



Medicaid Transformation Project

# Semi-Annual Report 3

January 1, 2019 – June 30, 2019



July 31, 2019

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

RE: CPAA Semi-Annual Report 3

Dear Semi-Annual Report Review Team:

Please find attached a copy of Cascade Pacific Action Alliance's (CPAA) third semi-annual report for the Medicaid Transformation Project (MTP). This report summarizes CPAA's work from January 1, 2019, through June 30, 2019, 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, hosting a regional Networking Event, Quality Improvement Conference, and MCO Contracting Conference; transitioning project specific workgroups to a regional Learning Collaborative; MTP partner site visits; and developing a MTP partner Quarterly Reporting template and collecting reports. During the reporting period, we also continued to round 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.

Sincerely,

Jean Clark, CEO  
Cascade Pacific Action Alliance

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*\*CPAA P4R Metric Reporting, Potential Site List, Design Funds, and Updated Project Implementation Work Plan are Separate Documents*

## ACH Contact Information

Include in the semi-annual report the 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.

<b>ACH name:</b>	Cascade Pacific Action Alliance (CPAA)
<b>Primary contact name</b>	Jean Clark
<b>Phone number</b>	360-539-7576 ext. 116
<b>E-mail address</b>	clarkj@crhn.org
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<b>Phone number</b>	360-539-7576 ext. 131
<b>E-mail address</b>	mitchellc@crhn.org

## Section 1. ACH Organizational Updates

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

### Attestations

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

Foundational ACH requirements	Yes	No
1. 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	
2. The ACH has an Executive Director.	X	
3. 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: <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Behavioral health providers</li> <li>• Health plans, hospitals or health systems</li> <li>• Local public health jurisdictions</li> <li>• Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region</li> <li>• 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.</li> </ul>	X	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH's decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this <a href="#">template</a> or a similar format) that addresses internal controls, including financial audits. <sup>1</sup>	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	X	

<sup>1</sup> <https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26>

If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

## Attachments

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

**9. Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

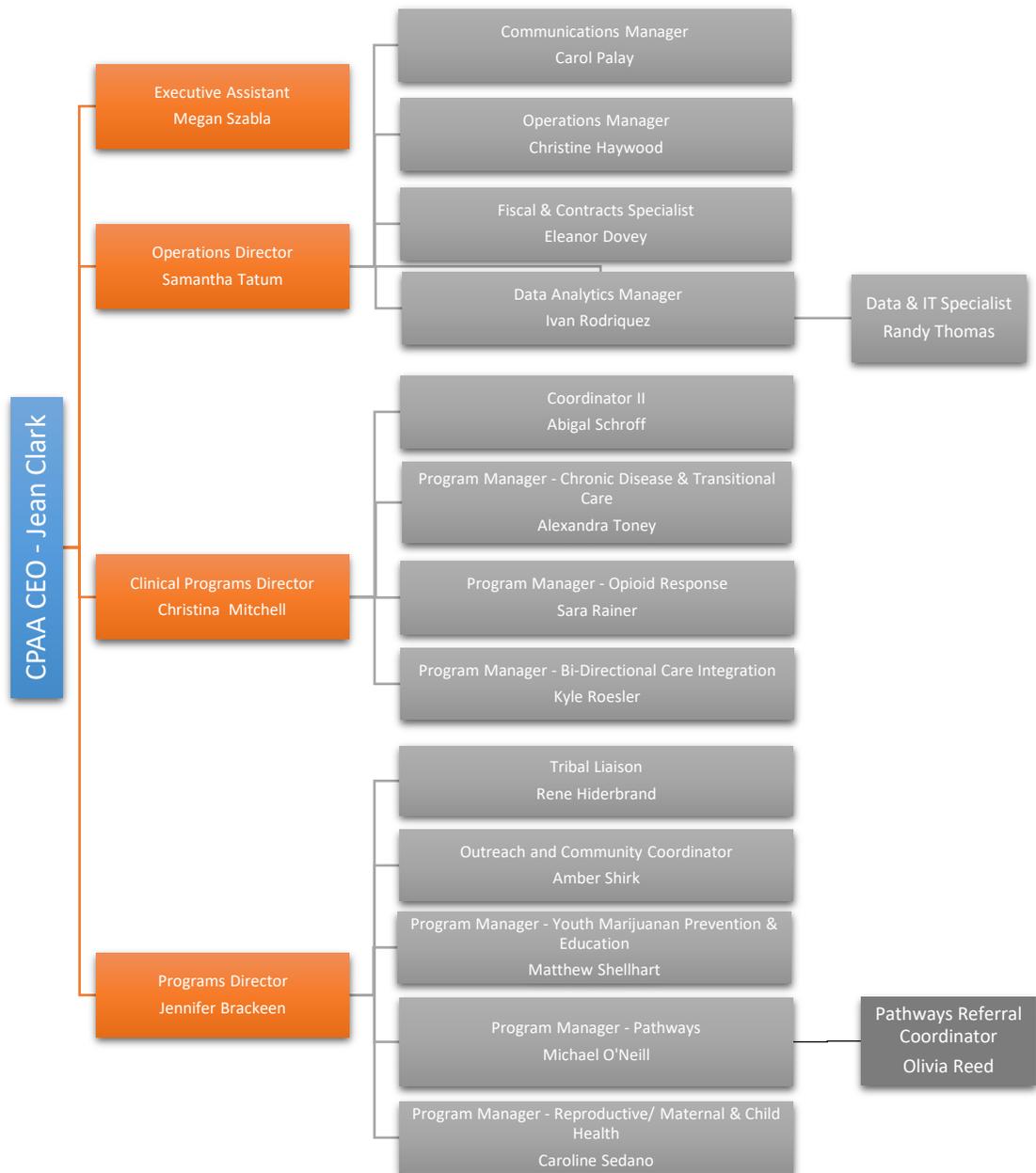
***If applicable, attach or insert current organizational chart.***

