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response:

CPAA is the HUB lead entity for its Pathways program. CHOICE Regional Health Network (CHOICE), the administrative support organization for CPAA, has more than two decades of experience leading successful community engagement and regional health improvement efforts, and HCA is familiar with CPAA's organizational structure. CPAA's HUB Advisory Committee (previously referred to as the Care Coordination Workgroup) members reviewed roles and responsibilities of the Pathways Community

HUB and affirmed their consensus that CPAA was the ideal organization to serve as the HUB for our region. HUB development and operations are implemented by CPAA's Pathways Program Manager and will be supported by a Pathways Referral Coordinator position. CPAA is currently interviewing for that position with the intention of having it filled in early 2019.

As the Pathways HUB, the Care Coordination project has additional capacity provided by CPAA/CHOICE staff as needed, including from Program Support Specialists for meeting notes and convening logistics, Operations support for contracting and procurement, Data and IT support for technical assistance and privacy and security monitoring and compliance, communications support, tribal and community engagement support, as well as access to CPAA/CHOICE senior leadership for support on decision-making and partner engagement.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response:

CPAA is open to pursuing national certification as a Pathways Community HUB, should it become a point of negotiation in developing contracts with HUB payers. To ensure readiness if the decision is made to pursue certification, CPAA's implementation of Pathways is following all of the minimum national HUB certification standards and has received extensive technical assistance in designing and executing its implementation from Dr. Sara Redding, one of the founders of the Pathways model. HUB certification standards have been incorporated into CPAA's HUB Policies and Procedures (<https://cpaa.gitbook.io/pathways-community-hub/>), and compliance with these standards will be monitored through CPAA's ongoing quality improvement process, utilizing data from the Care Coordination Systems (CCS) platform.

3. Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

ACH response:

CPAA is the HUB lead entity. CPAA has contracted with CCS as the platform to provide Pathways. The CCS software platform has received Health Information Trust Alliance (HITRUST) certification and adheres to health care industry best practices and standards for safeguarding client data in compliance with all federal privacy laws. CPAA's HUB data is stored on secure servers maintained and operated by CCS. User logins for the CCS platform are maintained by the Pathways Program Manager. There are

three user types, which restricts access to client information so that only assigned clients are viewable to agencies and individual care coordinators.

Additionally, CPAA appoints a technical security officer to ensure that all data systems that maintain protected health information are either operated on CPAA's server or are operated on secure servers that meet HIPAA-compliant standards for security, privacy, and access. The technical security officer ensures that security updates are installed appropriately. The technical security officer ensures that all of CPAA's staff receive training regarding the security and protection of CPAA's technical hardware and software, including training to identify malicious software risks and to avoid practices that could lead to the introduction of a virus, worm, or spyware into the CPAA network, workstations, portable electronic devices, or electronic storage media.

CPAA also appoints a privacy officer who is responsible for the implementation of adequate security measures for CPAA's physical facilities where protected health information is kept, including offices, records and copy rooms, and filing cabinets. Additionally, the privacy officer responds to all external requests for PHI, responds to request for history of disclosures of PHI, training CPAA workforce on PHI, and investigation complaints of unauthorized disclosure of PHI, in collaboration with the technical security officer, if applicable. CPAA's technical security officer and privacy officer can be the same employee. The privacy officer and technical security officer are authorized to access, process, modify, disclose, and transfer PHI as necessary and appropriate for performance of their duties, for purposes of CPAA business, and in compliance with this and all related CPAA policies and legal obligations. In the event of a disaster, such as fire, system failure, or natural disasters, the privacy officer and technical security officer will be jointly responsible for developing plans for recovery and security of PHI after such an emergency. Currently, the technical and privacy officer role is maintained by Ivan Rodriguez.

Care Coordinating Agencies and other CPAA partners that work with Pathways clients have formal Business Associate Agreements that specify data sharing agreements and specific protocols to be followed to ensure confidentiality and legal compliance. Each Pathways client reviews and signs a detailed release of information form that is uploaded to the client's electronic record, which specifies the specific agencies that a care coordinator may receive client information from and where it may be sent on behalf of the client.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects

and related activities.

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	

- If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not applicable.”

ACH response:

Not applicable.

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the 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

A. ACH organizational updates

- Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying 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/	X	

	Yes	No
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.		
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,” to all items respond “Not applicable.”

ACH response:

Not applicable.

3. **Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

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

Place an “X” in the appropriate box.

Yes	No
X	

- a. If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked “Yes,” to item A.3 respond “Not applicable.”

ACH response:

Not applicable.

4. **Key Staff Position Changes:** Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

	Yes	No
Changes to key staff positions	X	

during reporting period		
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If the ACH checked “Yes” in item A.4 above:

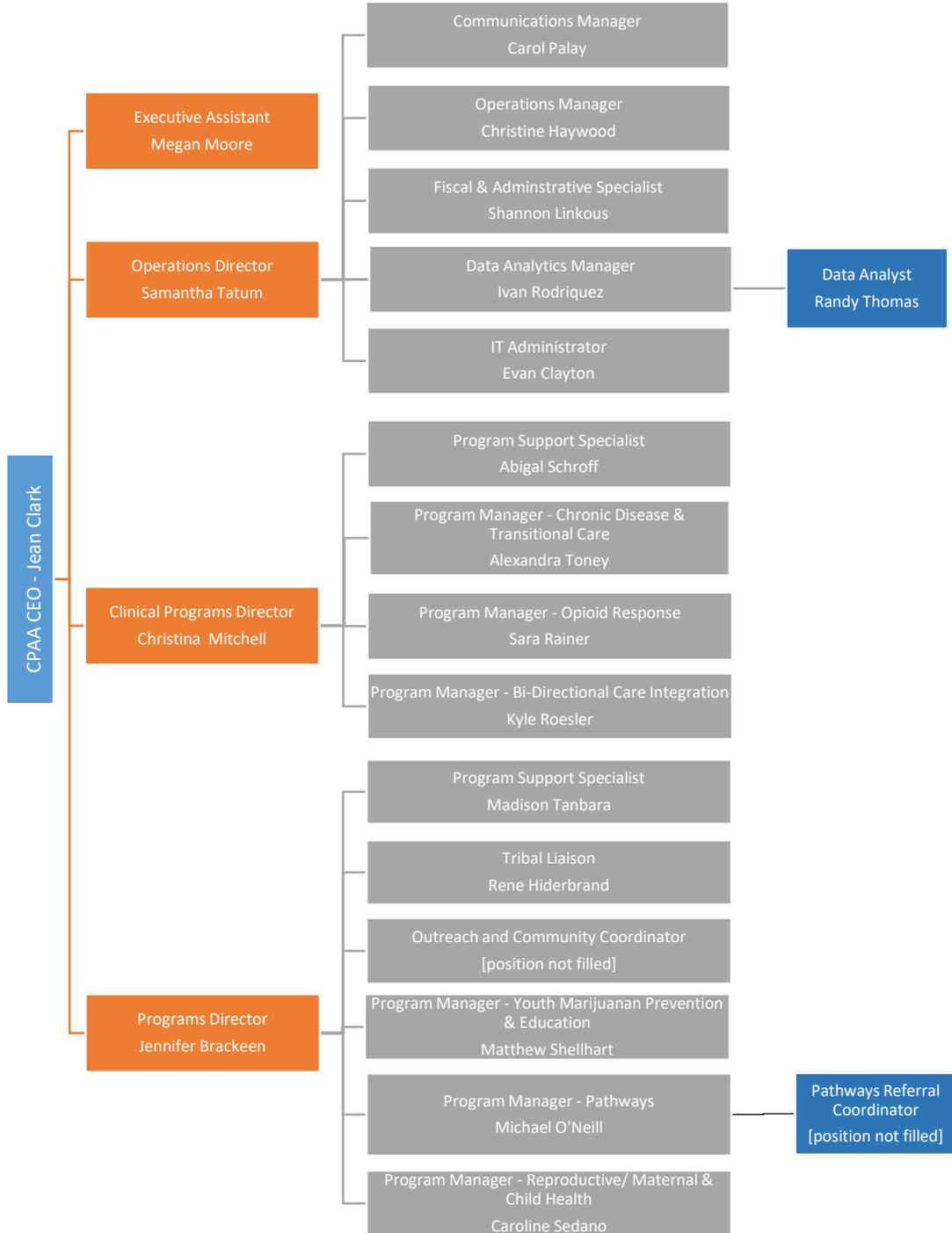
Insert or include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period.

Table 1: CCAA Organizational Updates

Name	Position	Role
<i>*Jean Clark</i>	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 the Youth Marijuana Prevention and Education program.
Matthew Shellhart	YMPEP Manager	Manages the Youth Marijuana Prevention and Education program.
Christine Haywood	Operations Manager	Provides operational support.
<i>*Ivan Rodriguez</i>	Data and IT Manager, Technical Officer, and Privacy Officer	Provides oversight of data analytics and IT, as well as maintains security of protected health information.
Kyle Roesler	Care Integration Manager	Manages the Bi-Directional Care Integration program.
Michael O’Neill	Pathways Hub Manager	Manages the Pathways program.
<i>*Sara Rainer</i>	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 Reproductive and Maternal/Child Health programs.
Megan Moore	Executive Assistant	Provides administrative support for the CEO.
Abigail Schroff	Program Support Specialist	Provides administrative support for the clinical programs and clinical director.
Madison Tanbara	Program Support Specialist	Provides administrative support for the Pathways, Reproductive and Maternal/Child Health, and Youth Marijuana Prevention and Education program, and program director.
Shannon Linkous	Fiscal and Administrative 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.
<i>*Position Not Yet Filled</i>	Pathways Referral Coordinator	Provides technical support for care coordination agencies in the Pathways HUB.
<i>*Rene’ Hilderbrand</i>	Tribal Liaison	Collaborates with the tribes to inform, make recommendations, and gather input.
<i>*Position Not Yet Filled</i>	Outreach and Community Coordinator	Collaborates and coordinates with outreach efforts, local forums, and the Consumer Advisory Committee.

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

Table 2: CPAA Organizational Chart



B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).¹

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

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response:

Not applicable.

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

ACH response:

CPAA changed its approach to tribal collaboration during this reporting period. 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 fully committed to working with tribes in a humble and culturally respectful way to help meet both 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 separated the Community and Tribal Liaison position into two separate positions: the Tribal Liaison and the Outreach and Community Coordinator. The Tribal Liaison is now dedicated solely to tribal priorities.

The Tribal Liaison meets one-on-one with each tribe in addition to supporting a bi-monthly meeting of the tribal health directors with CPAA. This meeting serves as one of the several ways CPAA communicates and collaborates with tribes. This engagement process 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.

¹ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response:

CPAA is a 2020 Adopter. Not Applicable.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response:

CPAA is a 2020 Adopter. Not Applicable.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

CPAA is a 2020 Adopter. Not Applicable.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

CPAA is a 2020 Adopter. Not Applicable.

5. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

CPAA is a 2020 Adopter. Not Applicable.

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.²

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
 - If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.
1. Provide the ACH’s current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

Please see CCAA.SAR2.Work Plan.1.31.19.

Table 3: Implementation Plan Work Step Status Legend

IP Work Step Status Legend	
Complete, Deliverable Met	■
Fulfilled for Quarter, Remains in Progress	■
Delayed, Remains in Progress	■
Not Started	■
Edited Work Step	■

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

ACH response:

CPAA has worked diligently this reporting period to prepare for implementation in January 2019. CPAA's top three achievements include finalizing paid implementation partners, completing Change Plans and contracts, and identifying interim measures that allow CPAA to closely track progress and provide targeted technical assistance to organizations to ensure MTP success. In addition to these achievements, CPAA identified and worked to mitigate the risks of partiality, insufficient participation of community-based social service organizations, traditionally siloed communications, and overly burdensome reporting for partners.

Selection of MTP Implementation Partners

To mitigate the risk of partiality when selecting Medicaid Transformation Project (MTP) partners, CPAA worked closely with an independent assessor, Oregon Health Science University (OHSU), in the selection of MTP implementation partners. Based on Request for Proposal (RFP) responses, 44 paid implementation partners were selected in addition to the seven federally recognized tribes in the region. The tribes did not participate in the RFP process because they were not required to compete for funding. CPAA announced this network of paid implementation partners on August 10, 2018 (Appendix G), and have been in close communication with all 50³ partners since that time.

To mitigate the risk of having too many clinical partners to affect sufficient regional transformation, CPAA was deliberate with this selection process, working with OHSU to intentionally choose a mix of both traditional and non-traditional partners, including public health departments and community-based organizations (CBOs) that cover all six project areas and span the seven-county CPAA region, ensuring maximum transformative impact. RFP applicants were sorted into categories based on services provided, Medicaid lives served, and service location to ensure broad sectoral and geographic representation.

CPAA recognizes 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 could be competitive in the RFP process, regardless of size or scope of practice, CPAA worked with an ad hoc committee made up of two MCOs, an independent assessor, and two directors from CPAA. The committee identified opportunities for up to 11 organizations (out of a total of 44 selected 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. To mitigate the risk of smaller, non-traditional social service organizations not having sufficient capacity to transform the health care delivery system in the region, CPAA has continued to offer additional support to our CBO partners, including TA and infrastructure investments.

³ One selected partner, Catholic Community Services, decided early in the process to not continue as a paid MTP implementation partner; CCS did not sign a contract with CPAA and did not complete a Change Plan.

Table 4: MTP Implementation Partners by Organization Type

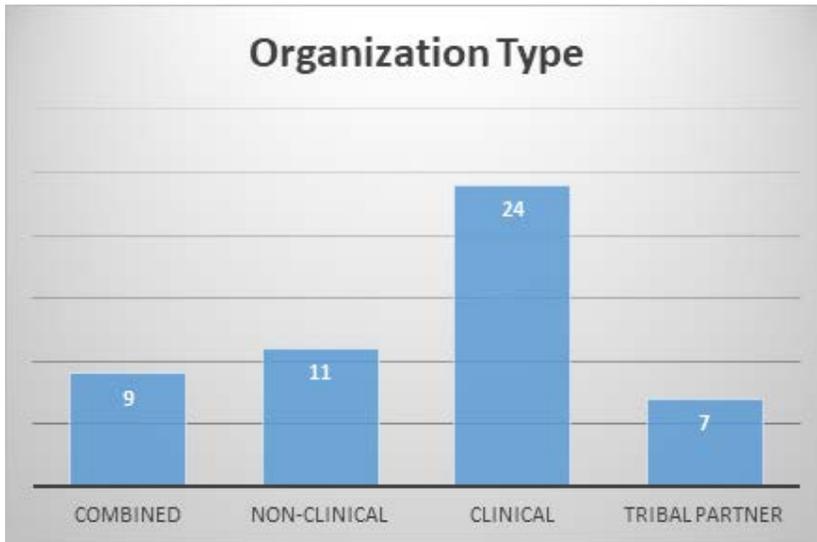
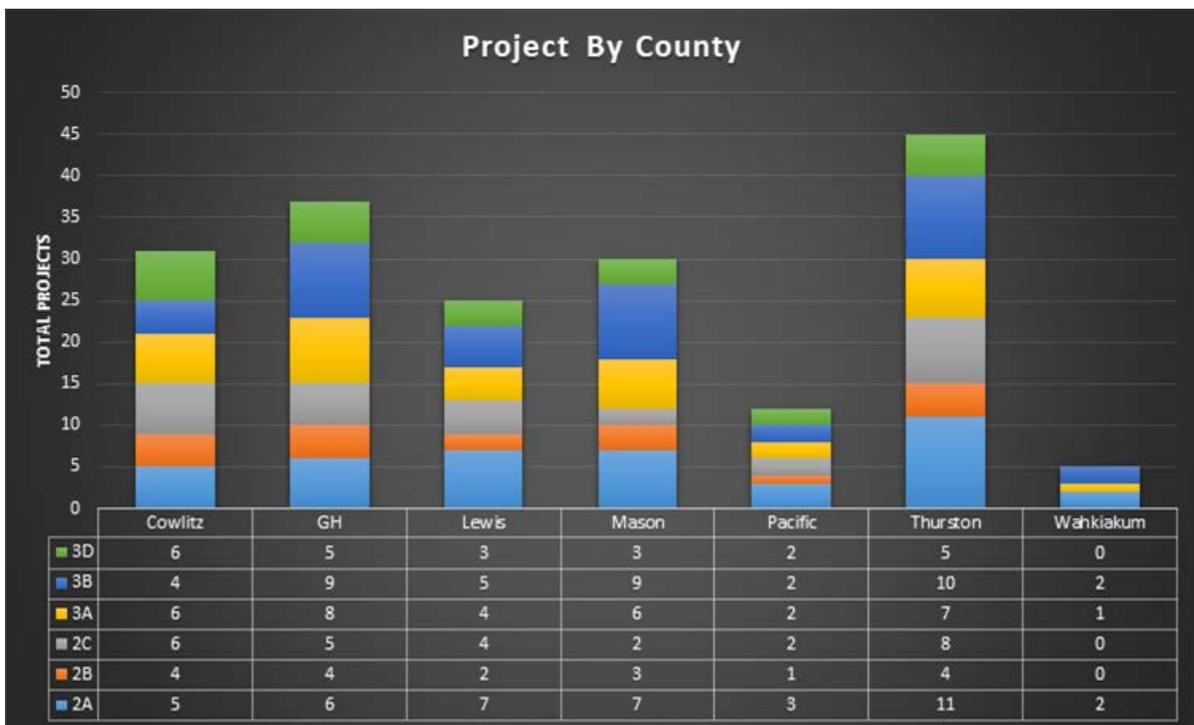


Table 5: MTP Implementation Partners by Project and County



To mitigate the risk of not impacting sufficient transformation in the region, CPAA has been actively working to address communication barriers inherent to the traditionally siloed healthcare service delivery services between partners by promoting networking throughout the region, facilitating

partnerships that will impact the region well beyond the MTP. The first networking activity was an MTP Kick-Off Event, held on October 11, 2018 (Appendix H). Paid implementation partners, tribes, members of the Consumer Advisory Committee, and the stakeholders who make up the CPAA Council networked, met the MTP program managers, and learned more about the MTP projects that will be implemented throughout the region beginning in January 2019. Our partners have articulated the need to build stronger community-clinical linkages throughout the region, and based on the success of the MTP Kick-Off Event, CPAA is planning more events specifically for partner networking and project collaboration, including an event scheduled February 27, 2019.

Executed Contracts and Approved Change Plans

In order to ensure alignment with the state MTP goals and mitigate the risk of not sufficiently impacting regional transformation, CPAA secured contracts with the selected implementation partners, traditional, non-traditional, and tribal, based on the projects they were selected for. The contracts detail the responsibilities of both parties and include key components such as: compliance with the terms of the contract, conditions for and distribution of DSRIP funds, and adherence to product request as stated in the contract Scope of Work such as implementation criteria, participation in collaborative endeavors, reporting requirements, performance elements, and project milestones.

To mitigate the risk of overly burdensome reporting, particularly with the smaller, community-based social service organizations critical to the success of the MTP, CPAA's goal is to place minimal reporting requirements on our partnering providers while providing CPAA with an effective performance monitoring tool that provides timely performance data so that we can actively monitor and track partnering provider performance. CPAA will monitor these commitments by tracking quarterly progress on project implementation milestones and semi-annual reporting of interim performance measures per agreed upon contracts with partnering providers.

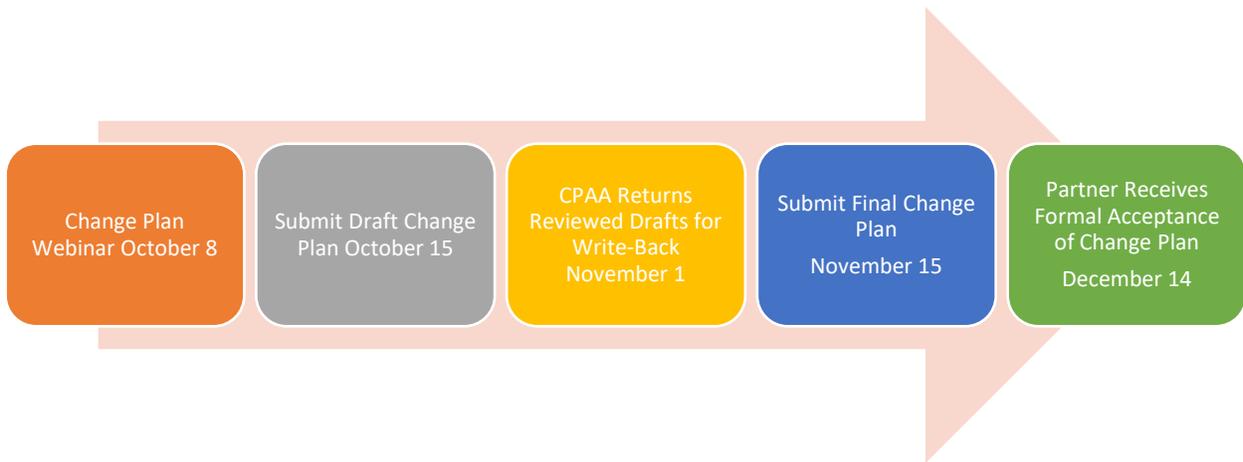
CPAA required all implementation partners, including tribes and community-based organizations, to complete a Change Plan detailing their work. After working internally to draft a concise Change Plan template that sufficiently captured all the necessary implementation information without being overly burdensome for organizations to complete, CPAA solicited the advice of the Clinical Advisory Committee and a focus group of beta-testers (including a clinical provider, a small, non-clinical community-based organization, a tribal partner, a MCO, and a public health department) to ensure the Change Plan template was satisfactory for each provider setting. After receiving feedback from the different types of organizations and partners, CPAA made the requested adjustments to the Change Plan template (Appendix I) before widely distributing it to the network of Implementation Partners on September 21, 2018. Change Plan drafts were due November 15, 2018, with final submission and approval by December 14, 2018.