Table 1: CPAA Organizational Updates

Name	Position	Role
Jean Clark	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. <b><i>*Last day was June 26</i></b>
Matthew Shellhart	YMPEP Manager	Manages the Youth Marijuana Prevention and Education program.
Christine Haywood	Operations Manager	Provides operational support.
Ivan Rodriguez	Data and IT Manager, Technical Officer, and Privacy Officer	Provides oversight of data analytics and IT, as well as maintains security of protected health information. <b><i>*Absorbs partial duties of the IT Administrator</i></b>
Kyle Roesler	Care Integration Manager	Manages the Bi-Directional Care Integration program.
Michael O'Neill	Pathways Hub Manager	Manages the Pathways program.
Sara Rainer	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.
<b><i>*Megan Szabla</i></b>	Executive Assistant	Provides administrative support for the CEO.
<b><i>*Abigail Schroff</i></b>	Coordinator II	Provides administrative support for the clinical programs and clinical director. <b><i>*Promoted from Program Support Specialist; absorbs partial duties of second Program Support Specialist.</i></b>
<b><i>*Position will not be rehired at this time.</i></b>	Program Support Specialist	Provides administrative support for the Pathways, Reproductive and Maternal/Child Health, and Youth Marijuana Prevention and Education program, and program director.
<b><i>*Eleanor Dovey</i></b>	Fiscal and Contracts Specialist	Provides fiscal and administrative support.
<b><i>*Randolph Thomas</i></b>	Data and IT Specialist	Provides data analytics. <b><i>*Absorbs partial duties of the IT Administrator</i></b>

Name	Position	Role
<b>*Position will not be rehired at this time.</b>	IT Administrator	Provides IT expertise to setup and maintain technology systems within the organization.
<b>*Olivia Reed</b>	Pathways Referral Coordinator	Provides technical support for care coordination agencies in the Pathways HUB.
Rene' Hilderbrand	Tribal Liaison	Collaborates with the tribes to inform, make recommendations, and gather input.
<b>*Amber Shirk</b>	Outreach and Community Coordinator	Collaborates and coordinates with outreach efforts, local forums, and the Consumer Advisory Committee.
Carol Palay	Communications Manager	Provides communications expertise and supports stakeholder, implementation partner, and community engagement.

Table 2: CPAA Organizational Chart



## 10. Budget/funds flow.

- Financial Executor Portal activity for the reporting period. The Financial Executor will provide to the Independent Assessor an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. Use Category reconciliation documentation will be included, if applicable. No action is required by the ACH for this item.
  - Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal, etc.).

To clarify portal activity during this reporting period, CPAA received \$49,797.00 from the FE Portal that was used to directly pay community-based organizations for capacity building investments. These organizations are not in the FE Portal because they are not MTP Implementation Partners. However, these organizations provide services to the Medicaid population that enhance the work of MTP partner providers in the region.