CPAA is keenly aware a well-developed Change Plan with clearly articulated expectations is critical to project success, ensures partner understanding of broader regional transformation goals, and is necessary to monitor progress in upcoming years. Specifically aiming to further reduce administrative burdens and to assist implementation partners, the Change Plan template for all partners (clinical, CBOs,

public health, and tribes) was prepopulated as much as possible, and CPAA encouraged partners to pull information and activities directly from their organization’s response to the RFP. To assist in filling out the template and to minimize write-backs, CPAA provided each partner a Change Plan Development Form (Appendix J), which included specific feedback and recommendations to strengthen their organization’s Change Plan based on their response to CPAA’s RFP.

Additionally, CPAA hosted a “virtual town hall” webinar on October 8, 2018, to publicly answer Change Plan questions and walk partners through the Change Plan process. CPAA required some organizations to consult with program managers before completing their Change Plan, and directors and managers were also available to any organization to assist in filling out the Change Plan if requested. CPAA’s Tribal Liaison close worked with each of the seven tribes individually to assist in filling out their Change Plans.

Table 6: MTP Change Plan Timeline



Each organization’s approved Change Plan will be used throughout the entire MTP by both the organization and CPAA. It will outline all reporting requirements, help develop MTP organizational goals specific to project area/s, and measure implementation successes: the activities listed in each Change Plan will detail the logical sequence of transformative events over the next four years that will result in each organization achieving MTP goals and vision of improved healthcare. Each Change Plan defines critical paths and key dependencies. The Change Plans are intended to be useable, working documents, and they can be updated as necessary throughout the MTP.

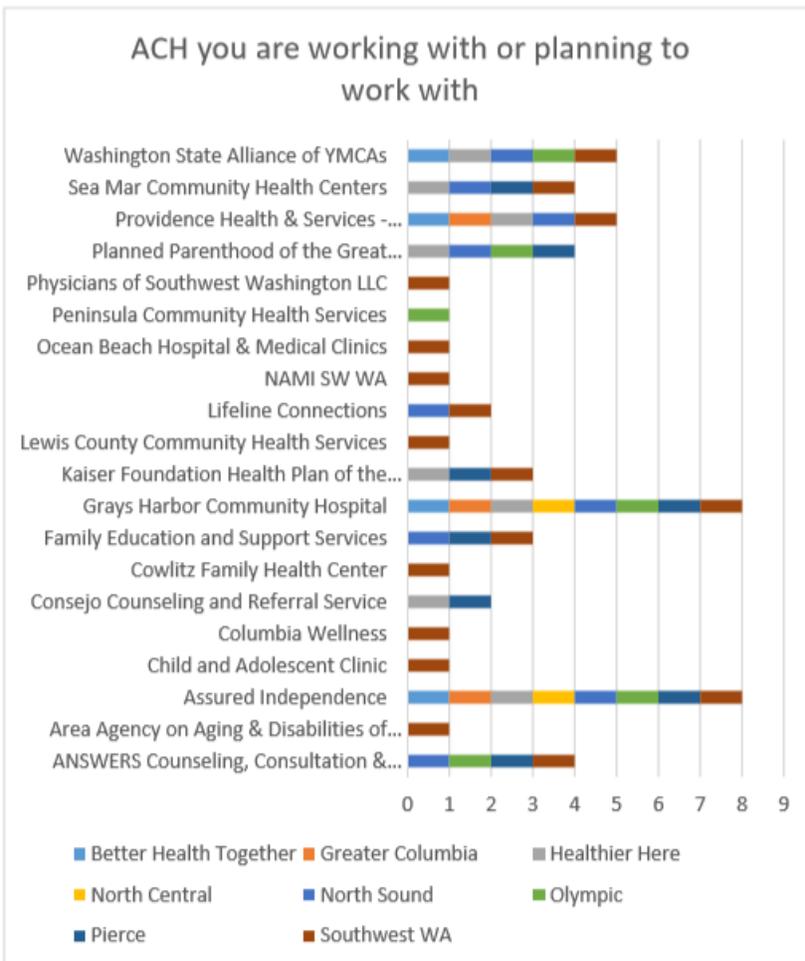
Interim Measures

As outlined in the contracts, implementation partners are required to report on Change Plan milestones quarterly and interim measures semi-annually. Interim measures are a combination of HCA measures (for projects 2A and 3A), CPAA measures, and proxy measures developed by partners and approved by CPAA based on the Implementation Plan and data available to partners. CPAA worked with Providence CORE (CORE) to determine what measures to be reported for each evidence-based intervention. By carefully choosing exactly what information needs to be captured and not asking for more, CPAA aims to

ensure milestone achievement and alignment with state MTP goal while minimizing our partnering providers’ administrative efforts and expenses throughout the entire MTP period. CPAA Operations reviewed the metrics, milestones, and Change Plan templates and intentionally kept contracting with implementation partners as simple as possible, with minimal administrative burdens. Interim measures were released to implementation partners in conjunction with the Change Plan template on September 21, 2018 (Appendix K).

To coordinate and streamline reporting tools to reduce burdens on providers working with multiple ACHs, CPAA shared interim measures with all ACHs and contributed to cross-ACH discussions on how to minimize reporting requirements for organizations who serve residents across ACH boundaries. CPAA collected data on those partnering providers working with multiple ACHs in the RFP. Now that MTP Implementation Partners have been selected, CPAA knows 20 of 44 MTP implementation partners are working with other ACHs in addition to CPAA. With this knowledge, CPAA can assess individual partner’s challenges and work on how best to overcome them.

Table 7: CPAA MTP Implementation Partners Working with Other ACHs



CPAA will combine all measures into a web-based reporting tool, currently still under development, which providers must submit by the end of the first month following every quarter. CPAA will host a webinar to walk partners through the tool once it is completed, at a date to be determined before the first reports are due April 30, 2019. The reporting tool will feed directly into Tableau, which will be administered by CPAA. CPAA will issue performance dashboards to partners no later than the last day of the second month following every quarter. To mitigate the risk of not sufficiently impacting regional transformation, the set measures will detect when implementation challenges are encountered. This will allow partners to make timely, informed decisions for improving outcomes and meeting project metrics.

Table 8: Quarterly Reporting

Quarter 1 (Jan-Mar)	*Quarter 2 (Apr-Jun)	Quarter 3 (Jul-Sep)	*Quarter 4 (Oct-Dec)
1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics	1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics 3. Change Plan Update
April 30, 2019	July 31, 2019	October 31, 2019	January 31, 2020
April 30, 2020	July 31, 2020	October 31, 2020	January 31, 2021
April 30, 2021	July 31, 2021	October 31, 2021	January 31, 2022
April 30, 2022	July 31, 2022	October 31, 2022	January 31, 2023

3. Did the ACH make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
	X

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response:

Not applicable.

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid

duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
Meeting between CPAA, SWACH, North Sound ACH, and PeaceHealth, a health system located within the three ACHS	Share how ACHs are partnering with PeaceHealth and potential opportunities to work collaboratively	CPAA shared the contract, Change Plan template, and interim measures currently in place with PeaceHealth in the CPAA region
Molina Health Care regional ACH P4P report	Provide monthly reports on year-to-date performance for Molina members for the CPAA region by county	Molina serves over 50% of Medicaid beneficiaries our region; this monthly report allows CPAA to monitor progress in our region by monitoring current claims data
ACH MCO Collaborative Workgroup	Workgroup is dedicated to advancing consistency across regions, adopting proposals that have broad value and commitment, and identifying long-term viability and sustainability of the projects beyond the MTP	Five of the nine ACHs have reviewed the charter and are currently working on expanding the workgroup to all nine ACHs, MCOs, and HCA

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response:

During the reporting period, CPAA has continued to engage providers, organizations, and community partners that were not selected as one of the 50 paid implementation partners. This has been done

through the Capacity Development Fund, Local Community Forum RFP, and regional training and information sharing.

Capacity Development Fund

CPAA established a Capacity Development Fund with Year 1 funding, totally \$335,179, to engage providers and community partners that were not selected as paid implementation partners but provide specialty services that are critical to MTP success. CPAA is awarding \$15,000 per organization for the first year. CPAA will evaluate outcomes after one year and will re-evaluate at that time.

CPAA is currently finalizing a recommendation with the Finance Committee on how the remaining balance of the Capacity Development Fund will be spent. The priority will be addressing gaps in care or services in the region which will not be addressed through the six MTP project areas CPAA is currently engaged in.

Local Community Forums

Local Community Forums are currently operating in the majority of the seven-county CPAA region. To support strong Local Community Forums across the region, CPAA elected to formalized these partnerships and provide additional resources. CPAA released a Request for Proposals on November 27, 2018, to identify one Local Community Forum per county.

The RFP closed on January 11, 2019, and successful bidders will be announced January 25. CPAA budgeted \$25,198 for 2019 from the Health Capacity Development Fund for each local forum. Local forums will identify local health priorities, adopt shared regional priorities that align with the local action agenda, align activities between stakeholders, and implement local action. CPAA’s Outreach and Community Coordinator will be available to support the local forums, and CPAA will communicate regularly with the local forums to identify and reach out to providers and community organizations identified by the local forums as critical to MTP success.

Table 9: Local Forum RFP Timeline



Regional Training and Information Sharing

Due to limited funding, CPAA made the strategic decision to fund up to 50 MTP implementation partners. However, we also understand importance of keeping all providers and community organizations in the region engaged in the MTP to improve health outcomes in our region and to be truly transformative. CPAA is planning multiple opportunities in early 2019 that will be open to all providers the region. A few of the upcoming trainings and events, which are still in development, include:

- February 2019 – Networking Event. CPAA hosted an MTP Kick-Off Event in October 2018, which was very well attended and received by partners. After the success of the event, partners requested a more robust networking event to learn about what other organizations in the region are doing and how to align synergies. Partners will be encouraged to identify their own gaps and engage with organizations who can bridge those gaps to improve health outcomes of their clients while reducing cost.
 - March 2019 – Quality Improvement Conference. CPAA is currently finalizing the agenda for a regional quality improvement conference. We recognize quality improvement knowledge and capacity is greatly varied based on the size and type of organization. The conference will highlight a keynote speaker and feature breakout sessions, which organizations can choose based on current level of knowledge. Responding to partner requests for networking opportunities, the conference will also include time for networking.
 - April 2019 – Integrated Managed Care Learning Symposium. CPAA is currently in negotiations with an expert who can present on effective Managed Care Organization contracting and negotiations. This will be open to all behavioral health agencies in the region and help them know what to expect moving toward IMC in 2020.
 - Quarter 2 2019 – Data and Reporting Webinar. CPAA is planning a data and reporting webinar prior to the first Pay for Reporting period, at a date to be determined in early Q2. This webinar will review Pay for Performance measures in the CPAA region, using data to identify areas in our region with the poorest health outcomes. This will allow for providers and community organizations to make well-informed decisions on where to direct resources, as well as walk partners through the reporting tool that will track MTP outcomes.
3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

CPAA supported active MCO participation to allow for MCO input and send common signals to providers regarding Medicaid Transformation in several ways. Representatives from the MCOs sit on several CPAA committees and decision-making groups, including the CPAA Board, Finance Committee, Council, Clinical

Provider Advisory Committee, Consumer Advisory Committee, and project workgroups. In each of these different committees, MCOs are actively providing feedback and included in the decision-making process. Kat Latet with Community Health Plan of Washington serves on the CPAA Board as the MCO representative. Also, Caitlin Safford with Amerigroup has served as the Reproductive/Maternal & Child Health (formerly known as the ACEs) Workgroup Chair. In addition to the structures in place, MCOs were requested to sit on an ad hoc Request for Proposals committee to select MTP implementation partners.

CPAA staff also reached out specifically to MCOs to gather feedback on CPAA’s monitoring systems. This includes reviewing draft interim measures CPAA providers will collect and share with CPAA. MCOs participated in the review of those measures. Additionally, MCOs participated in the development of the Change Plan template to monitor provider performance and provide feedback.

MCOs are a crucial element to the future success and sustainability to Pathways. Staff have reached out to individuals at Molina, UnitedHealthcare, and Amerigroup to discuss Pathways. Several meetings have taken place with Molina and UnitedHealthcare to educate them about CPAA’s approach and gather their feedback about the program. Amerigroup has recently engaged and is requesting to meet soon about the Pathways program.

CPAA and its partners, including MCOs, participated in a Qualis IMC and VBP two-day conference November 1 and November 14, 2018, at Little Creek Casino in Shelton, WA. MCOs were involved in both trainings and participated in panel discussions. This allowed regional partners to better understand the timeline of MCOs moving toward IMC and VBP and how they can best engage.

F. Community engagement and health equity

- 1. Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

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

Yes	No
X	

- 2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”**

ACH response:

Not applicable.

3. Provide three examples of the ACH's community engagement⁴ and health equity⁵ activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

ACH response:

CPAA is firmly committed to continuing to prioritize improving health equity and community engagement. During this reporting period, the three activities that exemplify CPAA's commitment to community engagement and health equity include designating a full-time position specifically for community engagement, holding regular Consumer Advisory Committee meetings and being responsive to the ideas of those consumers, and set aside funding specifically targeting community engagement, improving health equity, and addressing social determinants of health.

Designated Position Specifically for Community Engagement

Just as CPAA understands that building trust with the federally recognized tribes in the region takes time, building trust with consumers is a difficult, time-consuming task. To sufficiently support both community and tribal engagement, CPAA made the decision during this reporting period to separate the Community and Tribal Liaison role into two positions. While the Outreach and Community Coordinator position remains unfilled, CPAA is currently interviewing for a full-time staff member dedicated to community engagement.

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 LGBTQ community. CPAA is continuing to actively recruit 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 (Appendix L).

Many members of the Consumer Advisory 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

⁴ Community engagement is defined as 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.

⁵ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

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 LGBTQ community, including from health care providers. Statistically, ethnic and racial minorities experience 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. Ensuring consumers have a dedicated full-time staff position to support them will help ensure their priorities are being addressed.

Regular Consumer Meetings and Responsiveness to Consumer Opinions

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 monthly at a central location, but there is discussion of rotating the meetings within the region to make travelling more equitable for all committee members. Additionally, the Consumer Advisory Committee participated in the HCA's webinar about the MTP on October 4, 2018.

When the committee members felt the original stipend was insufficient to meet their time and expense traveling to regular meetings, a stipend increase proposal was brought before the CPAA Council and Board. The original stipend was \$45 a month to avoid possible disruption of benefits. Committee members, beginning January 2019, will have the option of receiving up to \$100 a month for regular meeting participation.

The challenge of conveying the complex, abstract nature of the Transformation work is being addressed by developing "plain talk" translations of program work. 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 Outreach and Community Coordinator will meet 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 their sector.

Dedicated Funding and Commitment to Local Forums

CPAA recognizes addressing health equity and improving foundational community supports is critical to improving overall health in the region. 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 payments for implementation partners based on attribution, equity, and services provided in rural communities.

CPAA established a Capacity Development Fund with Year 1 funding, totaling \$335,179, to engage providers and community partners that were not selected as paid implementation partners but provide specialty services that are critical to MTP success. CPAA is awarding \$15,000 per organization for the first year. CPAA will evaluate outcomes after one year and will re-evaluate at that time. CPAA is currently finalizing a recommendation with the Finance Committee on how the remaining balance of the Capacity Development Fund will be spent. The priority will be addressing gaps in care or services in the region which will not be addressed through the six MTP project areas CPAA is currently engaged in.

Additionally, CPAA set aside \$940,715 for the Regional Wellness Fund, which is a pool of funds available to support investments in smaller, community-based organizations that address social determinants of health. While the mechanism for payment is still under development, these funds will be used to make targeted upstream investments in community-clinical linkages that complement and support MTP goals and investments such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods. The fact that many of our partners already routinely assess for 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. Moving forward, CPAA intends to encourage partners to scale up both assessing for social support needs and facilitate linkages and referrals to the CBOs and social service organizations that address social determinants of health. CPAA believes the availability of viable solutions and connections to community-based supports will encourage more clinical providers to assess for social support needs in their most vulnerable patients. The target population for this fund is the most economically disadvantaged and vulnerable residents who experience the greatest health disparities. CPAA plans to utilize Local Forums to identify local needs to make the most impact with these investments.

Local Community Forums are currently operating in the majority of the seven-county CPAA region. To support strong Local Community Forums across the region, CPAA elected to formalized these partnerships and provide additional resources. CPAA released a Request for Proposals on November 27, 2018, to identify one Local Community Forum per county. CPAA budgeted \$25,198 for 2019 from the Health Capacity Development Fund for each local forum. Local forums will identify local health priorities, adopt shared regional priorities that align with the local action agenda, align activities between stakeholders, and implement local action. CPAA's Outreach and Community Coordinator will be available to support the local forums. CPAA will communicate regularly with the local forums to identify and reach out to providers and community organizations identified by the local forums as critical to MTP success.

G. 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 December 31, 2018.

1. Design Funds

Please see tab 3.G.1 of the semi-annual report workbook, CPAA.SAR2.Workbook.1.31.19.

2. **Earned Project Incentives**

Please see tab 3.G.2 of the semi-annual report workbook, CPAA.SAR2.Workbook.1.31.19.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

CPAA allocated \$3,285,272 in DY1 and \$674,880 in DY2 for Health Systems and Community Capacity, or Domain 1, investments intended to achieve short-term goals and/or broader transformation goals. CPAA has focused on providing technical assistance to partners for project implementation beginning in January 2019, as well as IT infrastructure investments related to the Pathways Community HUB.

1. AIMS Center Whole Person Care Training Program

- Our investment in the AIMS Center Whole Person Care Training Program intends to help partners develop and implement an integrated care program in primary care and behavioral health settings (Appendix M). Those enrolled will be guided to build and further enhance their current work to meet the Bree Collaborative's Behavioral Health Report and Recommendations and/or the Collaborative Care Model. This is intended to meet short-term and broad transformation goals to improve whole person care in the CPAA region. This training program includes implementing the AIMS Center Caseload Tracker, which is a specific population health strategy for project 2A. This training program is in addition to a summer webinar series (Appendix N), which provided an introduction to the concepts explored in the training program.

2. Pathways CCS and Health Bridge Software & Training

- As the Pathways Community HUB, CPAA has taken on the cost of a single community health records system that will be deployed to all participating partners across the CPAA region, along with training costs to educate partners on how to use the system and additional training on the Pathways model and general care coordination knowledge and skills. We purchased an add-on module to the system to create an online referral portal for all social and health services in our region that will be freely available to any organization choosing to participate. The information technology platform has already improved workflows for data entry among our Care Coordinating Agency partners, and during the Transformation Project time period will allow for data analysis that will provide CPAA partners with a better

understanding of population needs and barriers to accessing services. For future years, Pathways is exploring contracting with MCOs within the CPAA region to provide infrastructure and sustainability investments designed to continue care coordination through Pathways Community HUB after the Medicaid Transformation Project sunsets.

3. Qualis Health

- As the Transformation Hub sunsets in January 2019, CPAA recognizes the need for ongoing technical support for implementation partners. CPAA will contract with Qualis Health to provide technical support for up to 25 organizations that request support implementing any of the six projects areas. The focus may include, but is not limited to, process improvement, utilization of data, optimization of EHR reports, workflow workshops, staff training, forging community-clinical linkages, care coordination across settings, and project management.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly **describe the use or intended use of these funds** to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are **linked to Medicaid Transformation goals**.

ACH response:

While fund distribution methodology is still under development for both the Capacity Building Fund and the Regional Wellness Fund, CPAA set aside a pool of funds available to support investments in smaller, community-based organizations that address social determinants of health. These funds will be used to make targeted upstream investments in community-clinical linkages that complement and support MTP goals and investments such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods. Moving forward, CPAA intends to encourage partners to scale up both assessing for social support needs and facilitate linkages and referrals between providers, CBOs, and social service organizations that address social determinants of health. CPAA believes the availability of viable solutions and connections to community-based supports will encourage more clinical providers to assess for social support needs in their most vulnerable patients. The target population for this fund is the most economically disadvantaged and vulnerable residents who experience the greatest health disparities. CPAA plans to utilize Local Forums to identify local needs to make the most impact with these investments.

Working in conjunction with OHSU, CPAA developed an initial strategic framework as a way to assess opportunities for investing Capacity Building, Regional Wellness, and domain 1 funds (Appendix O). Focusing beyond the MTP, CPAA sees opportunities that ensure deliverables are met in the region by building cross-sector cohesion, collaboration, and sustainability. This framework will be applied as a lens for all future and ongoing investment opportunities and prioritizes investments that address health equity, increase organizational and partner capacity, ensure project success, create community and clinical integration, and ultimately sustain the ACH network in the region.

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁶

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.
 - b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
 - c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Please see tab 4.A in the semi-annual report workbook, CPAA.SAR2.Workbook.1.31.19.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities **at the clinic/site-level**? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response:

CPAA has established an Access Database to track partnering provider participation in MTP activities at the clinic/site level. For each partnering organization involved in the MTP, the Access Database tracks

⁶ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

project areas, interventions, and self-identified milestone. Additionally, the Access Database tracks broad communications to partners, contracts, funding, TA requests, and relevant internal notes and communications.