## Documentation

The ACH should provide documentation that addresses the following:

**11. Tribal Collaboration and Communication.** Provide two examples that demonstrate how the ACH furthered the relationships with Tribes and Indian Health Care Providers (IHCPs) with whom the ACH shares the region.

Cascade Pacific Action Alliance (CPAA) furthered the relationships with Tribes and Indian Health Care Providers (IHCPs) with whom we share the region by continuing to offer tribes access to the Tribal Liaison, directors, and program managers for one-to-one support, holding a regular Tribal Health Directors call, and including Tribes in regional trainings and partnership opportunities.

### Tribal Liaison

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, the Tribal Liaison meets one-on-one with each tribe in addition to supporting a monthly meeting of the Tribal Health Directors with CPAA. The one-on-one in-person visits and phone calls assist tribes with Medicaid Transformation Project (MTP) implementation, Change Plan modification, identify necessary TA requests and schedule follow-up, and Quarterly Reporting. CPAA respects the individual tribes' decisions on how best to communicate and collaborate with CPAA, whether directly with relevant directors and program manager(s) or through the Tribal Liaison.

### Monthly Tribal Health Director Call

The monthly Tribal Health Director call serves as one of several ways CPAA communicates and collaborates with tribes. While the call is occasionally canceled, this engagement process allows for strategizing with each tribe how to best support their MTP goals while meeting the tribes' individual health improvement goals, as well as finding alignment among the seven tribes. The call serves as a regular opportunity for CPAA to listen to the tribes discuss successes and challenges, identify any technical assistance needs and requests, and highlight regional training and partnership opportunities.

#### Regional Training and Partnership Opportunities

While all regional partners are invited to CPAA training opportunities (i.e. the networking event, Building Community; Advancing Outcomes: Quality Improvement Conference), the Tribal Liaison identifies and discusses these opportunities during the Tribal Health Director call, which allows for any questions or concerns to be immediately addressed. Most notably, CPAA's Tribal Liaison established a bridge between the Opioid Use Reduction and Recovery (OURL) Alliance and the Tribal Health Directors. That bridge helped establish a partnership between the Confederated Tribes of the Chehalis and OURL Alliance. Accessing recovery support services is particularly challenging for individuals in rural and tribal communities, and access to culturally appropriate services is critical to this population. Culturally appropriate services that "meet people where they're at" is a cornerstone of OURL Alliance program activities. Non-competitive procurement among the seven tribes was a foundational agreement within the OURL Alliance network. The Tribal Health Directors nominated the Confederated Tribes of the Chehalis, a key partner implementing MTP opioid response activities, to partner with OURL Alliance. As a result, Chehalis Tribal Behavioral Health and Wellness Center representatives will join CHOICE Regional Health Network, the administrative support organization for CPAA, the Pacific Mountain Workforce Development Counsel, and other OURL Alliance partners in this innovative endeavor to address the opioid crisis.

### **12. Design Funds.**

- Provide the ACH's total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.
- If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

Please see CPAA.SAR3.Design Funds.7.31.19

### **13. Funds flow.**

If the ACH has made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission, attach:

- The ACH's current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.

- **Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.**

While a DY3 funds flow methodology that takes into account P4P is currently under development by the CPAA Finance Committee, there are not substantive changes made during this reporting period to CPAA's present decision-making process for the distribution of funds and incentives held in reserve.

CPAA released an application for Infrastructure Funds (Domain 1) to MTP Implementation Partners on June 3, 2019 (Appendix A). This one-time funding opportunity, open only to MTP partners, is intended to make targeted investments to support MTP projects and help offset MTP project start-up costs. The funding can be used for small, discrete, one-time project costs including, but not limited to, medical equipment and supplies, IT equipment, office furniture, minor building modifications, and Health Information Exchange/Technology investment. The Infrastructure Fund awards (\$2,000 to \$20,000) will be announced on August 1, 2019.

As previously reported, while fund distribution methodology remains under development for both the Capacity Building Fund and the Regional Wellness Fund, CPAA set aside these funds to support investments in smaller, community-based organizations that address social determinants of health. CPAA is being deliberate and intentional with this funding, which will be used to make targeted upstream investments in community-clinical linkages that complement and support MTP goals such as affordable housing, economic security, safe neighborhoods, transportation, and access to adequate and healthy foods.