When CPAA’s reporting tool, still under development, is complete, it will be embedded in the Access Database so CPAA can ensure goals and milestones are met and swift action is taken if they are not.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

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

Yes	No
	X

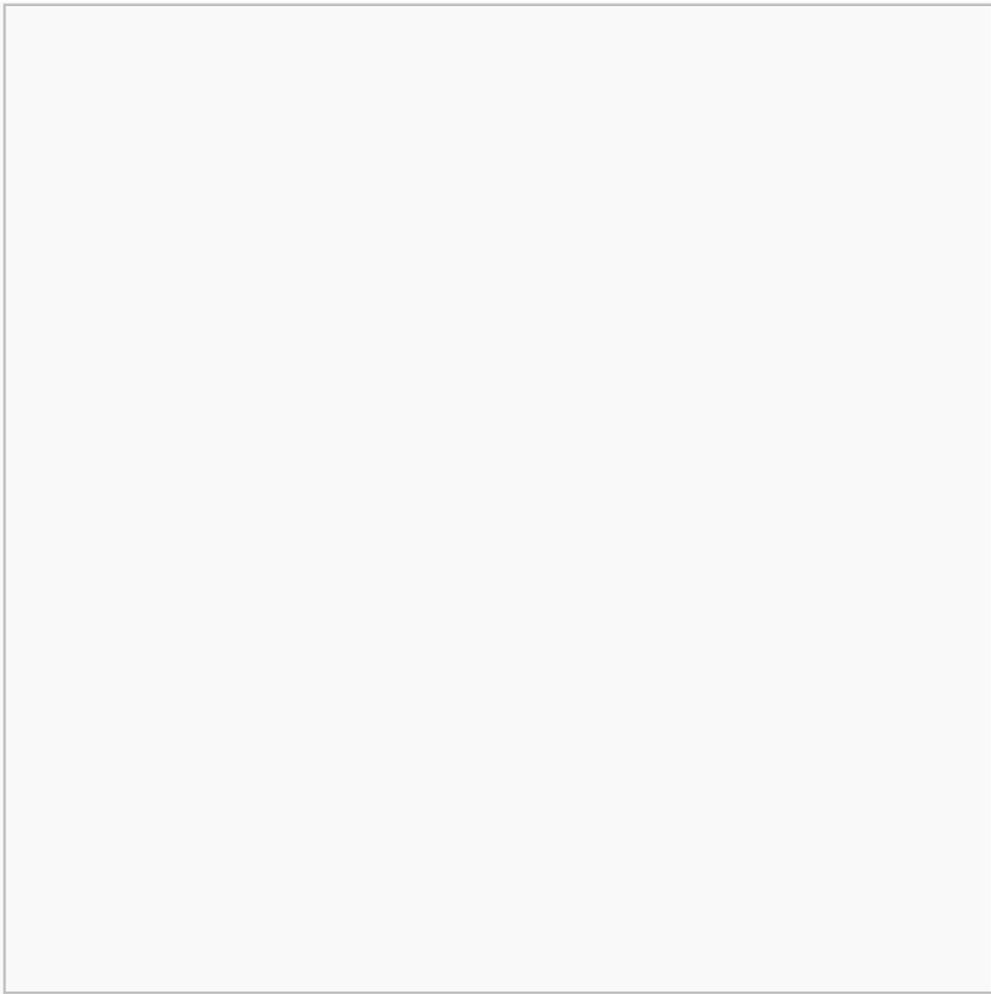
CPAA is a 2020 Adopter. Not Applicable.

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

CPAA is a 2020 Adopter. Not Applicable

Appendixes



CPAA Shares Value-Based Payment Information and Materials

Dear CPAA MTP Implementation Partners,

The Medicaid Transformation Project aims to improve the health system by addressing local health priorities, improving population health, and reducing the per capita cost of health care. One key area of improvement is transitioning away from volume-based payment models to advanced value-based payment (VBP) arrangements. The Health Care Authority (HCA) is leading a statewide effort to achieve the goal of 90% value-based payment contracting by 2021.

CPAA is beginning an awareness campaign in 2018 to share resources, educational materials, and VBP tools with partner organizations to support regional VBP goals. Below are links to several one-pagers sourced from HCA's Value-Based Roadmap 2018-2021 & Beyond ([click here to view entire](#)

[document](#)) which provide a brief description, desired outcome, and challenges as they relate to various VBP initiatives.

- [State Innovation Models Grant](#)
- [Healthier Washington Medicaid Transformation](#)
- [Integrated Managed Care](#)
- [Managed Care Organization Premium Withhold](#)
- [Performance Measures](#)
- [Rural Multi-Payer Model](#)
- [Accountable Communities of Health](#)
- [Value-Based Payment Practice Transformation Academy](#)
- [Alternative Payment Methodology 4](#)
- [Payment Model 4: Multi-Payer Data Aggregation Pilot](#)
- [Prescription Drug Program](#)

Please review and share these documents as applicable for your organization.

CPAA will continue to regularly share VBP resources, news, and updates from across the state. Please feel free to contact Kyle Roesler with any questions: roeslerk@crhn.org. Thank you.



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You are receiving this email because you have been identified as an interested stakeholder in our region's Accountable Community of Health.

Our mailing address is:

CHOICE Regional Health Network
1217 4th Ave E Ste 200
Olympia, WA 98506-4246

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You can [update your preferences](#) or [unsubscribe from this list](#).

[View this email in your browser](#)



CPAA Shares Value-Based Payment Information and Materials

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CPAA will continue to regularly share VBP resources, news, and updates from across the state. Please feel free to contact Kyle Roesler with any questions: roeslerk@crhn.org. Thank you.



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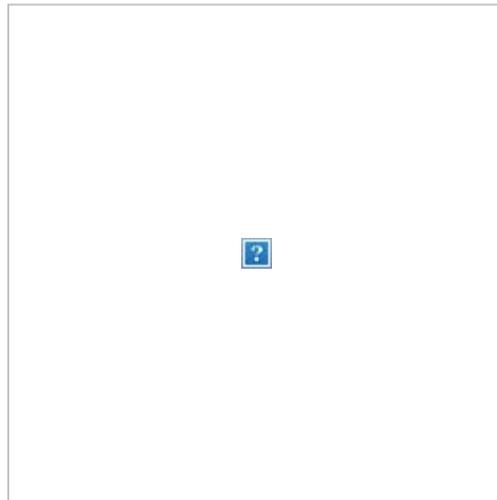
Want to change how you receive these emails?
You can [update your preferences](#) or [unsubscribe from this list](#).



From: Jennifer Brackeen
To: [Christina Mitchell](#)
Subject: CPAA July News
Date: Tuesday, July 24, 2018 8:15:09 AM

Email not displaying correctly?
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Cascade Pacific Action Alliance
Monthly Newsletter



July 2018

Annual HCA Value-Based Payment Survey

Cascade Pacific Action Alliance (CPAA) is working with the Washington State Health Care Authority on its annual survey to measure the use of value-based payments among Washington State providers. This survey will provide valuable insight into the challenges providers face as they consider adopting new payments and will help guide the HCA in assisting in that transition.

The survey is designed to be filled out by an administrative leader with consultation from clinicians. Only one response per organization, please. It should take no more than 30 minutes to complete.

CPAA is encouraging partnering providers to participate in the Value-Based Payment Survey. [Click here to access the survey.](#) If you prefer to fill out the survey via phone with HCA assistance, contact payingforvalue@hca.wa.org to set up a time.

There is a section within the survey that allows HCA to share results with CPAA; we encourage you to permit sharing your results with us. It will reduce the need for additional surveys that would collect the same type of information.

Upcoming Events, Dates, and Meetings

AIMS Center Webinar - Billing and Sustainability

July 25
12:00 - 1:00pm

ACEs Work Group

July 25
3:15 - 5:15pm

Reception Honoring Winfried Danke

July 26
5:00 - 7:00pm

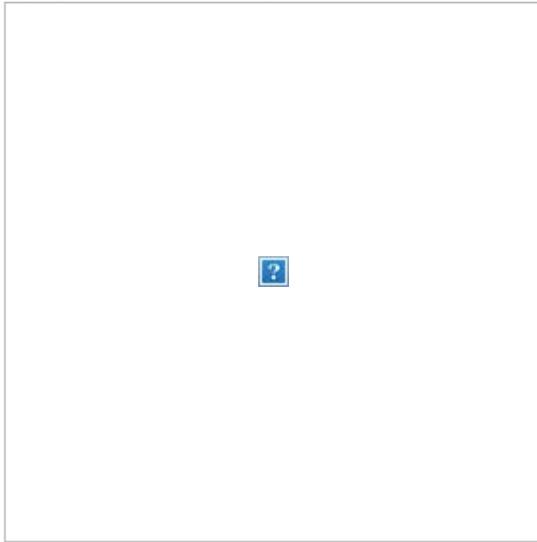
Care Integration Work Group

July 31
9:00 - 10:30am

Chronic Disease Work Group

July 31
10:45am - 12:15pm

Please complete the survey by **3:00pm August 31** and send it to: payingforvalue@hca.wa.org



Hot Topics in Whole Person Care: A Summer Webinar Series

CPAA, in collaboration with the University of Washington AIMS Center, is offering a summer webinar series covering requested topics related to whole person care. These training efforts are intended to support organizations in the CPAA region to meet the Bree Collaborative Recommendations or Collaborative Care Model, as outlined in the MTP 2A toolkit.

- Introduction to Whole Person Care for Community Behavioral Health Agencies - Wednesday, July 11 12-1:00pm
- Billing and Sustainability Considerations - Wednesday, July 25 12-1:00pm
- Hiring and Staffing an Integrated Team - Wednesday, August 8 12-1:00pm
- Measurement-Based Care and Using a Registry to Track Outcomes - Wednesday, August 22 12-1:00pm

[Click this link for more information and to register.](#) Contact Kyle Roesler with questions or concerns: roeslerk@crhn.org

Transitional Care Work Group

July 31
1:30 - 3:00pm

Care Coordination Work Group

July 31
3:15 - 4:45pm

AIMS Center Webinar - Hiring and Staffing

August 8
12:00 - 1:00pm

No August Council Meeting

The August Council and Board meetings have been canceled. **There will not be a CPAA Council Meeting on August 9th.** The next Council meeting will be September 13, 2018.

Nominate Outstanding Health Care Providers

The WA State Department of Health is accepting nomination for the **2018 Featherstone Reid Award for Excellence in Health Care**. The award recognizes and honors providers who exhibit exceptional quality and value in the delivery of health services. There are two award categories: individual and facility. Do you know an exception provider or facility that deserves recognition? [Click this link to nominate them today.](#)

Health Workforce

From: [Megan Moore](#) on behalf of [John Masterson](#)
Subject: WA HCA Annual Survey
Date: Monday, August 13, 2018 12:33:48 PM
Attachments: [Provider VBP Survey Template 2018.xlsx](#)

Dear CPAA Partner,

We included an invitation in the last two newsletters to participate in the Washington State Health Care Authority's annual survey to measure the use of value-based payments among Washington State providers. The survey template is attached for your convenience.

If you have not already done so, please send the completed survey by 3 p.m. August 31 to PayingforValue@hca.wa.gov.

The survey is designed to be filled out by an administrative leader, with consultation where necessary from clinicians, and with only one response per organization. It should take no more than 30 minutes to complete.

The survey includes five sections: Provider Information; Participation in VBP; Health Disparities & Health Equity; Integration, Workforce, & Technical Support; and Attestation. The financial questions included in the second section refer to the 2017 calendar year (January 1 to December 31, 2017).

There is a section within the survey that allows HCA to share your results with CPAA. **I encourage you to permit sharing your results with us, as it will reduce the need for additional surveys that would ultimately collect the same type of information.** We will not use survey results for any purposes other than to inform how we might best serve your needs.

Again, please send the completed survey by 3 p.m. August 31 to PayingforValue@hca.wa.gov.

Thank you for your time,

John Masterson
Interim Executive Director

Megan Moore | Executive Assistant
CHOICE Regional Health Network
Cascade Pacific Action Alliance
1217 4th Ave E, Suite 200 • Olympia, WA 98506
p. 360.539.7576 ext. 101 • f. 360.943.1164
moorem@crhn.org | www.crhn.org | www.cpaawa.org

Behavioral Health Administration
Office of Consumer Partnerships

Transforming
Lives



Great Rivers

Behavioral Health Integration Forum

For those in services, their families, and supporters

When: September 17th, 2018

Time: 11:00 am - 4:00 pm

Location: Cascade Mental Health Care
2428 W Reynolds Ave
Centralia WA 98531

Free Pizza! Free Raffles!

Great Networking!

Amazing Information!

Learn about changes planned in your area in 2020!

- Review recovery principles with Mary Jadwisiak, Holding the Hope, and Jennifer Bliss, Manager of the Office of Consumer Partnerships
- Find out how integration will affect you. Meet and talk with representatives from:
 - your Accountable Community of Health
 - the Health Care Authority
 - the new Managed Care Organizations that will soon be authorizing your services
- Discuss strengths and needs in your area, including:
Recovery Consumer voice Peer support
- Ask the questions that are on your mind—and express any concerns



To register for the integration forum, please visit:
<http://dbhrforums.eventbrite.com>



Integrated Managed Care Changes and Our Most Vulnerable in 2019/2020

Join the Thurston Asset Building Coalition and the Safety Net Council
July 24th for an in-depth exchange at the **Behavioral Health Forum**

Washington Health Care Authority

Community Services NW

NAMI - National Alliance on Mental Illness

MCOs - Molina Healthcare, United Healthcare and Amerigroup

Behavioral Health Forum

Our Most Vulnerable in 2019/2020



Save the Date

July 24, 2018

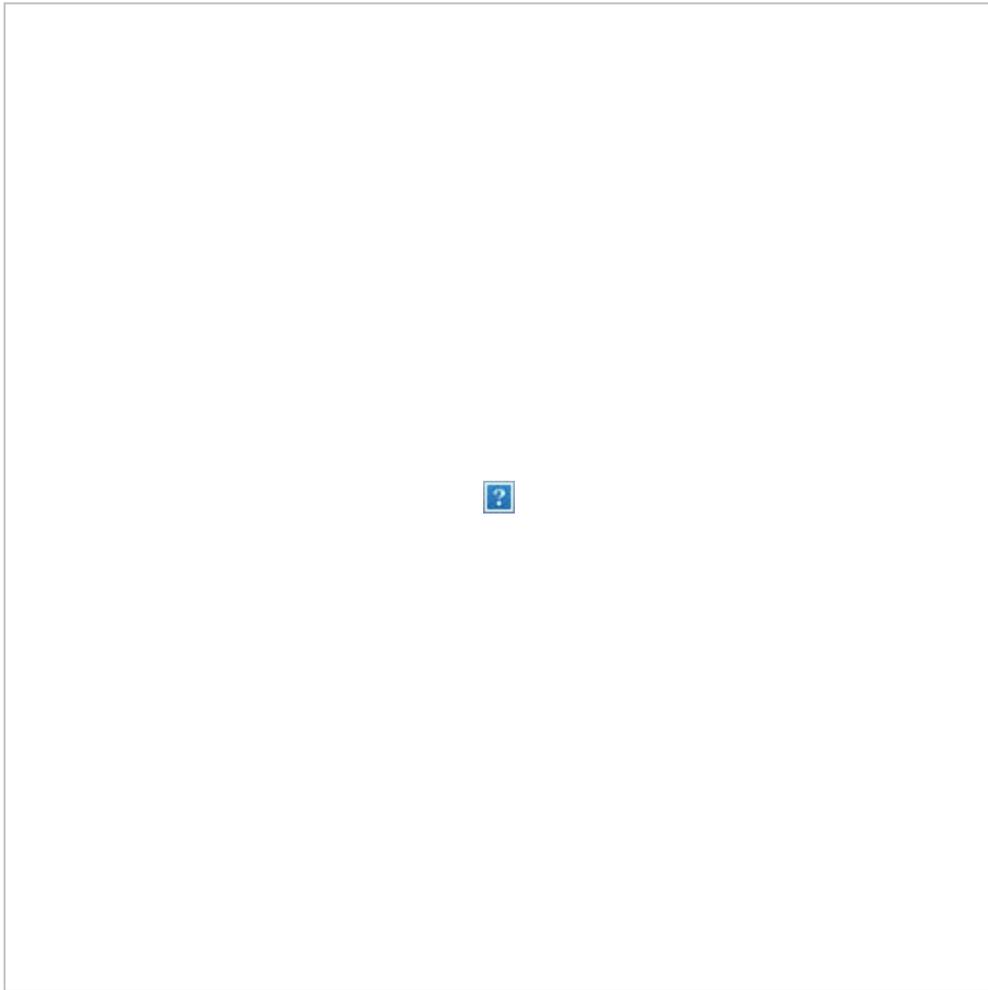
9:30 AM - 12 PM

SPSCC Lacey

www.thurstonabc.org/events

From: [Jennifer Brackeen](#)
To: [Carol Palay](#)
Subject: CPAA Announces MTP Implementation Partners
Date: Wednesday, August 22, 2018 9:26:38 AM

[View this email in your browser](#)



CPAA Announces Medicaid Transformation Project Implementation Partners

CPAA, through an independent assessor, has selected 44 organizations, in addition to the 7 federally recognized tribes, to be part of CPAA's network of paid MTP Implementation Partners. We are looking forward to this new phase of health care delivery system transformation work. Congratulations to the following partners:

ANSWERS Counseling, Consultation, and CM
Area Agency on Aging & Disabilities of SW Washington

Behavioral Health Resources
Capital Recovery Center
Cascade Mental Health Care
Catholic Community Services Family Behavioral Health
Child and Adolescent Clinic
Child Care Action Council
Coastal Community Action Program
Columbia Wellness
Community Action Council
Community Youth Services
Confederated Tribes of the Chehalis
Consejo Counseling and Referral Services
CORE Health
Cowlitz Family Health Center
Cowlitz Indian Tribe
ESD 113
Gather Church
Grays Harbor Community Hospital
Kaiser Foundation Health Plan of the Northwest
Lewis County Community Health Services (Valley View)
Lewis County Sheriff's Department
Lifeline Connections
Longview Fire Department
Lower Columbia CAPS
Mason County Public Health
Mason General Hospital and Family of Clinics
Morton General Hospital
Nisqually Indian Tribe
Northwest Pediatric Center
Ocean Beach Hospital and Medical Clinics
Olympia Pediatrics
Pacific County Public Health
PeaceHealth
Pediatric Associates
Peninsula Community Health Services
Physicians of Southwest Washington
Planned Parenthood
Providence Health & Services

Quinault Indian Nation
Sea Mar Community Health Centers
Shoalwater Bay Tribe
Skokomish Indian Tribe
Squaxin Island Tribe
Summit Pacific Medical Center
Thurston County Public Health
Wahkiakum Health and Human Services
Willapa Behavioral Health
Youth and Family Link
YWCA of Olympia

In the coming weeks, selected partners will receive an invitation to a CPAA MTP Implementation Partners kick-off event. This will be a casual event to celebrate the work they have done and provide an opportunity for partnering providers across the region to come together.

Additionally, due to Health Care Authority's (HCA) MTP implementation timeline, there will soon be multiple communications and required deliverables from CPAA to the Implementation Partners, including more information about CPAA's MTP Implementation Plan (submitted to HCA by October 1, 2018), memorandums of understanding/contracts for partners to sign, and a Change Plan template. CPAA leadership and staff are working to finalize pay for performance measures, reporting tools, and the Change Plan template, which we will send out in early September.

The Change Plan will function as a tool for Implementation Partner organizations to map out planning and implementation activities throughout the MTP. CPAA will provide specific feedback to strengthen the Change Plan based on the organizations' response to the RFP to ensure HCA's pay for performance requirements are met.

Please don't hesitate to contact us with any questions or concerns. For Bi-Directional Care Integration, Transitional Care, Opioid Response, and Chronic Disease, please contact Christina Mitchell: mitchellc@crhn.org. For Pathways and Reproductive/Maternal & Child Health, please contact Jennifer Brackeen: brackeenj@crhn.org.



Join Us

Medicaid Transformation Kick-Off Party

October

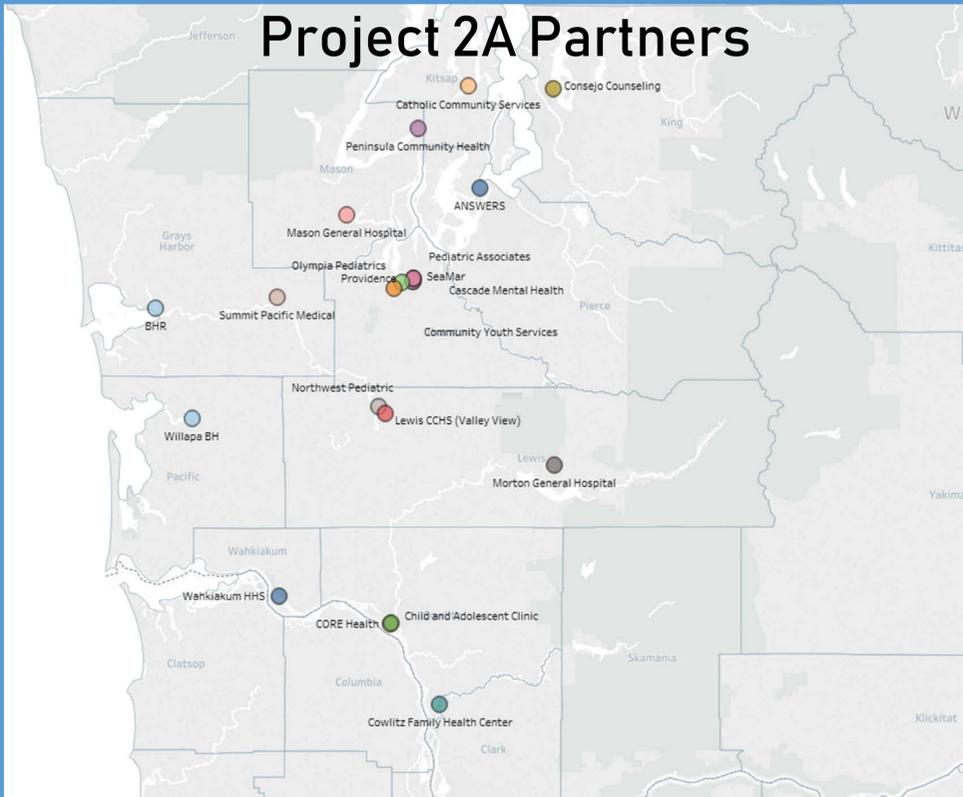
11

Interact with fellow Medicaid Transformation Partners, learn about the different program areas, and enjoy great food! The CPAA Council & Board meeting will follow.

2A: Bi-Directional Care Integration

Integrating Behavioral and Physical Health

Kyle Roesler, roeslerk@crhn.org



Did You Know?

20%

Medicaid beneficiaries have a behavioral health diagnosis

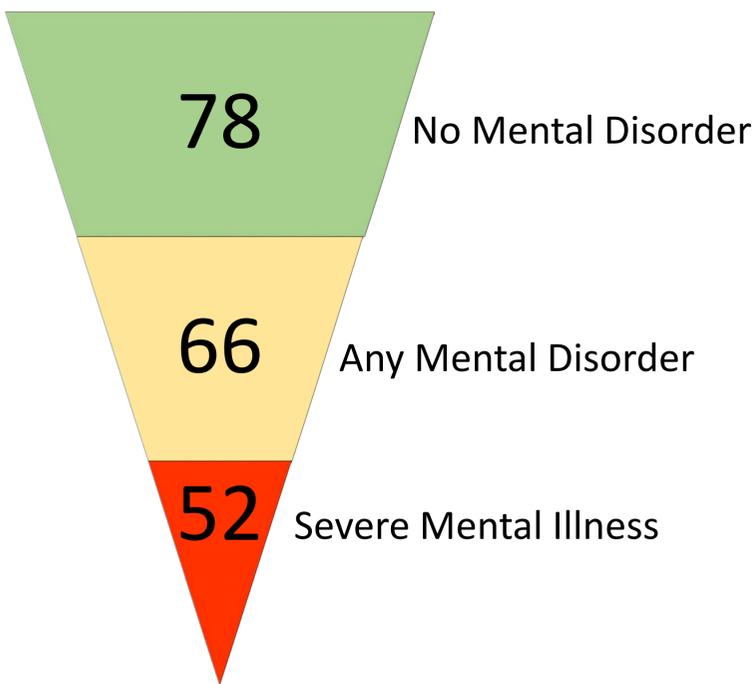
46%

Adults experiencing mental illness or a substance use disorder at some point in their lifetime

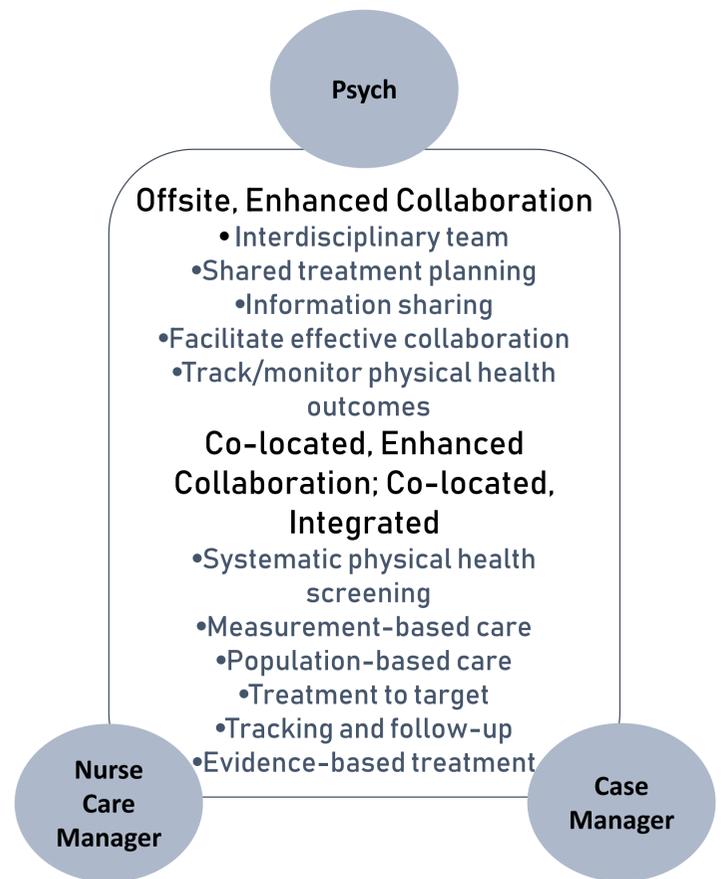
50%

Patients who receive a referral for specialty mental health care follow through with the referral

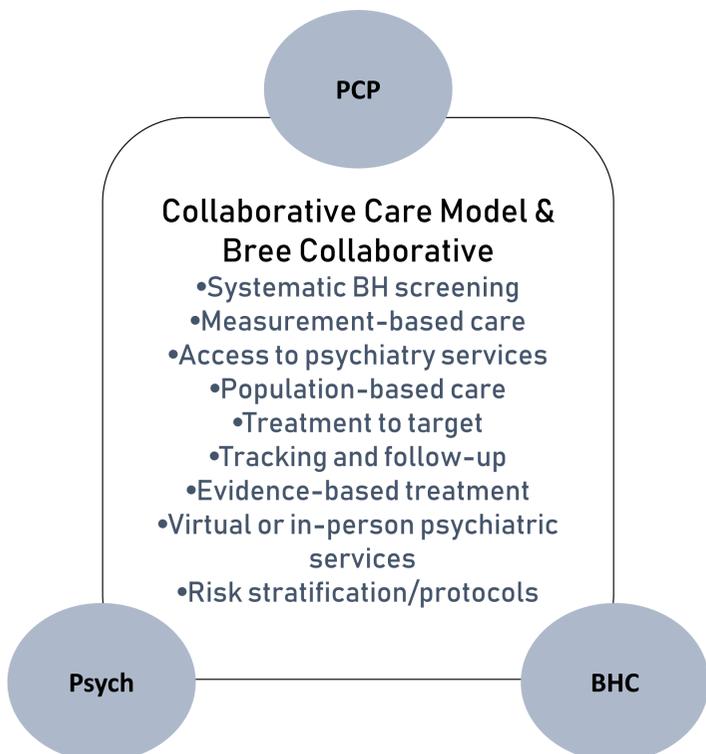
Average Life Expectancy



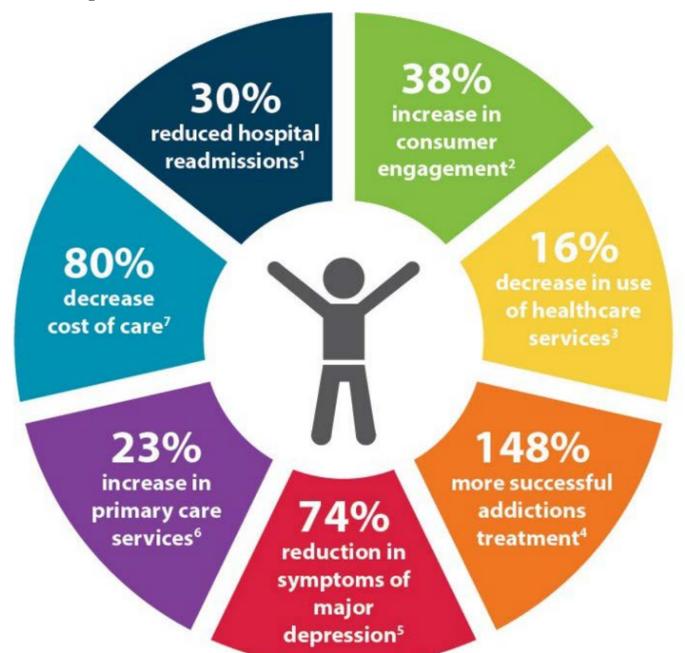
Physical Health Integration



Behavioral Health Integration



The Impact of Whole Person Care



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Bar 3: Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

1. Source: New York State Office of Mental Health. 2. Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). 3. Source: Robert Wood Johnson Foundation. 4. Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). 5. Source: American Psychological Association. 6. Source: Robert Wood Johnson Foundation. 7. Source: Robert Wood Johnson Foundation.

2B: Community Care Coordination

Michael O'Neill, oneillm@crhn.org



Systems Transformation

Establishing the CPAA Pathways HUB is a region-wide shared investment in infrastructure that will transform systems of care.

- Training & workforce development
- Capture and reinvest shared savings
- Robust Health Information Technology platform
- New data and broad partnerships to inform local and regional decision making

Pathways model benefits



Whole Person Design

Community Based Care Coordination

Delivered in the home or other community setting



Community Health Workers are gaining widespread recognition in Washington for their ability to authentically connect with and empower clients. Through trusting relationships that put client goals in the forefront, care coordination services will increase access and client engagement in their own care.

Find | Treat | Measure

Region-Wide Implementation

CPAA recognizes the need for region wide infrastructure improvements that increase coordination, and is committed to creating Pathways HUB capacity to serve all seven counties.

- Up to 400 clients by 2020
- Up to 4000 clients by 2022
- Pathways + additional coordination as feasible
- Online referral portal & resource directory (free for anyone to use)

Cohort I

- Peninsula Community Health Services
- Community Action Council
- Coastal CAP
- Sea Mar Community Health Centers
- Lower Columbia CAP
- Youth and Family LINK

Cohort II

- Mason General Hospital & Family of Clinics
- Summit Pacific Medical Center
- Physicians of Southwest WA
- Lifeline Connections
- Gather Church
- Area Agency on Aging & Disabilities of SW WA
- Love Overwhelming



2C: Transitional Care

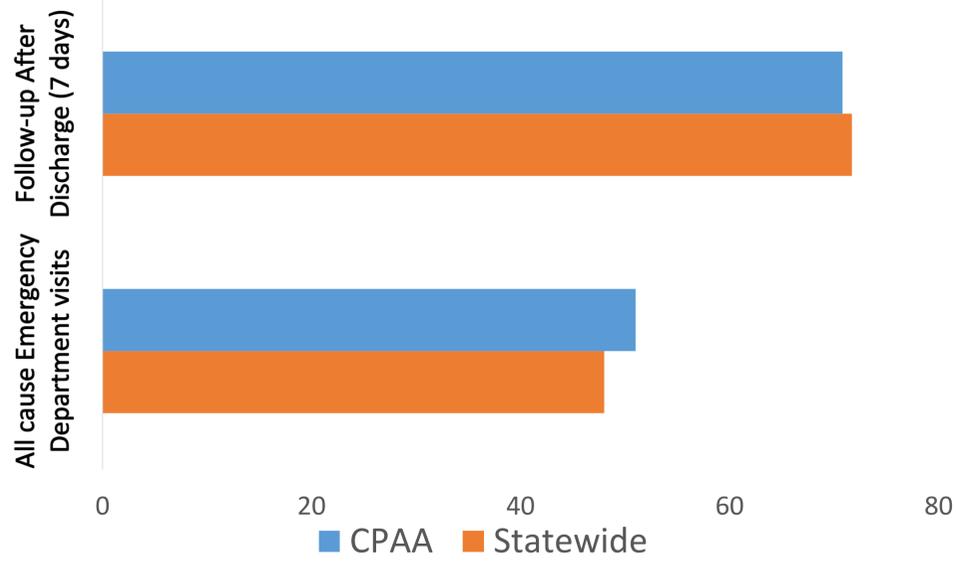
Alexandra Toney, Transitional Care Program Manager
toneya@crhn.org



Transitional Care Model Components



Data Snapshot



Grays Harbor

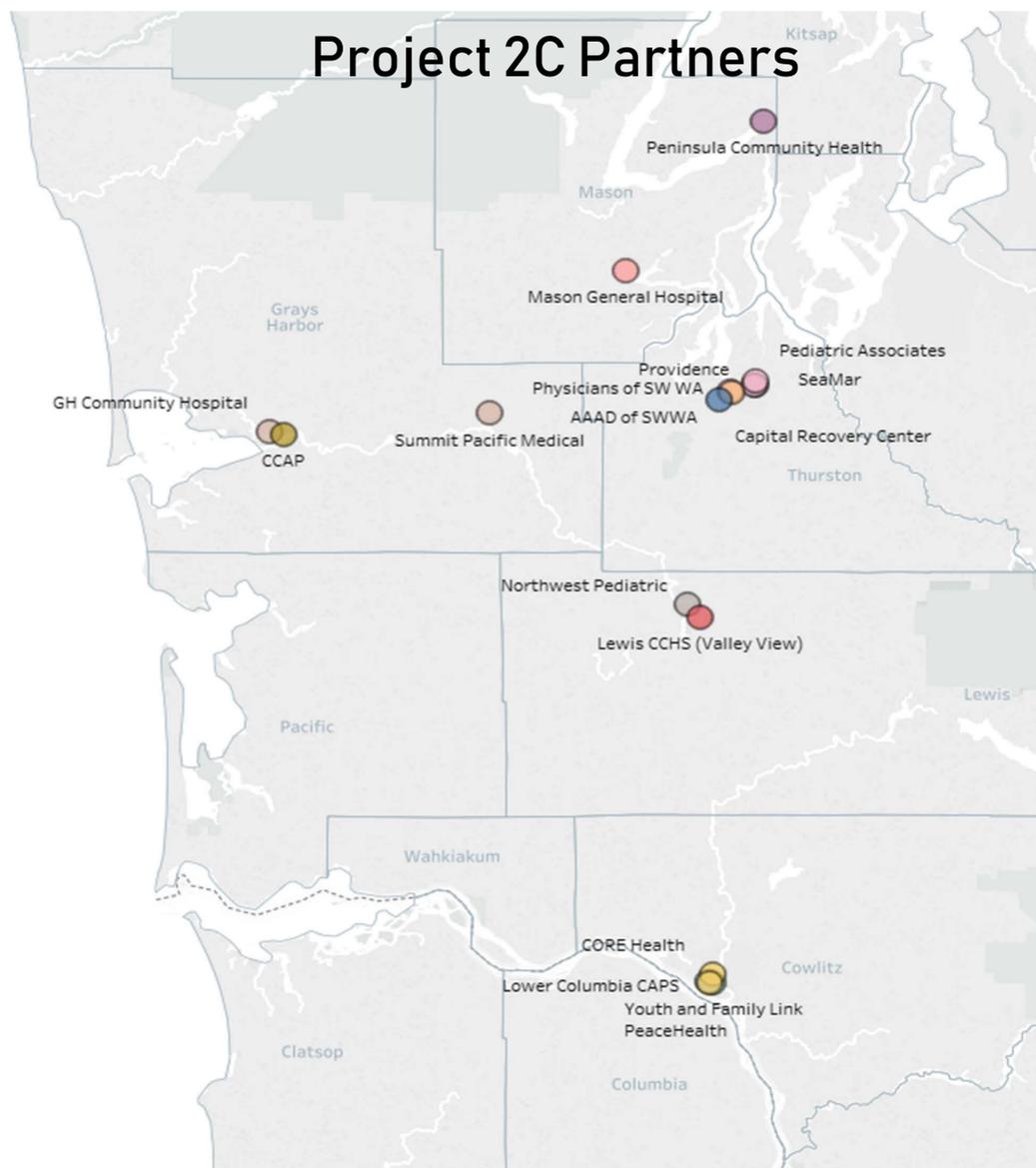
- 1 Patient Navigator
- 1 Transitional Care Model
- 1 Care Transition Intervention
- 1 Social Determinants of Health
- Other

Thurston County

- 3 Patient Navigator
- 1 Transitional Care Model
- 1 INTERACT Model
- Enhanced Registry
- 1 Social Determinants of Health
- Other

Pacific County

- 1 Transitional Care Model
- 1 Social Determinants of Health



Mason County

- 1 Transitional Care Model
- 1 Care Transition Interventions
- 2 Social Determinants of Health

Lewis

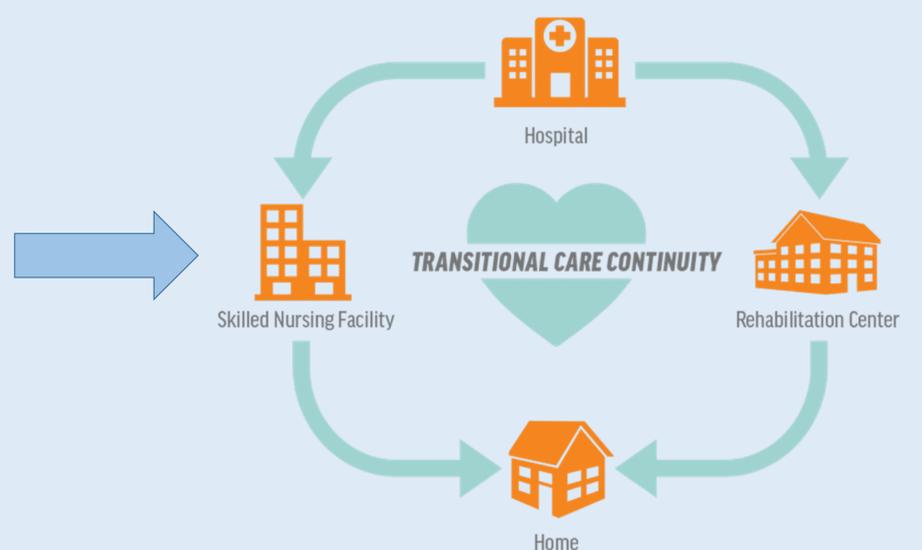
- 3 Patient Navigator
- 1 Transitional Care Model
- 1 Non-Emergency Medical Transport
- 1 Social Determinants of Health

Cowlitz

- 2 Patient Navigator
- 2 Transitional Care Model
- 2 Non-Emergency Medical Transport
- 4 Social Determinants of Health
- Other

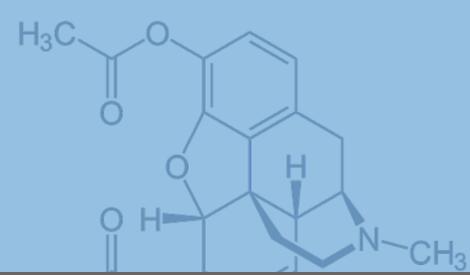
PROGRAM GOAL

Design a sustainable and coordinated approach to care transitions using patient-centered interventions that improve health outcomes, avoid preventable ED visits and hospital readmissions, and reduce health care costs



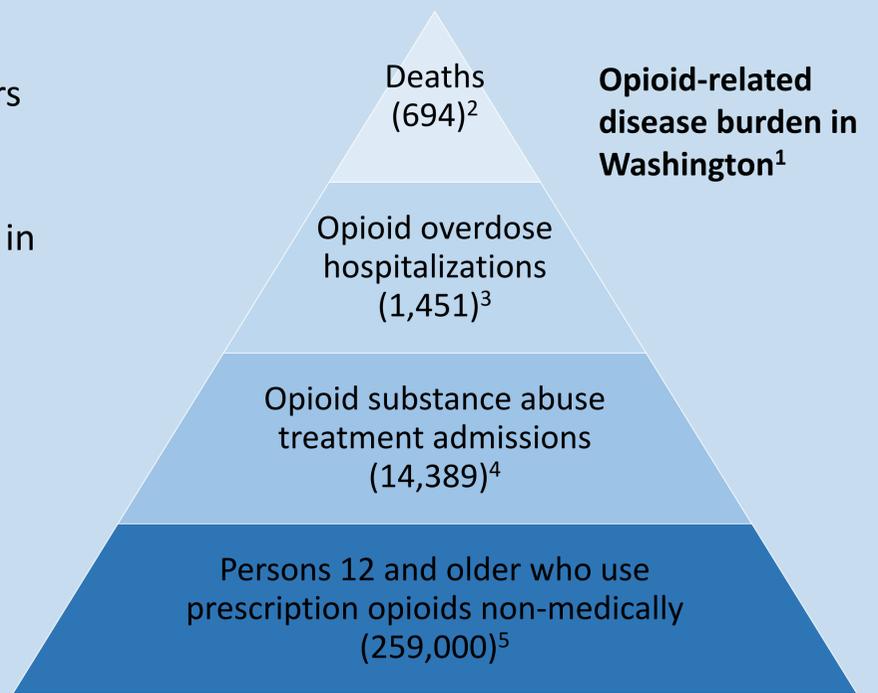
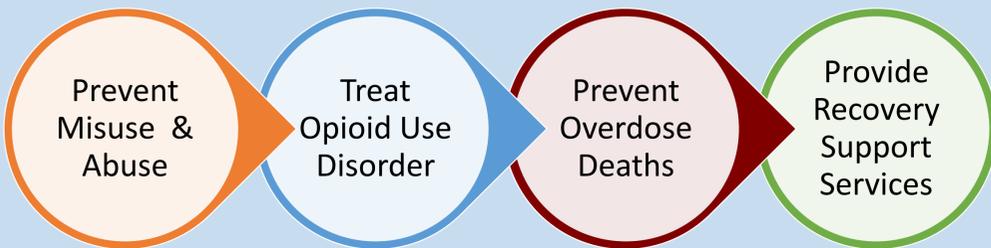
3A: Opioid Response Program