Working in conjunction with Oregon Health and Science University (OHSU), CPAA developed an initial strategic framework as a way to assess opportunities for investing Capacity Building and Regional Wellness funds. Focusing beyond MTP, CPAA seeks opportunities that ensure deliverables are met in the region by building cross-sector cohesion, collaboration, and sustainability. This strategic framework, once finalized, 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. With project implementation now underway, CPAA plans to utilize Local Forums to identify ongoing local needs and gaps in existing services to make the most impact with these types of investments.

#### **14. Incentives to support integrated managed care.**

Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care.

- **Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.**
- **ACHs may use the table below or an alternative format as long as the required**

information is captured.

- Description of use should be a brief line item (not narrative).

<b>Use of incentives to assist Medicaid behavioral health providers</b>		
<b>Description of Use</b>	<b>Expenditures (\$)</b>	
	<b>Actual</b>	<b>Projected</b>
Managed Care Contracting from a Position of Strength: an IMC training event with Adam Falcone, held on April 18, 2019.	\$12,000	\$15,000
EHR enhancement funding to support partners in IMC.	\$270,000	\$330,000
Contract with XPIO Health to provide technical assistance for up to 12 behavioral health agencies.	N/A (Contract signed May 2019)	\$150,000
Host MCO-BHA Forum on May 8, 2019	\$1,950	\$1,500

## Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

### Attachments

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

#### 15. Implementation Work Plan

Implementation plans are “living documents” that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA with the information required to monitor the ACH activities and project implementation timelines.

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.<sup>2</sup>

- The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
  - Work steps and their status.
    - At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:
      - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
      - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
      - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
      - Not Started: Work step has not been started.
    - The ACH is to add a “Work Step Status” column to the work plan between the

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

“Work Step” column and the “Timing” column. This column should reflect the status assigned to the work step.

- The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to be started.
- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

***Submit updated implementation work plan that reflects progress made during reporting period.***

Please see CPAA.SAR3.Work Plan.7.31.19.

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	

## 16. 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 through the ACH under Medicaid Transformation.<sup>3</sup> ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:<sup>4</sup>

- *Health systems and community capacity building*
- *Financial sustainability through participation in value-based payment*
- *Bidirectional integration of physical and behavioral health*
- *Community-based whole person care*
- *Improve health equity and reduce health disparities*

The partnering provider roster is a standard component of semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in Medicaid Transformation activities.

To earn the achievement value associated with this reporting component, ACHs are required to confirm and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites (“potential site list”), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites (“potential site list”) to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific “potential site list” to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
  - Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).
  - When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

***Submit partnering provider roster.***

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<sup>3</sup> Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

<sup>4</sup> <https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf>

## Documentation

The ACH should provide documentation that addresses the following:

### **17. Quality improvement strategy update**

The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and the IA apprised of quality improvement activities and findings. ACHs may determine the format to convey this information.

Semi-annual updates should demonstrate that the ACH has insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided by the ACH to partnering providers to promote achievement of transformation outcomes and objectives.

Through these updates, ACHs are expected to report developments over the reporting period, such as:

- Modifications to the ACH's quality improvement strategy
- Summary of findings, adjustments, and lessons learned
- Support provided to partnering providers to make adjustments to transformation approaches
- Identified best practices on transformation approaches

For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of forward momentum, including evidence that partnering providers have the resources and support required for success.

***Attach or insert quality improvement strategy update.***

## Quality Improvement Strategy Update: Defining and Communicating Expectations and Responsibilities for Partnering Providers in Continuous Quality Improvement

CPAA required all MTP Implementation Partners, including tribes and community-based organizations, to complete a Change Plan detailing their Transformation work (Appendix B). Each organization's approved Change Plan will be used throughout the entire MTP by both the organization and CPAA; Change Plans define critical paths and key dependencies. Change Plans 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 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. The Change Plans are intended to be useable, working documents, and they can be updated as necessary throughout the MTP.

CPAA combined all Change Plan milestones and measures into a Quarterly Reporting Tool to ensure goals and milestones are met and swift action is taken if they are not (Appendix C). All implementation partners, including tribes and community-based organizations, must submit a report by the end of the first month following every quarter. As outlined in the contracts, all implementation partners, including tribes and community-based organizations, are required to report on Change Plan milestones quarterly and interim measures semi-annually. Interim measures, or Change Plan 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 (Appendix D). CPAA worked with Providence CORE (CORE) to determine what measures to be reported for each evidence-based intervention.