Sara Rainer, Opioid Response Program Manager
rainers@crhn.org

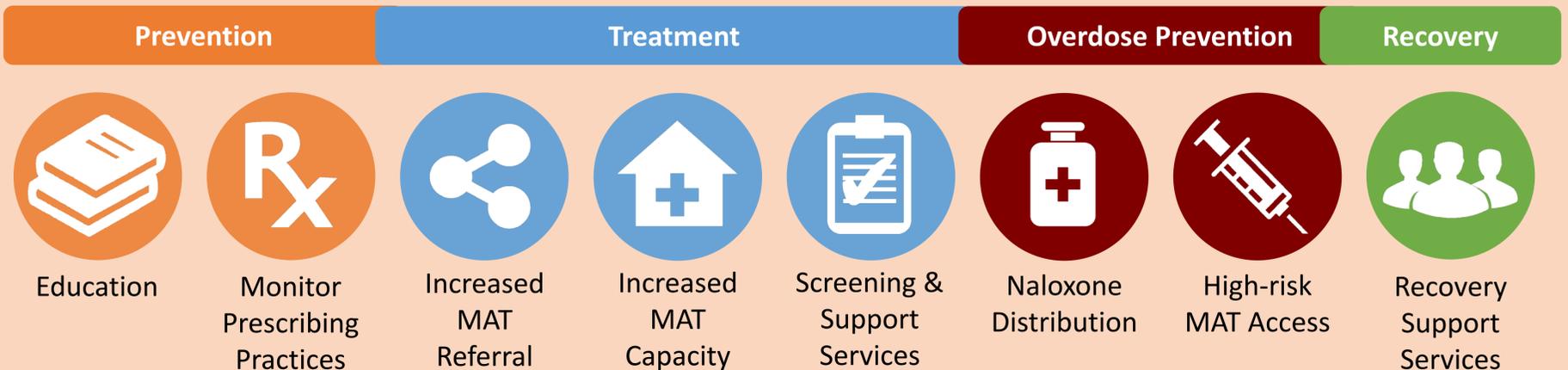


Opioid Prescribing and Overdose Deaths

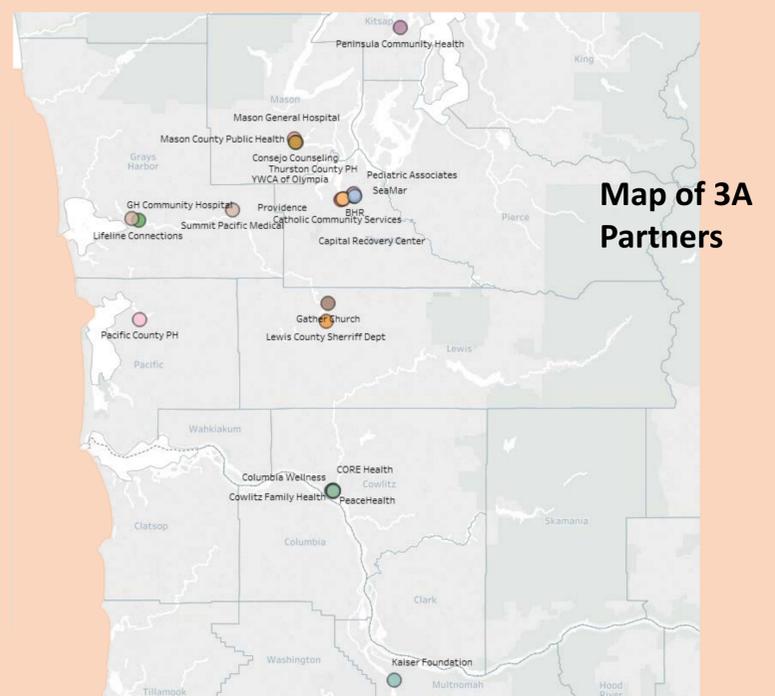
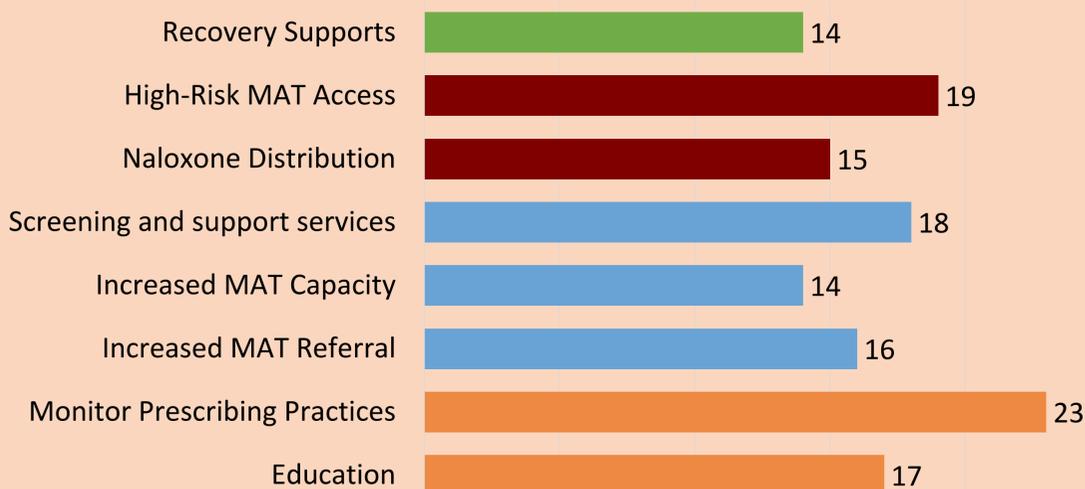
Cascade Pacific Action Alliance (CPAA) is working with partners across the continuum of care to implement evidence-based approaches for opioid prevention and response. A mix of interventions is needed to address opioid use disorder (OUD) in our communities.



Partner Activities



Intervention Categories Across 23 Partners



References

- Fontinos, C. (2018). Opioid Use in Washington State: A Treatment Update. Senate Health and Long Term Care Committee.
- Opioids involved in an overdose death listed as underlying cause of death. Washington State death certificate data, 2016.
- Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS), 2016.
- Treatment and Assessment Report Generation Tool, 2015.
- National Survey on Drug Use and Health, 2013-2014.

3B: Reproductive, Maternal, and Child Health

Caroline Sedano, Program Manager, sedanoc@crhn.org

26% of Washington adults have experienced 3 or more adverse childhood experiences (ACEs). Those with ACEs are at higher risk for:



The experiences children have early in life, shape their developing brains and strongly affect their health as throughout their life

By providing the **right care at the right time**, CPAA aims to reduce ACEs passed down to the next generation

6 RMCH Interventions

Home Visiting programs	 Long Acting Reversible Contraceptives (LARCs)	Pregnancy intention screenings questions
Immunizations and well child visits	 School based health centers	 Trauma informed training

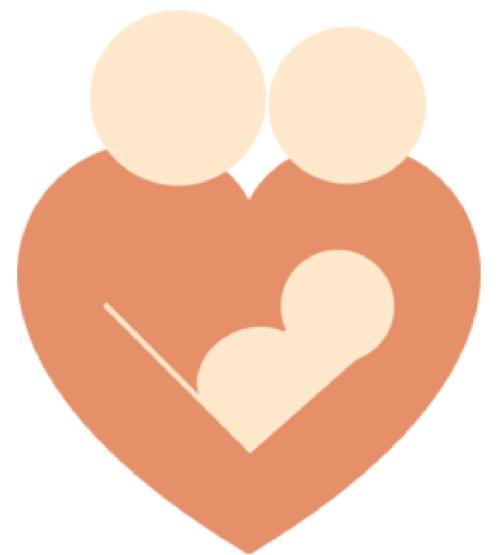
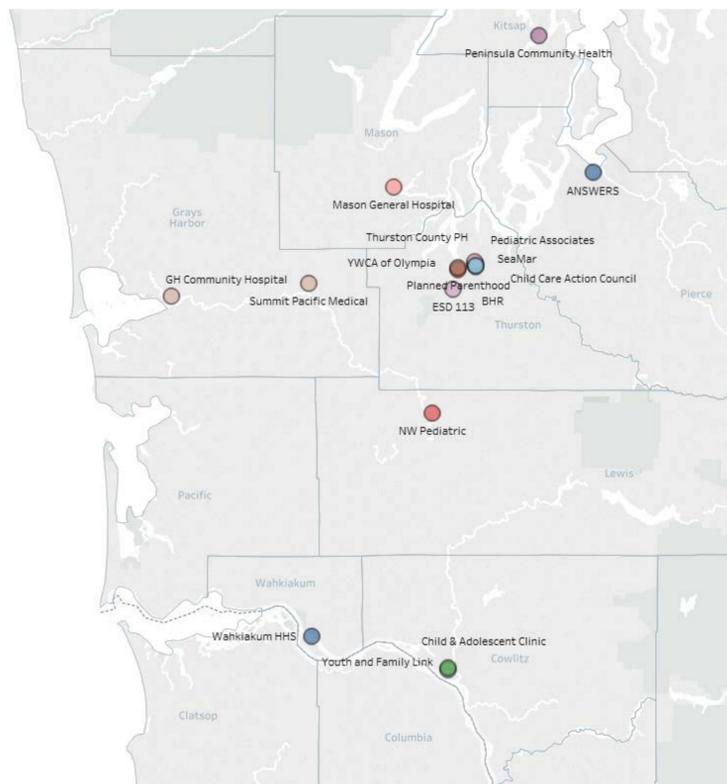
RMCH Partners

Partner Snapshot

- 9 Pregnancy Intention Screenings projects
- 9 LARC provider training programs
- 3 Home visiting program expansions
- 5 Immunization and well child access projects
- 3 School based health centers

Washington Data Snapshot

- 48% of pregnancies are unintended
- 34% of children from low income families met national standards for school readiness
- 77% of two year olds have required vaccines
- 74% of women received prenatal care during their first trimester
- 7% of eligible families are enrolled in a home visiting program



Community Impact

- Increase access to family planning
- Increase well child visit rate
- Increase STI screenings
- Improve immunization rates
- Reduce preterm births

Short term goals

Long term outcomes

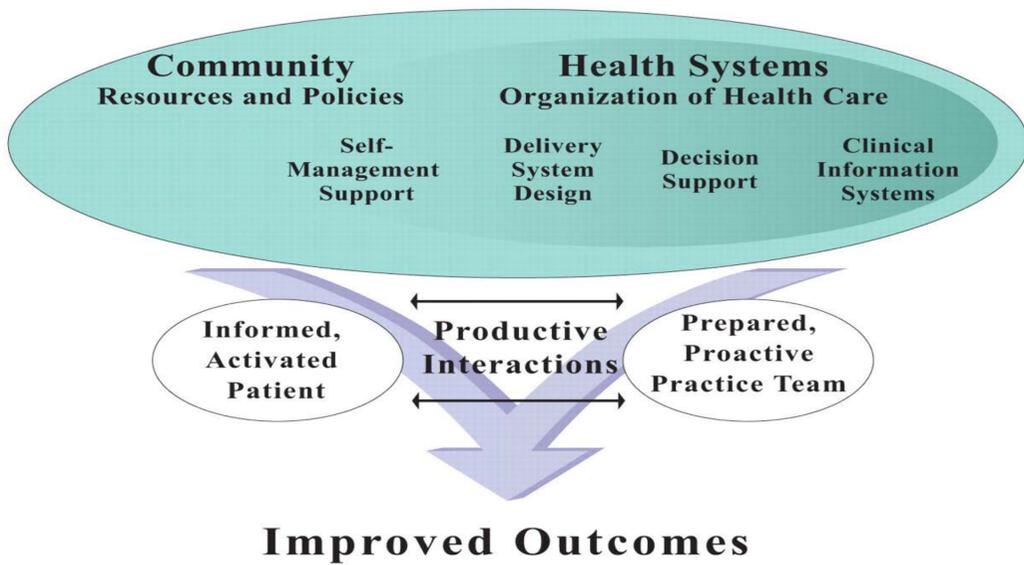
- Reduce teen pregnancy
- Increase birth weight
- Reduce chronic absenteeism
- Improve high school graduation rates
- Improve kindergarten readiness

3D: Chronic Disease Prevention and Control

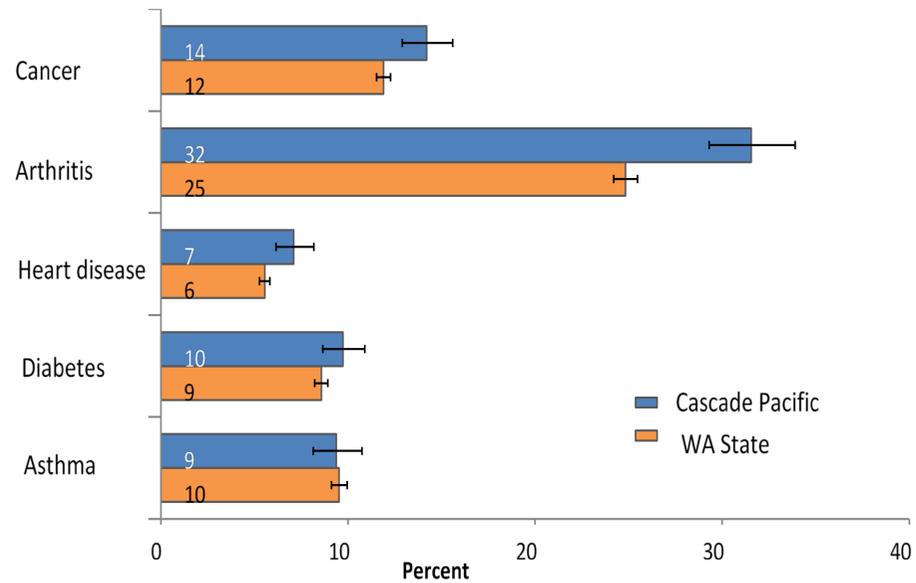
Alexandra Toney, Chronic Disease Prevention and Control Program Manager
toneya@crhn.org



Wagner's Chronic Care Model



Chronic Disease Prevalence



Grays Harbor

- 2 Chronic Disease Self-Management Program
- 1 Million Hearts Campaign
- 1 Wagner's Chronic Care
- 1 Other

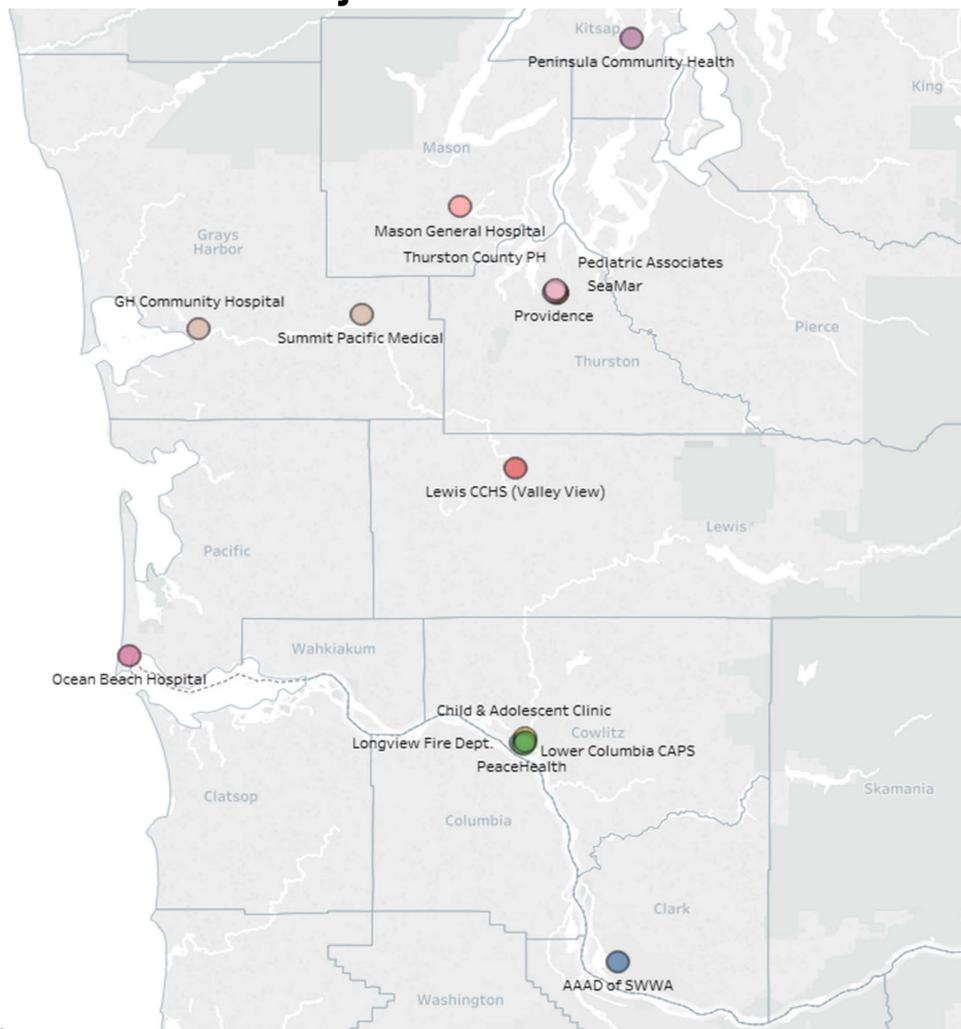
Thurston County

- 2 Chronic Disease Self-Management Program
- 1 Diabetes Prevention Program
- 2 Wagner's Chronic Care
- 1 Team Based Care
- 1 Other

Pacific County

- 2 Chronic Disease Self-Management Program
- 1 Million Hearts Campaign
- 1 Diabetes Prevention Program

Project 3D Partners



Mason County

- 2 Chronic Disease Self-Management Program
- 1 Diabetes Prevention Program
- 1 Million Hearts Campaign

Lewis

- 1 Chronic Disease Self-Management Program
- 2 Wagner's Chronic Care

Cowlitz

- 2 Chronic Disease Self-Management Program
- 1 Social Determinants of Health
- 2 Wagner's Chronic Care
- 2 Community Paramedicine
- 2 Team Based Care
- 1 Policy Systems and Environmental Change

Chronic Disease Prevention and Control Mission Statement



Our communities are educated about health risks and chronic disease prevention.



Our community members eat healthy, exercise and practice other healthy lifestyle behaviors (e.g., non-smoking) to prevent chronic diseases, and our workplaces and built environments support them in doing so.



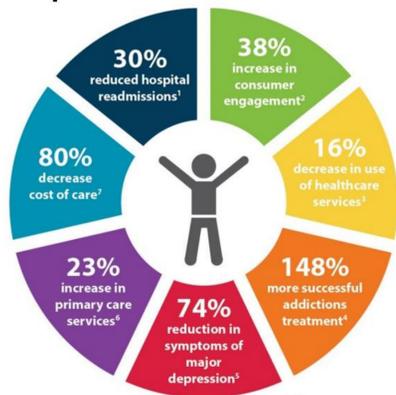
Community members who suffer from chronic diseases have the tools and resources to manage their chronic conditions successfully. Policies and motivational support systems will also help to support chronic disease management



Medicaid Transformation Activities

2A: Care Integration

The Impact of Whole Person Care



- Did You Know?**
- 20%** Medicaid beneficiaries have a behavioral health diagnosis
 - 46%** Adults experiencing mental illness or a substance use disorder at some point in their lifetime
 - 50%** Patients who receive a referral for specialty mental health care follow through with the referral

2B: Pathways HUB

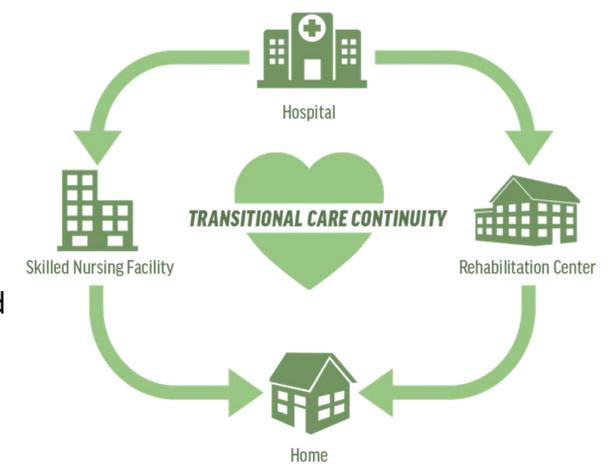
Community Based Care Coordination



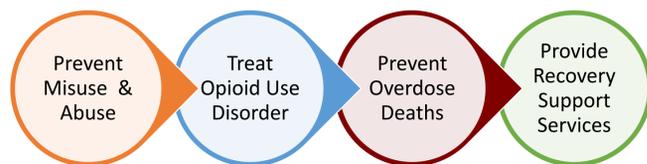
Find | Treat | Measure

2C: Transitional Care

Design a sustainable and coordinated approach to care transitions using patient-centered interventions that improves health outcomes, avoid preventable ED visits and hospital readmissions, and reduce health care costs



3A: Addressing the Opioid Crisis



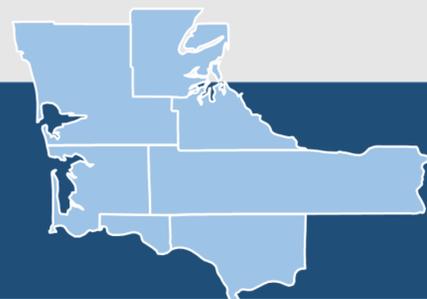
3B: Reproductive, Maternal & Child Health

26% of Washington adults have experienced 3 or more adverse childhood experiences (ACEs). Those with ACEs are at higher risk for:



3D: Chronic Disease

- Our communities are educated about health risks and chronic disease prevention.
- Our community members eat healthy, exercise and practice other healthy lifestyle behaviors (e.g., non-smoking) to prevent chronic diseases, and our workplaces and built environments support them in doing so.
- Community members who suffer from chronic diseases have the tools and resources to manage their chronic conditions successfully. Policies and motivational support systems will also help to support chronic disease management



Medicaid Transformation

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

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



Cascade Pacific Action Alliance (CPAA) Region

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

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

ACH Regions Map



BOARD MEMBERS*

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

*2 seats vacant at this time.

01/10/2019

CPAA PROJECTS

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

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

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

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

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

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

FUNDS FLOW

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

CPAA's funding allocation principals:

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

Social Determinants of Health

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

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

CONTACT INFORMATION

Jean Clark, CEO

Address: 1217 4th Ave E, Olympia, WA 98506

Email: info@cpaawa.org

Website: www.cpaawa.org

360-539-7576



Medicaid Transformation Change Plan

This Change Plan is a required document that will function as a tool for your organization to map out Medicaid Transformation Project (MTP) planning and implementation activities.

Your Change Plan will be used throughout the entire MTP by both your organization and CPAA. It will help develop MTP goals and measure implementation successes: the activities listed in your Change Plan will detail the logical sequence of transformative events over the next four years that will result in your organization achieving your MTP goal and vision of improved healthcare. Although you only have to fill it out once, your Change Plan is intended to be a useable, working document and will be updated annually throughout the MTP.

CPAA provided you with a Change Plan Development Form with recommendations based on your RFP response. These recommendations are based on future pay for performance (P4P) measures outlined by Health Care Authority. P4P measures are directly related to future funding for the region.

CPAA directors and program managers are available to answer questions and provide technical assistance in completing your Change Plan.

This Change Plan will be a public facing document to increase transparency, collaboration, and shared learning.

Medicaid Transformation Change Plan

Organization Information

Organization Name	
Employer Identification Number (EIN)	
CEO/Executive Director	
Transformation Lead Name	
Lead Contact Information (email, phone, address)	

Summary of Interventions

PROJECT AREA	INTERVENTION	METRIC SELECTION
2A: Bi-Directional Integration of Care	<i>CPAA staff will prepopulate based on selected RFP responses.</i>	
2B: Pathways		
2C: Transitional Care		
3A: Opioid Response		
3B: Reproductive Maternal Child Health		
3D: Chronic Disease Prevention and Management		

Program Manager Contacts

2A: Bi-Directional Integration of Care	2B: Pathways	2C: Transitional Care
Kyle Roesler Program Manager roeslerk@crhn.org	Michael O’Neill Program Manager oneillm@crhn.org	Alexandra Toney Program Manager toneya@crhn.org
3A: Opioid Response	3B: Reproductive – Maternal and Child Health	3D: Chronic Disease Prevention & Management
Sara Rainer Program Manager rainers@crhn.org	Caroline Sedano Program Manager sedanoc@crhn.org	Alexandra Toney Program Manager toneya@crhn.org

Reporting

Organizations are required to report on Change Plan progress quarterly, while intervention-specific metrics are reported semi-annually during Quarter 2 and 4 to CPAA. The Change Plan is due November 15, 2018, and updated annually during Quarter 4.

Quarter 1 (Jan-Mar)	*Quarter 2 (Apr-Jun)	Quarter 3 (Jul-Sep)	*Quarter 4 (Oct-Dec)
1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics	1. Change Plan Progress Report	1. Change Plan Progress Report 2. Intervention Metrics 3. Change Plan Update
April 30, 2019	July 31, 2019	October 31, 2019	January 31, 2020
April 30, 2020	July 31, 2020	October 31, 2020	January 31, 2021
April 30, 2021	July 31, 2021	October 31, 2021	January 31, 2022
April 30, 2022	July 31, 2022	October 31, 2022	January 31, 2023

*Intervention specific

Instructions

1. CPAA pre-populated your Change Plan with project area(s), corresponding interventions, and intervention-specific metrics. Metrics will allow you to monitor your progress for each SMART goal.
2. Review the Change Plan Development Form, which provides feedback based on your RFP response. Please use this feedback as a first step in identifying your own milestones.
3. In the Change Plan, identify one SMART (specific, measurable, achievable, relevant, and time-bound) goal per evidence-based intervention.
 - a. *SMART goal example: By 2021, increase the annual capacity from 1000 non-emergency transport services of Medicaid beneficiaries to 5700.*
4. CPAA has identified the metrics for each intervention, which are prepopulated into your organization's Change Plan template. For a limited number of interventions, please contact the program manager regarding metrics as indicated. Enter information for data source, data frequency, baseline data, and yearly targets.
 - a. Data Source: *Where will you collect the data?*
 - b. 2017 Baseline: *HCA is using 2017 data as a baseline for P4P measures in future years. Baseline is based off end of calendar year. If data is not available, describe the process in which you will collect data.*
 - c. 2019 – 2021 Targets: *What is your yearly attainable target for improvement over baseline?*
 - d. Reference supplemental document for additional metric information.
5. Under each SMART goal, write out the timeline of milestones to meet that goal with target dates and lead person(s). We understand activities may change over time; updates can be made to the Change Plan on an ongoing basis.
 - a. *Example: Schedule and conduct Long Acting Reversal Contraceptive (LARC) with 80% of providers*
 - b. *Example: Target Date: June 2018*
6. Once you have identified goals and milestones, complete the following sections:
 - a. Describe external supports or technical assistance needed to be successful in the project areas and interventions.
 - i. *Example: LARC Training: Justification – Providers are not trained in LARC insertion and removal.*
 - b. Describe potential risk and mitigation strategies as they apply to project areas and interventions.
 - i. *Example: Provider capacity is limited: Plan – Block schedules and plan training in advance to minimize revenue loss.*
 - c. Describe how you plan to use health equity to inform decision-making or provide service.
 - i. *Example: Create workflow to provide same day access.*
7. Submit the draft Change Plan to reporting@cpaawa.org no later than **October 15, 2018**, for initial feedback and recommendations.

Cascade Pacific Action Alliance

8. Sign Change Plan attesting to the required elements of the Change Plan. Person signing must be CEO, equivalent, or delegated authority.
9. Submit final Change Plan to reporting@cpaawa.org no later than **November 15, 2018**.

PROJECT AREA:					
EVIDENCE-BASED INTERVENTION:					
SMART Goal:					
Metric(s)	Data Source	2017 Baseline ¹	2019 Target	2020 Target	2021 Target
1.					
2.					
Notes:					
Planning (October 2018-December 2018)					
Milestones	Target Date	Lead Person			
Implementation (January - December 2019)					
Milestones	Target Date	Lead Person			

¹ If data is not available, describe the process in which you will collect data.

Cascade Pacific Action Alliance

Scale and Sustain (Jan 2020-2021)		
Milestones	Target Date	Lead Person

MTP Transformation Activities

External Supports Needed (CPAA Staff, Technical Assistance, Training)		
Supports Needed	Related Intervention	Justification
Potential Implementation Risks (What could go wrong? How could the risk be mitigated?)		
Potential Risk	Related Intervention	Mitigation Plan
Health Equity Activities (How do you use health equity to inform decision making and provide services?)		
Milestone(s)	Related Intervention(s)	Expected Outcome

Date Updated/Reviewed: __/__/__

Attestations:

1. We are registered and active in the Financial Executor Portal.

Yes	No

If "No," what steps have you taken to register in the portal?

2. A quality improvement/assurance plan is in place and ready for review upon request.

Yes	No

If "Yes," what quality improvement tools do you use or who are you currently working with to improve quality in your organization?

3. The information in this change plan is true and complete to the best of my knowledge.

Yes	No

Partner Organization Authorizing Authority

Printed Name: _____

Title: _____

Cascade Pacific Action Alliance

Signature _____

Date: _____



Change Plan Development Form

Partner Name:

Approved Project Areas:

Development Form Overview:

- CPAA reviewed all successful Request for Proposals (RFP) responses and provided recommendations to ensure all Change Plans are in alignment with the overall Medicaid Transformation Project (MTP) goals and program approaches as developed by CPAA. A successful implementation of all interventions is important for regional pay for performance measures and is directly tied to future funding.
- This form was pre-populated by CPAA for your organization’s approved projects areas.
- Partners should use the RFP feedback included in this form as guidance when completing their organization’s Change Plan.
- CPAA may not have provided feedback for all project areas or interventions if response to the RFP aligned closely with MTP goals.
- CPAA will retain a copy of each partner’s response to the RFP, Change Plan Development Form, and document progress towards Change Plan completion.

Work Steps:

Change Plan Development Steps	No Later Than Date
CPAA provides feedback on RFP responses for consideration when completing the Change Plan	September 15, 2018
Consult with appropriate CPAA Program Manager(s) for feedback and technical assistance as recommended	October 1, 2018
Submit draft Change Plan to reporting@cpaawa.org for review and recommendations	October 15, 2018
CPAA reviews draft Change Plan and provides feedback	November 1, 2018
Submit final Change Plan to reporting@cpaawa.org	November 15, 2018
CPAA reviews and accepts Change Plan, or returns to partner for write-back	November 28, 2018
Partners provide additional information as requested by CPAA	December 7, 2018
Partner receives formal acceptance of Change Plan and reporting requirements from CPAA	December 15, 2018



Change Plan Development Form

To ensure the best possible outcomes and largest impact for our region, listed below are CPAA’s specific recommendations for your organization’s Change Plan based on your RFP response. Each organization’s Change Plan will be used to measure progress during the MTP. As a tool that will act as a foundation for MTP health care delivery systems change and be utilized by each organization to map out planning and implementation activities throughout the MTP, a strong Change Plan is critical to MTP success.

Change Plan Recommendations

[] **If this box is checked, partner should consult with CPAA staff regarding Change Plan recommendations.** Please schedule a call with the following CPAA Program Managers: [List names of PMs]

PROJECT AREA	INTERVENTION	INTERVENTION FEEDBACK
2A: Bi-Directional Care Integration	Integrating Primary Care into Behavioral Health: Off-Site-Enhanced Collaboration Co-located-Enhanced Collaboration	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
	Integrating Behavioral Health into Primary Care: Collaborative Care Model	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
3B: Reproductive Maternal Child Health	One Key Question	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>
	Enriched Medical Home Intervention Screening	<u>Areas that lacked sufficient detail:</u> <u>Recommended elements:</u> <u>Required adjustments to fit evidence-based model:</u>

*Each project area used the same format for intervention feedback

Change Plan Metrics Definitions

Below you find the detail documentation related to MTP measurements. The purpose of this document is to describe, in detail, the set of measures attached to your project/s and intervention/s. CPAA has identified the metrics for each intervention, which are prepopulated into your organization's Change Plan template. For a limited number of interventions as indicated, please contact the program manager regarding metrics.

[Related Worksheet: \[Interventions\]](#)

Worksheet [MTP Metrics]

Column heading	Column Description
Column A	<p>Project ID, According to the MEDICAID TRANSFORMATION PROJECT TOOLKIT:</p> <p>Domain 2: Care Delivery Redesign: Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.</p> <p>Domain 3: Prevention and Health Promotion: Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.</p> <p>CPAA Projects:</p> <p>2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation</p> <p>2B: Community-Based Care Coordination</p> <p>2C: Transitional Care</p> <p>3A: Addressing the Opioid Use Public Health Crisis</p> <p>3B: Reproductive and Maternal and Child Health</p> <p>3D: Chronic Disease Prevention and Control</p> <p>More details: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf</p>
Column B (hidden)	MetricID , Unduplicated metric code for CPAA internal use. First two digits corresponds to the Project ID, third and fourth digits is an autonumeric by project.
Column C	Sub Category / Intervention
Column D	Short Description [Metric ID] : Measurement description as pre-populated in your Change Plan.
Column E	Measure Description : Detailed description of each measurement.
Column F	Numerator : The upper part of a fraction. The metric which has been counted. (e.g. # of people developed the disease of interest)
Column G	Denominator : The lower part of a fraction, used to calculate a rate or ratio. The population from which the numerator was derived. (e.g. total # of people in the population at risk)
Column H	Initial reporting date: Initial date that the data should be submitted to CPAA using the tool provided.
Column I	Set of data, "From - To", specific set of data to be reported.

Explanation of Metrics Definitions Supplemental Document

Instructions

1. CPAA pre-populated your Change Plan with project area(s), corresponding interventions, and intervention-specific metrics. This document provides a more detailed description of each metric than the Change Plan template, including how the metrics are calculated (the numerator and the denominator).
2. This document also captures the reporting period for each metric.
3. This document is a supplemental reference guide, not a reporting tool. The reporting tool is still under development and will be released at a later date.
4. Submit the draft Change Plan to reporting@cpaawa.org no later than **October 15, 2018**, for initial feedback and recommendations. CPAA will respond with any necessary write-backs by November 1, 2018.
5. Submit final Change Plan to reporting@cpaawa.org no later than **November 15, 2018**.

Intervention by Project	Total
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	4
Behavioral health integration in primary care settings	2
Physical health integration in behavioral health settings	2
2B: Community-Based Care Coordination	3
Pathways	3
2C: Transitional Care	10
Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	3
Implement evidence-based transitional care tool	1
Other	1
Provide non-emergency medical transport services	3
Provide Services that address social determinants of health	1
Utilize a patient navigator to improve health outcomes	1
3A: Addressing the Opioid Use Public Health Crisis	10
Opioid Response - CBO	5
Opioid Response - Clinic	4
Opioid Response - Emergency Department	1
3B: Reproductive and Maternal and Child Health	12
Home visiting	5
Immunization (Bright Future or Enriched Medical Home)	1
Long-acting reversible contraception (LARCs)	2
One Key Question (OKQ)	3
School-based health center	1
3D: Chronic Disease Prevention and Control	19
Adopt medical home or team-based care models	1
Adopt policy systems and environmental change	1
Establish linkages and provide services that address the social determinants of health	1
Implement Chronic Disease Self-Management Program	3
Implement Diabetes Prevention Program	3
Implement Mobile Integrated Healthcare / Paramedicine Model	2
Implement Wagner's Chronic Care Model	4
Million Hearts Campaign	3
Other	1
Total measures in this document	58

CPAA Change Plan Metrics

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
2A	Behavioral Health Integration in Primary Care Settings	% Depression screening [2A01]	Depression Utilization of the PHQ-9 Tool (eCQM 2018) Measure Description: The percentage of patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying visit. *For pediatrics, age range is 12-18.	Patients who have a PHQ-9 tool administered at least once during the four-month period.	Patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during the four month period. *For pediatrics, age range is 12-18. **Exclusions: patients who died, patients who received hospice or palliative care services, patients who were permanent nursing home residents, patients with a diagnosis of bipolar disease, patients with a diagnosis of personality disorder	7/31/2019
2A	Behavioral Health Integration in Primary Care Settings	% Depression remission [2A02]	Depression Remission at Twelve Months (eCQM 2018) Measure Description: The percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit. A client's most recent PHQ-9 score is less than 5 or 50% improved from the baseline score.	Patients who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five or improved by 50%	Patients age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during the index visit. *For pediatrics, age range is 12-18. **Exclusions: patients who died, patients who received hospice or palliative care services, patients who were permanent nursing home residents, patients with a diagnosis of bipolar disease, patients with a diagnosis of personality disorder.	7/31/2019
2A	Physical Health Integration in Behavioral Health Settings	% Universal BMI [2A03]	Percentage of Patients with Body Mass Index (BMI) Recorded in EHR Measure Description: The percentage of Medicaid beneficiaries with a BMI documented in an EHR during the reporting period	All members who had a documented BMI in during the reporting period	All Medicaid beneficiaries who had an encounter during the reporting period	7/31/2019
2A	Physical Health Integration in Behavioral Health Settings	% Universal blood pressure screening [2A04]	Percentage of Patients with Blood Pressure (BP) Recorded in EHR Measure Description: The percentage of Medicaid beneficiaries with a BP documented in an EHR during the reporting period.	All members who had a documented BP during the reporting period	All Medicaid beneficiaries who had an encounter during the reporting period	7/31/2019
2B	Pathways	# of active clients during the performance period. [2B01]	number of active clients during the performance period.	number of active clients during the performance period.	# of eligible clients referred to CCA from HUB	7/31/2019
2B	Pathways	AVG # of completed Pathways per client [2B02]	Average # of completed Pathways per Care Coordination Agency client			7/31/2019
2B	Pathways	AVG # of months per client [2B03]	Average # of months Care Coordination Agency client			7/31/2019
2C	Utilize a patient navigator to improve health outcomes	# Clients in Patient Navigator Service [2C01]	Number of clients/patients engaged with patient navigator within the reporting period			7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% of No Show [2C02]	Percent of scheduled appointment in which the beneficiary was not present for service delivery (reported as ratio)	number of scheduled appointment with Medicaid beneficiaries in which the beneficiary was not present for service delivery	total number of scheduled appointment during reporting period)	7/31/2019
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% of First App Completed [2C03]	Percent of scheduled appointments with patients, who were referred to the co-located primary care service and attended first scheduled appointment. (reported as ratio)	Number of scheduled appointments with patients, who were referred to the co-located primary care service and attended first scheduled appointment	Total number of scheduled first appointments with patients, who were referred to the co-located primary care service)	7/31/2019
2C	Develop co-located primary care service and Emergency Department with case management protocol for triage and referral	% patients received services within 7 days [2C04]	Percent of patients who received service within 7 days of contact (reported as ratio)	Number of service request in which patients received service within 7 days of contact	Total number of service requests of patients	7/31/2019
2C	Implement Evidence-Based Transitional Care Tool	% Patients enrolled in a Transitional Care program [2C05]	Percent of patients identified as high risk patients who are enrolled in a Transitional Care program within your health system. *	Patients identified as high risk patients who are enrolled in transitional care services	Total number of Patients identified as high risk patients	7/31/2019
2C	Provide Non-Emergency Medical Transport Services	# of transports to healthcare [2C06]	Number of transports to a healthcare appointment provided during reporting period (a ride is defined as a one way or round trip ride provided to a single health service destination)			7/31/2019
2C	Provide Non-Emergency Medical Transport Services	% consumers who rebook [2C07]	Percent of consumers who rebook a services within the reporting period	Number of consumers who rebooks a service within the reporting period	Total number of consumers during reporting period	7/31/2019
2C	Provide Non-Emergency Medical Transport Services	% of transportation service within 7 days [2C08]	Percent of transportation request in which consumers received service within 7 days of contact	Number of transportation request in which consumers received service within 7 days of contact	Total number of transportation requests of consumers	7/31/2019
2C	Provide Services that Address Social Determents of Health	Eligible to Contact Program Manager to get specific metrics approved [2C09]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019
2C	Other	Eligible to Contact Program Manager to get specific metrics approved [2C10]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019
3A	Opioid Response - Emergency Depart	ED protocols MAT & Naloxone distribution [3A01]	Does the ED site have protocols in place to initiate Medication Assisted Treatment (MAT) and offer take-home naloxone for individuals seen for opioid overdose?	Drop Down Box	<ul style="list-style-type: none"> •MAT initiation •Take-home naloxone •Our ED does not offer these services •Not applicable. Our site is not an ED. 	7/31/2019
3A	Opioid Response - Clinical	Follow opioid prescribing guidelines? [3A02]	Do providers follow [specific] opioid prescribing guidelines?	Drop Down Box	AMDG guidelines / Washington State prescribing guidelines <ul style="list-style-type: none"> •Bree Collaborative guidelines •CDC guidelines •None of the above 	7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
3A	Opioid Response - Clinical	Clinical decision support for opioid prescribing [3A03]	What features does the site's clinical decision support for opioid prescribing include? (EHR or another support system)	Drop Down Box	<ul style="list-style-type: none"> •IntegratedMED calculator •Links to opioid prescribing registries or PDMPs •Automatic flags for co-prescriptions of benzos •None of the above 	7/31/2019
3A	Opioid Response - Clinical	Protocol for BH intervention [3A04]	What protocols are in place to provide a pathway for patients with opioid use disorder to be evaluated for behavioral health interventions?	Drop Down Box	<ul style="list-style-type: none"> •Screeningand treatment for depression/anxiety occurs on site •Screening for depression/anxiety occur on site, patients referred to treatment •Contracting with providers who offer these services •Formalized referral relationship with providers who offer these services (MOUs or similar arrangement) •Informal referral relationship with providers who offer these services •None of the above 	7/31/2019
3A	Opioid Response - Clinical	Protocols for MAT [3A05]	What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assistedtreatment (MAT)?	Drop Down Box	<ul style="list-style-type: none"> •Medicationsare provided on site •Contracting with providers who offer these services •Formalized referral relationship with providers who offer these services (MOUs or similar arrangement) •Informal referral relationship with providers who offer these services •None of the above 	7/31/2019
3A	Opioid Response - CBO	CBO refer to MAT [3A06]	Does the CBO site have protocols in place to refer people with opioid use disorders to providers of medication-assisted treatment?	Drop Down Box	<ul style="list-style-type: none"> •Yes •No 	7/31/2019
3A	Opioid Response - CBO	CBO refer to psychosocial care? [3A07]	Does the CBO site refer people with opioid use disorders for psychosocial care?	Drop Down Box	<ul style="list-style-type: none"> •Yes •No 	7/31/2019
3A	Opioid Response - CBO	CBO refer to Hub & Spoke [3A08]	Does your site actively refer patients with opioid use disorder to a Hub & Spoke network or Opioid Treatment Network, where both medication and behavioral health treatments are available?	Drop Down Box	<ul style="list-style-type: none"> •Yes, via warm handoff •Yes, via providing information •No, we provide these services on site •No , we do not refer for another reason 	7/31/2019
3A	Opioid Response - CBO	CBO syringe exchange [3A09]	Does your CBO receive technical assistance to organize or expand a syringe exchange program, or to learn about locally available access to clean syringes?	Drop Down Box	<ul style="list-style-type: none"> •Yes, to organize and expand •Yes, to learn about access •No, we did not receive technical assistance 	7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
3A	Opioid Response - CBO	CBO refer Hep C & HIV [3A10]	Does your CBO provide referral information for clients interested in testing or treatment for Hepatitis C and HIV?	Drop Down Box	<ul style="list-style-type: none"> •Yes,via warm handoff •Yes, via providing information •No, we provide these services on site •No, we do not refer for another reason 	7/31/2019
3B	One Key Question	# women screened for pregnancy intentions [3B01]	# of women of reproductive age (15-44) were screened for their pregnancy intentions	# of women of reproductive age (TBD) who had an office visit who were screened for pregnancy intentions during the measurement period	# of women of reproductive age (TBD) who had an office visit	7/31/2019
3B	One Key Question	% women with response to pregnancy intention screening [3B02]	% of women of reproductive age (15-44) who have a documented response to the pregnancy intention screening	# women of reproductive age (TBD) who had an office visit with documented response to pregnancy intention screening during the reporting period	# women of reproductive age (TBD) with an office visit	7/31/2019
3B	One Key Question	% chlamydia screening [3B03]	% of women age (15-44) identified as sexually active who had an office visit having at least one test for chlamydia during the reporting year	# women of reproductive age (TBD) identified as sexually active with an office visit and a documented STI test	# women of reproductive age (TBD) identified as sexually active with an office visit	7/31/2019
3B	LARCs	% trained in insertion/removal of IUDs, implants [3B04]	% Clinicians trained in routine insertion and removal of IUDs and implants	# Clinicians trained in routine insertion and removal of IUDs and implants	# clinicians in site	7/31/2019
3B	LARCs	% trained in complicated insertion/removal of IUDs, implants [3B05]	% Clinicians trained in complicated insertion and removal of IUDs and implants	# Clinicians trained in complicated insertion and removal of IUDs and implants	# clinicians in site	7/31/2019
3B	Home visiting	% of eligible families enrolled [3B06]	% of eligible families enrolled into services	# of families enrolled in services	# of those that qualify	7/31/2019
3B	Home visiting	% of families lost to care [3B07]	% of families lost to care	# of families enrolled in services	# of those that qualify	7/31/2019
3B	Home visiting	% of families transitioned out of the program [3B08]	% of families transitioned out of the program	families who opt out of the program due to moving, positive life transition etc)	# of families in the program	7/31/2019
3B	Home visiting	# graduated [3B09]	# graduated	families successfully completing the full range of services of the program and marked as graduated by home visitor	# of families in the program	7/31/2019
3B	Home visiting	% of enrolled families with 6 visits [3B10]	% of enrolled families with 6 visits during the measurement period	families with 6 visits during the measurement period	# of families in the program	7/31/2019
3B	School-based health center	% students who received services at the School Based health Center [3B11]	% students in the school who accessed services at the School Based health Center at least once during the measurement period	students in the school who accessed services at the SBHC at least once during the measurement period	all students in the school	7/31/2019
3B	Immunization (Bright Future or Enriched Medical Home)	% children with 6 or more well child visits at 15 months [3B12]	% of children who turn 15 months of age during the measurement period with 6 or more well child visits	# of children who turn 15 months of age during the measurement period with 6 or more well child visits	# of children who turn 15 months of age during the measurement period	7/31/2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who are enrolled [3D01]	Number of clients/patients who are enrolled			7/31/2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who complete 1st class [3D02]	Number of clients/patients who complete the first class of the series			7/31/2019
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who completed course [3D03]	Number of clients/patients who completed course			7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
3D	Implement Diabetes Prevention Program	# of clients/patients who are enrolled [3D04]	Number of clients/patients who are enrolled			7/31/2019
3D	Implement Diabetes Prevention Program	# of clients/patients who complete 1st class [3D05]	Number of clients/patients who complete the first class of the series			7/31/2019
3D	Implement Diabetes Prevention Program	# of clients/patients who completed course [3D06]	Number of clients/patients who completed course			7/31/2019
3D	Million Hearts Campaign	% Blood Pressure Control [3D07]	Blood Pressure Control: Percentage of Patients 18-85 YO, who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90) during the measurement period (reported as ratio)	Number of Patients 18-85 with a diagnosis of HTN whose blood pressure was adequately controlled	Total population of Patients 18-85 with a diagnosis of HTN	7/31/2019
3D	Million Hearts Campaign	% Statin Therapy [3D08]	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: Percentage patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period (reported as a ratio)	Number of patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period	Total number of patients considered high risk of cardiovascular event during reporting period	7/31/2019
3D	Million Hearts Campaign	% Smoking Assessment and Treatment [3D09]	Smoking Assessment and Treatment: Preventive Care and Screening: Tobacco Use Percentage of Patients 18 + who were screened about tobacco use one or more times within the reporting period and who received cessation counseling intervention if identified as a tobacco user	Number of Patients 18 + who were screened about tobacco use one or more times within the reporting period and who received cessation counseling intervention if identified as a tobacco user	Number of Patients 18 + who were screened about tobacco use	7/31/2019
3D	Establish linkages and provide services that address the social determinants of health	TBD [3D10]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019
3D	Implement Mobile Integrated Healthcare / Paramedicine Model	Number of Patients on caseload [3D11]	Number of Patients who are active and on (received service within the last 60 days) caseload.			7/31/2019
3D	Implement Mobile Integrated Healthcare / Paramedicine Model	% reduction in non-emergency 911 [3D12]	% reduction in non-emergency 911 utilization of contracted clients	Total number non-emergency 911 utilization of contracted clients during reporting period	Total number non-emergency 911 utilization of contracted clients before intervention	7/31/2019
3D	Implement Wagner's Chronic Care Model	Diabetes Care : HbA1c Testing [3D13]	Percentage of patients with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%	Patients with diabetes with a visit during the measurement period	7/31/2019
3D	Implement Wagner's Chronic Care Model	Med Management People with Asthma (5-64) [3D14]	Percent of patients 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications that they remained on for at least 75% of their treatment period	Total number of Patients 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications that they remained on for at least 75% of their treatment period	Total number of patients 5-85 who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications	7/31/2019
3D	Implement Wagner's Chronic Care Model	Statin therapy for patients with CVD [3D15]	Percent of patients who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.	Number of patients who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.	Number of patients who have clinical atherosclerotic cardiovascular disease (ASCVD).	7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
3D	Implement Wagner's Chronic Care Model	% Patients enrolled in Clinical Case Management [3D16]	Percent of patients identified as high risk patients who are currently enrolled in a Clinical Case Management Service for Chronic Disease within your health system.	Patients identified as high risk patients who are currently enrolled in a Clinical Case Management Service for Chronic Disease within your health system	Total number of Patients identified as high risk patients within your health system	7/31/2019
3D	Adopt medical home or team-based care models	# patients receiving care under team-based model [3D17]	Number of patients receiving care under team-based model			7/31/2019
3D	Adopt Policy Systems and Environmental change	Eligible to Contact Program Manager to get organization specific metrics approved [3D18]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019
3D	Other	Eligible to Contact Program Manager to get organization specific metrics approved [3D19]	Eligible to Contact Program Manager to get organization specific metrics approved			7/31/2019



Whole Person Care in Behavioral Health Settings

CPAA/AIMS Center Training - Description

About

Cascade Pacific Action Alliance (CPAA) and the University of Washington AIMS Center are offering a training program for developing and implementing an integrated care program in behavioral health settings. Those enrolled will be guided to build and further enhance their current work based on the core principles of the Collaborative Care Model to offer off-site, enhanced collaboration, co-located, enhanced collaboration, or co-located integrated services, as outlined in the Medicaid Transformation Project 2A toolkit. Below is an overview of the training to take place in three phases.

Phase 1: Planning for Whole Person Care

Timeline: 3 - 4 Months

Planning for Whole Person Care includes identifying an integration strategy and defining program goals, developing a staffing plan, selecting a registry for measurement-based physical health care tracking and developing/testing physical health screening workflows.

During this phase, the AIMS Center will support your team members in the following ways:

- **All Team Members**
 - Webinars taking an in-depth look at core concepts, such as measurement-based health care, clinic workflows, staffing, and registry options. *Monthly up to three months, 60-minutes each.*
- **Operations and Clinical Leadership**
 - Individual site planning and coaching calls to address site readiness, workflows, funding and sustainability, clinician and staff buy-in, and staffing considerations. *Monthly up to four months, 60-minutes each.*
- **Primary Care Consultants/Partners Introduction Call (Optional)**
 - Orientation Call to introduce primary care consultants or partners to population-based strategies, assisting them to prepare for supporting whole person care caseloads and behavioral health agency needs. *One call, 60-minutes.*

Phase 2: In-Person Training CPAA Region

Timeline: 2 Days

Learn to apply and integrate the knowledge and skills gained during Phase 1. New concepts will be introduced along with time for skill building. Some sessions will include all trainees together and other concurrent sessions will break-out trainees to focus on role-specific tasks and skills. Teams will learn how to operationalize the collaborative care principles of measurement-based, treat-to-target, whole person care working together as a team. As needed, the AIMS Center will coordinate trainers from the National Council through the Washington Council for Behavioral Health to fit training needs in the region. Training will focus on metabolic monitoring, follow-up after hospitalization, and medication adherence.

Who should attend?

- **Required:** Nurse care managers and/or care coordinators, behavioral health clinicians, and supervisors
- **Optional:** Primary care consultants/partners and site leaders





Phase 3 - Virtual Coaching and Additional Training

Timeline: 3 - 6 Months

Integrated care teams need support as they launch their practice to ensure they understand the nuances and maintain fidelity to the model to achieve desired outcomes.

During this phase, the AIMS Center will support your team members in the following ways:

- **Operations and Clinical Leadership**
 - Leadership calls to support launching care in a behavioral health setting, review key process and outcome metrics, and discuss sustainability and spread. *Up to three calls, 60-minutes each.*
- **Nurse Care Managers and/or Care Coordinators**
 - Coaching calls with an experienced clinician trainer to review caseloads, discuss clinical cases and strategies, and share best practices. *Monthly for up to six months, 60-minutes each.*
 - Three clinical training webinars and case conference calls. *Monthly for up to six months, 60-minutes each.*
 - Topics might include, but are not limited to; tobacco cessation counseling, tracking clinical outcomes (i.e., maximizing use of selected registry), self-management support for clients with chronic medical conditions.
- **Primary Care Consultants/Partners Coaching Calls (Optional)**
 - Coaching calls with an experienced AIMS Center or National Council faculty member. *Up to three calls, 60-minutes each.*

Training Website

All participants will be given access to a website that will support work during all three phases of the training program. The website will include items such as a calendar of events, referenced learning materials, and webinar recordings.

Questions?

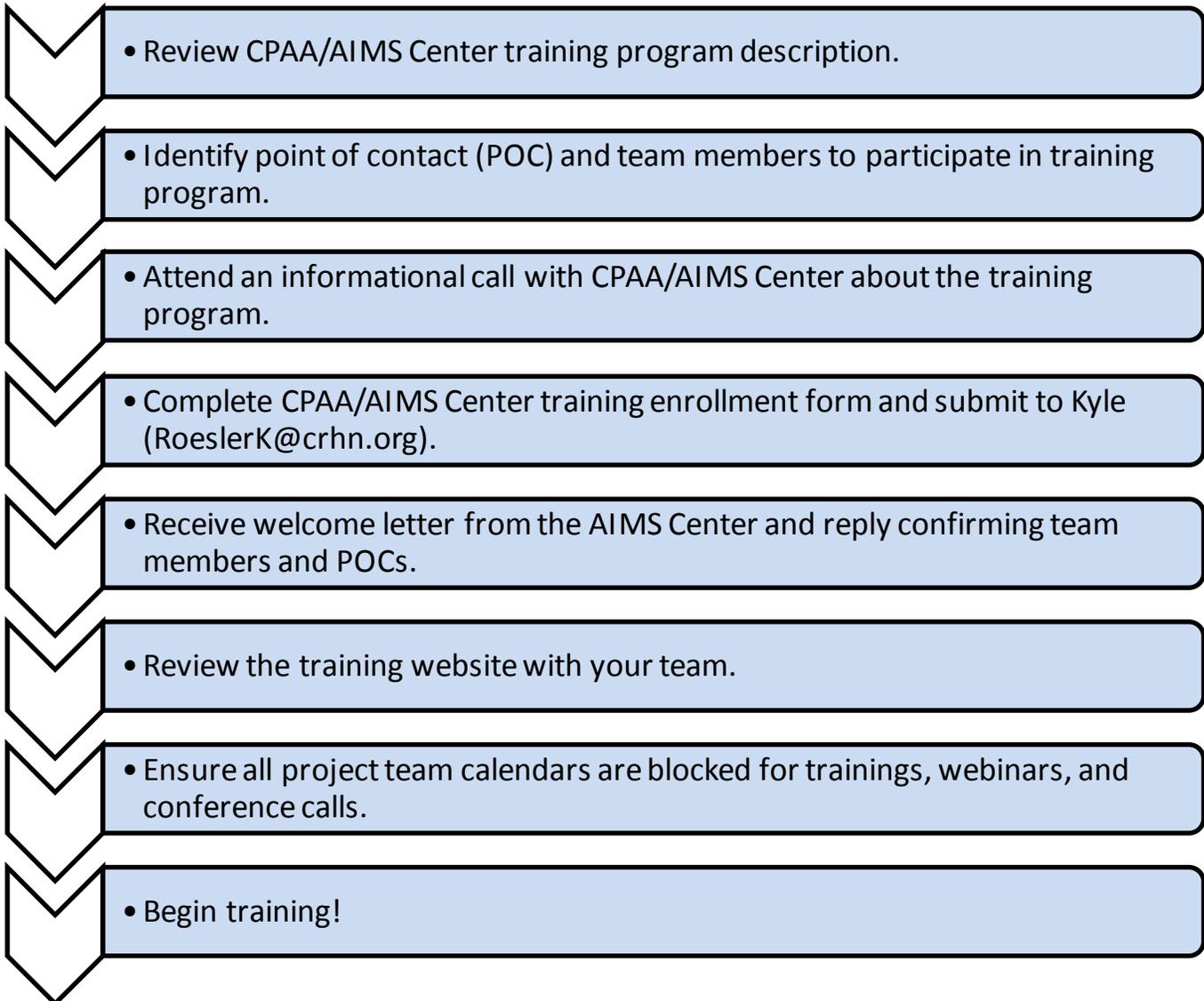
Contact Sara Barker (barkers@uw.edu) or Kyle Roesler (RoeslerK@crhn.org).





Whole Person Care in Behavioral Health Settings

CPAA/AIMS Center Training - Enrollment Process





Whole Person Care in Behavioral Health Settings CPAA/AIMS Center Training - Enrollment Form

In order to join the CPAA/AIMS Center Training my organization is committed to the following:

- Senior and clinical leadership support the program and have agreed to commit staff time and resources to fully develop an integrated care program for the organization.
- Senior leadership is aware of potentially competing projects and/or grant initiatives and has a plan in place for coordinating across multiple projects.
- We have identified a project team to manage and coordinate the integrated care program. The project team agrees to be available for planning meetings and webinars. Team members include:

Senior Leader: _____ Site Manager: _____
 Clinical Director: _____ Other Staff: _____
 Day-to-Day Leader: _____

- We have a staffing plan in place for a care manager and/or a care coordinator to help clients with chronic medical conditions. As part of our staffing plan, we agree to allow staff to attend in-person and virtual trainings and coaching calls.
- Within three to four months from the start of training program we agree to hire, contract, or train an existing staff member as a care manager and/or care coordinator to help clients' with their medical needs.
- Within three to four months from the start of the training program we will make arrangements for facilitating direct primary care services to improve access to primary care for our clients onsite or in collaboration with a local provider.
- Within three months from the start of the training program we will choose a registry and be ready to use it for measurement-based physical health care tracking.
- Within three months from the start of the training program we will work internally and with the AIMS Center to develop and test a physical health screening workflow.

CPAA will provide:

- Full cost of Whole Person Care Training Program

Training Start Date: January 2019

Organization/Practice: _____

Printed Name: _____

Signature: _____

Date: _____





Whole Person Care in Primary Care Settings

CPAA/AIMS Center Training - Description

About

Cascade Pacific Action Alliance (CPAA) and the University of Washington AIMS Center are offering a training program for developing and implementing an integrated care program in primary care settings. Those enrolled will be guided to build and further enhance their current work to meet the Bree Collaborative's Behavioral Health Report and Recommendations and/or the Collaborative Care Model, as outlined in the Medicaid Transformation Project 2A toolkit. Below is an overview of the training to take place in three phases.

Phase 1: Planning for Whole Person Care

Timeline: 3 - 4 Months

Planning for Whole Person Care includes identifying an integration strategy and defining program goals, developing a staffing plan for behavioral health clinicians and psychiatric services, selecting a registry for measurement based behavioral health care tracking and developing/testing behavioral health screening workflows and protocols for managing suicidal patients.

During this phase, the AIMS Center will support your team members in the following ways:

- **All Team Members**
 - Webinars taking an in-depth look at core concepts, such as measurement-based behavioral health care, clinic workflows, staffing, and registry options. *Monthly up to three months, 60-minutes each.*
 - Access to online, self-paced training materials for behavioral health clinicians.
- **Operations and Clinical Leadership**
 - Individual site planning and coaching calls to address site readiness, workflow, funding and sustainability, PCP buy-in, and staffing considerations. *Monthly up to four months, 60-minutes each.*
- **Psychiatric Consultant Introduction Call for Sites Implementing the Collaborative Care Model**
 - Orientation Call. Introduce psychiatric providers to population-based strategies, assisting them to prepare for supporting caseloads, and consultation strategies. *One time, 60-minutes.*

Phase 2: In-Person Training CPAA Region

Timeline: 1 or 2 Days*

Learn to apply and integrate the knowledge and skills gained during Phase 1. New concepts will be introduced along with time for clinician skill building. Some sessions will include all trainees together and other concurrent sessions will break-out trainees to focus on role-specific tasks and skills.

*Day 2: For sites implementing the Collaborative Care Model, the second day will focus on how to do a psychiatric case review process, consultation roles and further building team roles around the care manager and psychiatric consultant.

Who should attend?

- **Required:** Behavioral health clinicians, behavioral health supervisors, and site leadership
- **Optional:** Primary care champions and operations leaders





Phase 3 - Virtual Coaching and Additional Training

Timeline: 3 - 6 Months

Integrated care teams need support as they launch their practice to ensure they understand the nuances and maintain fidelity to the model to achieve desired outcomes.

During this phase, the AIMS Center will support your team members in the following ways:

- **Operations and Clinical Leadership**
 - Leadership calls to support launching care in the primary care setting, review key process and outcome metrics, and discuss sustainability and spread. *Up to three support calls, 60-minutes each.*
- **Behavioral Health Clinicians**
 - Coaching calls with an experienced clinician trainer to review caseloads, discuss clinical cases and strategies, and share best practices. *Monthly up to six months, 60-minutes each.*
 - Three clinical training webinars and case conference calls. *Monthly up to six months, 60-minutes each.*
 - Topics might include, but are not limited to; tracking clinical outcomes (i.e., maximizing use of selected registry), depression relapse prevention planning, screening for and intervening in substance use disorders.
- **Psychiatric Consultant Coaching Call for Sites Implementing the Collaborative Care Model**
 - Coaching calls with experienced AIMS Center psychiatry faculty. *Up to three support calls, 60-minutes each.*

Psychotherapy Training & Certification: Problem Solving Treatment and Patient Activation

Timeline: 6 Months

- **Licensed Clinicians**
 - *Problem Solving Treatment (PST) in Primary Care* training includes didactic instruction, case conference calls, and individual skill building and training through patient recordings and review. *Up to 22 hours, over six months for each trainee.*
- **Bachelor's or Master's Level Non-licensed Staff or Master's-level Licensure Candidates**
 - Patient Activation skill building through didactic presentation, case conference calls, and patient recordings and review. *Up to 17 hours, over six months for each trainee.*

Training Website

All participants will be given access to a website that will support work during all three phases of the training program. The website will include items such as a calendar of events, referenced learning materials, and webinar recordings.

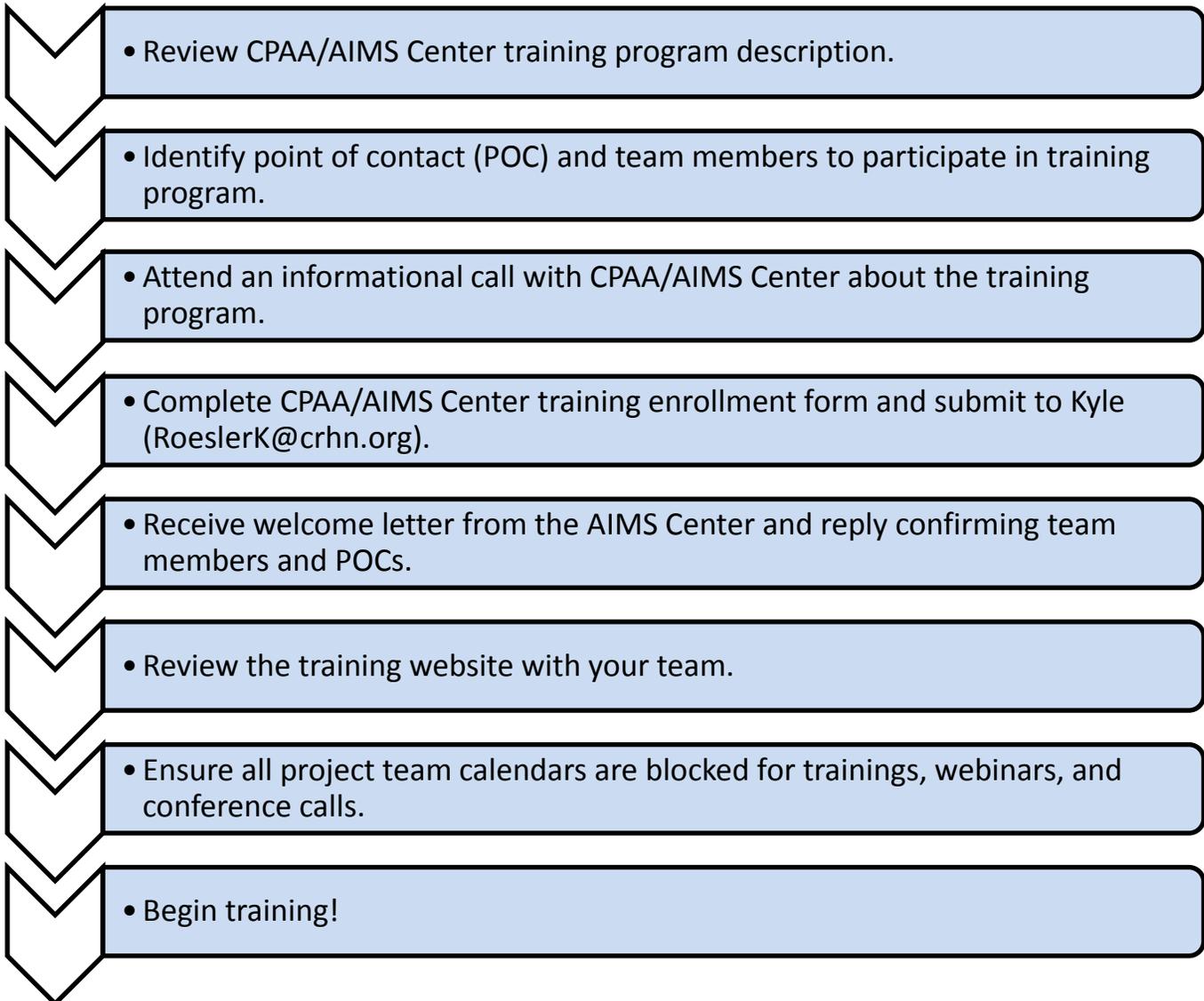
Questions?

Contact Sara Barker (barkers@uw.edu) or Kyle Roesler(RoeslerK@crhn.org).





Whole Person Care in Primary Care Settings CPAA/AIMS Center Training - Enrollment Process





Whole Person Care in Primary Care Settings CPAA/AIMS Center Training - Enrollment Form

In order to join the CPAA/AIMS Center Training my organization is committed to the following:

- Senior and clinical leadership support the program and have agreed to commit staff time and resources to fully develop an integrated care program for the organization.
- Senior leadership is aware of potentially competing projects and/or grant initiatives and has a plan in place for coordinating across multiple projects.
- We have identified a project team to manage and coordinate the integrated care program. The project team agrees to be available for planning meetings and webinars. Team members include:

Senior Leader: _____

Site Manager: _____

PCP Champion: _____

Other Staff Members: _____

Day-to-Day Leader: _____

- We have a staffing plan in place for behavioral health (BH) provider(s), including psychiatric services. As part of our staffing plan, we agree to allow providers to attend in-person and virtual trainings and coaching calls.
- Within three to four months from the start of training program we agree to utilize an existing BH provider, hire, or contract with another agency for a BH provider(s).
- Within three to four months from the start of the training program we agree to provide access to psychiatric services or psychiatric consultation in-house or by contract with another agency.
- Within three months from the start of the training program we will choose a registry and be ready to use it for measurement-based behavioral health care tracking.
- Within three months from the start of the training program we will work internally and with the AIMS Center to develop and test a behavioral health screening workflow and protocol to manage suicidal patients.

CPAA will provide:

- Full cost of Whole Person Care Training Program
- Problem Solving Treatment Training and Certification (if applicable)
- Behavioral Activation Training and Certification (if applicable)
- UW AIMS Center Caseload Tracker (if applicable)

Preferred Training Start Date: October 2018 January 2019

Organization/Practice: _____

Printed Name: _____

Signature: _____

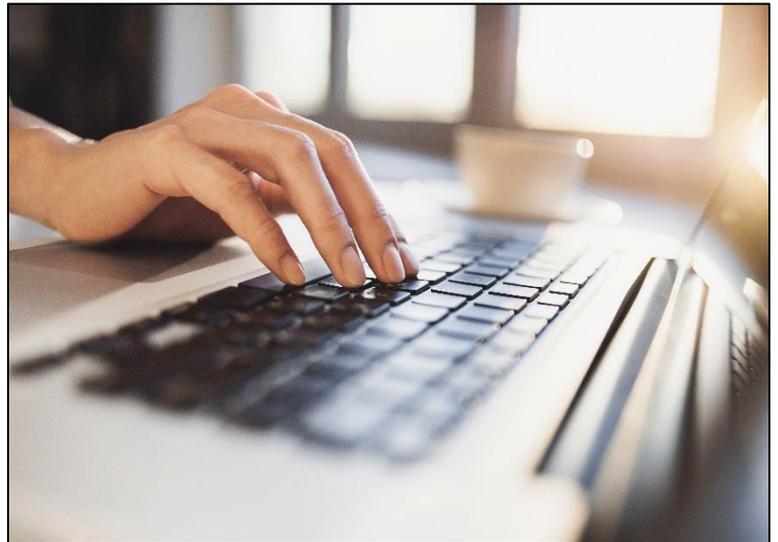
Date: _____



Hot Topics in Whole Person Care

Summer 2018 Webinar Series

Join Us! Cascade Pacific Action Alliance, in collaboration with the University of Washington AIMS Center, is offering a summer webinar series covering requested topics related to whole person care. The summer series provides an introduction to concepts explored in the fall training program. These training efforts are intended to support organizations in the Cascade Pacific region to meet the Bree Collaborative Recommendations or Collaborative Care Model, as outlined in the Medicaid Transformation Project 2A toolkit.



Who Should Attend

Administrative staff, primary care providers, behavioral health providers, billing specialists, and anyone involved with your integrated care program

Series Topics and Schedule



So You Want Me to Do What?

Introduction to Whole Person Care for Community Behavioral Health Agencies

Dive into Whole Person Care as part of your behavioral health agency's mission, learn guiding principles and how to get started, and explore the challenges and opportunities that lie ahead.

Wednesday, July 11, 2018 12:00 – 1:00 PM



Billing and Sustainability Considerations for Whole Person Care

Explore billing opportunities for behavioral health integration in a primary care setting, and learn to plan for sustaining your integrated care team, includes reviewing a financial modelling tool.

Wednesday, July 25, 2018 12:00 – 1:00 PM



Hiring and Staffing an Integrated Care Team

Discover what to look for when hiring an integrated care team and learn how to prepare for new integrated care team members, includes special considerations for rural settings.

Wednesday, August 08, 2018 12:00 – 1:00 PM



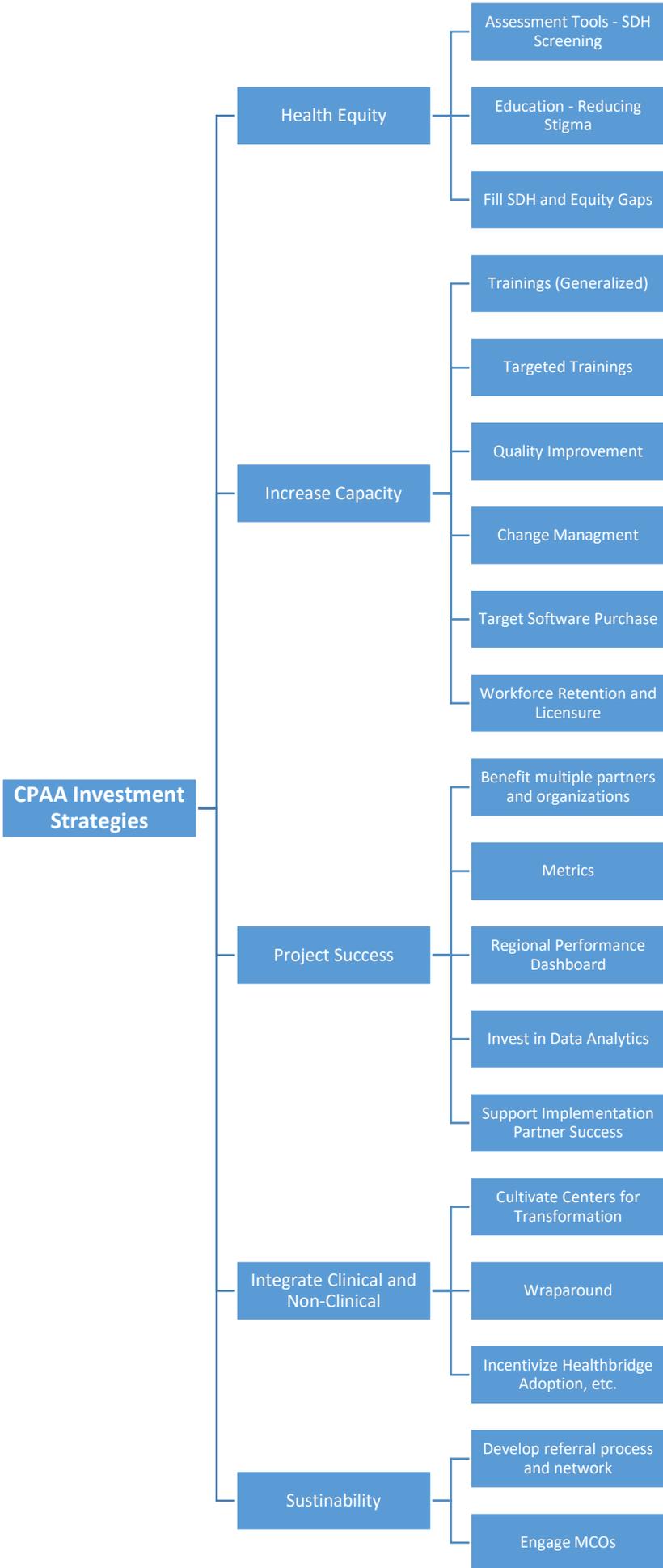
Measurement-Based Care and Using a Registry to Track Outcomes

Understand the basics of measurement-based care, weigh the pros and cons of registry options, and explore the functionalities of a registry used to support whole person care.

Wednesday, August 22, 2018 12:00 – 1:00 PM

Register Today! <https://tinyurl.com/CPAA-AIMS-Webinar-Series>

Questions or Comments? Contact Juliann Salisbury, salisi2@uw.edu



Cascade Pacific Action Alliance

ACH Earned Incentives and Expenditures

July 1, 2018 - December 31, 2018

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period ²	
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$4,195,696
2B: Community-Based Care Coordination	\$2,884,541
2C: Transitional Care	\$1,704,501
2D: Diversion Interventions	
3A: Addressing the Opioid Use Public Health Crisis	\$524,462
3B: Reproductive and Maternal/Child Health	\$655,578
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	\$1,048,924
Behavioral Health Integration Incentives	
Value-Based Payment (VBP) Incentives	
IHCP-Specific Projects	
High Performance Pool	
Total Funds Earned	\$11,013,701

Funds Distributed by ACH During Reporting Period, by Use Category ³	
Administration	
Community Health Fund	
Health Systems and Community Capacity Building	\$237,374
Integration Incentives	
Project Management	
Provider Engagement, Participation and Implementation	\$2,995,376
Provider Performance and Quality Incentives	\$769,680
Reserve / Contingency Fund	
Shared Domain 1 Incentives	\$2,777,813
Total Funds Distributed During Reporting Period	\$6,780,243

Funds Distributed by ACH During Reporting Period, by Provider Type ³	
ACH	
Non-Traditional Provider	\$1,060,183
Traditional Medicaid Provider	\$2,337,501
Tribal Provider (Tribe)	\$604,746
Tribal Provider (UIHP)	
Shared Domain 1 Provider	\$2,777,813
Total Funds Distributed During Reporting Period	\$6,780,243

Total Funds Earned During Reporting Period	\$11,013,701
Total Funds Distributed During Reporting Period	\$6,780,243
Total Funds Left Available for Distribution During Reporting Period	\$4,233,458

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 4, 2019 to accompany the second Semi-Annual Report submission for the reporting period July 1 to December 31, 2018.

² For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.

- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

³ Definitions for [Use Categories and Provider Types](#)



February 18, 2019

Dear Ms. Clark:

Thank you for the submission of Cascade Pacific Action Alliance's Semi-Annual Report Assessment 2. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project, Myers and Stauffer LC (Myers and Stauffer) has assessed the Semi-Annual Review 2 submission requirements.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information.

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, Excel or Word format following the resubmission instructions below to WA CPAS (<https://cpaswa.mslc.com/>) within the Request for Information folder (pathway is Semi-Annual Report > Semi-Annual Report 2 – January 31, 2019 > Request for Information). **We ask for your response no later than 5:00 p.m. PST, March 12, 2019.** 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 2 Assessment
*Reporting Period: January 1 to December 31, 2018***

Request for Supplemental Information

Upon review of the ACH's Semi-Annual Report Assessment, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification.

- If the question applies to the project narrative, please provide a response within this document. The naming convention should be as follows: "RESPONSE ACH name.SAR2.RFI.Date"
- If the question applies to the workbook, please respond with an **updated** workbook. The naming convention should be as follows: "REVISED ACH Name.SAR2 Workbook.Date"

Section 1: Required Milestone Reporting (VBP Incentives)

Part D, Milestone 4, Question 1: Provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTE or fewer), and 3) behavioral health providers.

1. **Independent Assessor Question:** Please identify the specific provider/organization for each of the three unique provider type examples.

The table below identifies the specific provider/organization for each of the three unique provider types. VBP information is distributed broadly to over 300 individuals and posted in the CCAA newsletter and website.



ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
Provider with low VBP knowledge: Morton General Hospital, Behavioral Health Resources, Cascade Mental Health, Community Youth Services, Mason General Hospital, Olympia Pediatrics, South Sound Pediatrics	Investment and infrastructure	Develop action plan to incentivize VBP survey	Target resources and investments based on completion and VBP survey results	Encourage partnering providers to increase VBP survey completion and VBP arrangements beginning in 2019
Small provider: Northwest Pediatrics	Education	Individual meeting to explain VBP goals, changes in payment methodology, and VBP survey	N/A	Encourage partnering provider to engage with MCOs about VBP
Behavioral health provider: Willapa Behavioral Health, Behavioral Health Resources, Sea Mar, Cascade Mental Health, Eugenia Center, Community Youth Services	Education	Promoted the VBP Practice Transformation Academy	N/A	Encourage partnering providers to engage in the VBP Practice Transformation Academy



2. **Independent Assessor Question:** In response to Section 1, Part C, Milestone 3, CPAA indicates no incentive is offered for completion of survey. In response to Section 1, Part D, Milestone 4, CPAA appears to suggest that providers needs will be addressed by completion of the VBP survey (an incentive may be provided). Please clarify the ACH provider support activity and if an incentive is offered to support completion of the state's 2018 provider VBP survey.

To clarify CPAA’s position on incentivizing participation in the VBP survey, for the SAR2 reporting period, CPAA did not provide incentive funding to organizations that completed the 2018 VBP survey. However, during the SAR2 reporting period, CPAA developed a payment methodology to incentivize provider completion of the 2019 VBP survey. The milestone CPAA reported achieved was the approved budget that includes VBP survey completion incentives for the 2019 survey.

Section 2: Required Milestone Reporting (Project Incentives)

Part A, Milestone 1, Question 2: Attestation- The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. If the ACH checked "No" in item A.2, provide the rational for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone.

3. **Independent Assessor Question:** The ACH attested “No” to developing a plan and description of steps that need to occur for regional transition to integrated managed care with county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners. The ACH provided a rationale for having not developed a plan for regional transition to integrated managed care, and noted that the stakeholders “moved towards developing a plan.” Please describe in more detail, the steps and associated timeline the ACH will take to complete this milestone.

During the SAR2 reporting period, the Great Rivers region proposed possible steps and timelines within their draft charter for transition to IMC. It is expected the Great Rivers region will finalize their Interlocal Leadership Structure charter in March 2019. After that time, the steps and timeline will be fully developed.

CPAA leadership meets with Interlocal Leadership Structure	March 2019
Identify milestones to achieving IMC	March 2019



Identify which organizations will lead which committees	March 2019
Monitor progress quarterly and report to HCA in semiannual reports	Quarterly

CPAA reached out to HCA and confirmed they received no response from the Thurston-Mason region on their Interlocal Leadership Structure. CPAA is maintaining bi-directional communication with HCA regarding the two BHOs and is working closely with Thurston-Mason BHO to determine next steps and an associated timeline to transition to IMC. Thurston-Mason BHO plans to reach out to county commissioners to determine how they would like to proceed with their Interlocal Leadership Structure. However, RCW 71.24.880, Section 4062, states, *“leadership structures must be chaired by the counties and jointly administered by the authority, managed health care systems, and counties.”* While IMC is BHO-led, CPAA has reached out to the Thurston-Mason BHO and, if no progress is made, CPAA will attempt to convene partners in the Thurston-Mason region to clarify the situation in March 2019.

Part A, Milestone 1, Question 3: Has the region made progress during the reporting period to establish an early warning system (EWS)? If yes, describe the region’s plan to establish an EWS Workgroup, including: i) Which organization will lead the workgroup, ii) Estimated date for establishing the workgroup, iii) An estimate of the number or workgroup participants. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

- 4. Independent Assessor Question:** What organization will lead the EWS Workgroup for the Great Rivers region?

Cowlitz County Health & Human Services Department

- 5. Independent Assessor Question:** What organization is anticipated to lead the EWS Workgroup for the Thurston-Mason region?

It has not been determined which organization will lead the EWS Workgroup for the Thurston-Mason region. CPAA reached out to HCA and confirmed they had received no response from the region on the Interlocal Leadership Structure. CPAA is maintaining bi-directional communication with HCA regarding the two BHOs and is working closely with Thurston-Mason BHO to determine next steps. Thurston-Mason BHO plans to reach out to county commissioners to determine how they would like to proceed with the Interlocal Leadership Structure. RCW 71.24.880, Section 4062,



states, “leadership structures must be chaired by the counties and jointly administered by the authority, managed health care systems, and counties.” While IMC is BHO-led, CPAA will continue to work closely with the BHO. If no progress is made, CPAA will attempt to convene partners in March 2019.

6. **Independent Assessor Question:** What is the estimated date for establishing an EWS Workgroup in the Thurston-Mason region?

Transition to IMC is BHO-led. An estimated date for establishing an EWS Workgroup in the Thurston-Mason region has not been established. CPAA will continue to meet with the Thurston-Mason BHO monthly to determine progress. If no progress has been made, CPAA will attempt to convene all appropriate organizations in March 2019.

7. **Independent Assessor Question:** Please clarify the number of stakeholders that participate in the Great Rivers EWS Workgroup.

Member composition of the Great Rivers EWS Workgroup is as follows:

Leadership (with alternates) from each of the five County Administration
HCA Representative
One Representative/CEO from each MCO (with alternates)
BHO Representative
ACH Representative
Tribal Representative

The distribution list has 23 different individuals participating in the workgroup.

8. **Independent Assessor Question:** The ACH provided a rationale for not establishing an EWS this reporting period. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

While transition to IMC is BHO-led, CPAA is maintaining bi-directional communication with HCA regarding the two BHOs and is working closely with both BHO regions to determine next steps and an associated timeline to transition to IMC. CPAA will persist in monitoring the transition to IMC by continuing to initiate communications and engage with the Thurston-Mason region on the establishment of an Interlocal Leadership Structure. CPAA will also continue working closely with HCA, MCOs, BHOs, and our implementation partners throughout the region to identify individual needs of our partners.



An example of one need identified by our partners is EHR enhancement to ensure BHAs are able to meet the billing and coding requirements of MCOs. By working closely with the BHOs and our partners, CPAA will provide funding for EHR enhancement. Another example of a need identified by partners is additional contract training. CPAA is finalizing the contract to provide MCO contract training in April 2019 to all BHAs in our region. CPAA extended the invitation to this training to Olympic ACH, which is also an on-time adopter.

Part A, Milestone 1, Question 4: Describe the region's plan to establish a communications workgroup, including: i) Which organization will lead the workgroup, ii) Estimated date for establishing the workgroup, and iii) An estimate of the number and type of workgroup participants.

9. **Independent Assessor Question:** The ACH confirmed that a Communications Workgroup is not yet established, but planning is in process. What organization is anticipated to lead the Communications Workgroup?

Cowlitz County Health & Human Services Department will lead the Communications Workgroup for the Great Rivers region. This role is written into the proposed charter, which should be finalized in March 2019. The Communications Workgroup will work with HCA and/or BHOs to coordinate, develop, and disseminate communications among enrollees, providers, and other stakeholders.

It is currently unknown who will lead the Communications Workgroup in the Thurston-Mason region. Although it is clear HCA advises each region to create a Communications Workgroup to work with HCA to coordinate, develop, and disseminate these communications, it is expected this work will be conducted by a sub-committee of the Inter Local Leadership Structure in the Thurston-Mason region.