CPAA hosted a webinar on April 2, 2019, to walk partners through the reporting tool before the first report was due on April 30, and we will host another webinar July 11 for any questions related to Quarter 2 reporting.

Table 4: CPAA MTP Implementation Partner 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

CPAA has established an Access Database to track all partnering provider participation, including tribes and community-based organizations, in MTP activities at the clinic/site level. For each partnering organization involved in the MTP, regardless of provider type, the Access Database tracks project areas, interventions, and self-identified milestones. Additionally, the Access Database tracks broad communications to partners, contracts, funding, TA requests, and relevant internal notes and communications. CPAA used this database to customize quarterly reporting templates for all partners. The database is subsequently updated based on provider responses to the quarterly reports. To mitigate the risk of not sufficiently impacting regional transformation, the set measures will detect when implementation challenges are encountered. This allows partners to make timely, informed decisions for improving outcomes and meeting project metrics.

CPAA issues compliance emails to partners no later than the last day of the second month following every quarter (Appendix E). Additionally, a regional performance report, currently under development, will be shared with the broad stakeholder group semi-annually. The regional performance report will include an overview of finances, training opportunities, community engagement, and Community CarePort (Pathways) data. (Appendix F).

CPAA is keenly aware that equity is not treating all implementation partners the same, but rather ensuring all MTP Implementation Partners have the same opportunities to achieve success. While reporting requirements and compliance/performance reports are the same for all implementation partners, regardless of provider type, CPAA understands that smaller, community-based organizations may require additional supports than the larger, traditional, clinical organizations with robust organizational quality improvement practices already in place. To that end, CPAA has contracted with Comagine (formerly Qualis Health) to provide technical support for up to 25 organizations that request assistance 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. Additionally, CPAA is intentionally including information for non-traditional partners like tribes and smaller, community-based organizations at all conferences, networking events, and Learning Collaboratives to ensure quality improvement practices are relevant and inclusive for all provider types (Appendix G).

<b>Regional Framework for Supporting Partnering Providers’ Quality Improvement Processes</b>	
<b>QI Area for Improvement</b>	<b>QI Activities</b>
<b>Structured Quality Improvement Activities and Partnering Provider Support Provided by CPAA</b>	<ul style="list-style-type: none"> <li>• Develop, test, and distribute Change Plan template for partners to develop their MTP planning and implementation activities and quality improvement targets; support implementation partners in completing a quality Change Plan</li> <li>• Develop menu of project metrics that align with HCA metrics to monitor evidence-based practices and monitor outcomes</li> <li>• Review new quality improvement methods with the regional Learning Collaborative</li> <li>• Test new quality improvement methods with partnering providers</li> <li>• Continue to embed ongoing learning opportunities, best practices, implementation successes and challenges, and collaboration throughout the region into Learning Collaborative, local community forums, and CPAA Council meetings</li> <li>• Host regular webinars, CPAA Council meetings, and Learning Collaborative</li> <li>• Host annual regional Quality Improvement Conference</li> <li>• Conduct MTP Implementation Partner site visits</li> </ul>
<b>Methods and Frequency of Tracking Partner QI Progress</b>	<ul style="list-style-type: none"> <li>• MTP Implementation Partners report on Change Plan milestones quarterly – Excel milestone report and Word narrative report submitted to CPAA</li> <li>• MTP Implementation Partners report on metrics semi-annually - Excel milestone report and Word narrative report submitted to CPAA</li> <li>• Conduct annual MTP Implementation Partner site visits</li> <li>• Monitor qualitative and quantitative data for intervention/s to evaluate success of organizations' implementation of selected evidence-based interventions</li> </ul>

	<ul style="list-style-type: none"> <li>• Regular check-ins with Qualis Health regarding partners they're assisting</li> <li>• CPAA issues quarterly performance emails to individual MTP partners and a regional report to the broad stakeholder group</li> <li>• TA partners (Qualis Health and AIMS Center) provide quarterly reports to target efforts and advise progress</li> </ul>
<b>Process of Communicating and Implementing Adjustments to Optimize MTP Approaches</b>	<ul style="list-style-type: none"> <li>• Provide targeted technical assistance for partners to address quality concerns as indicated in Quarterly Reports; this TA could come from appropriate program manager/s and/or external consultants as needed</li> <li>• Identify partnering providers who need additional technical assistance to expand/improve their program</li> <li>• TA request form sent to MTP Implementation Partners</li> <li>• Solicit advice from clinical experts, including the Clinical Advisory Committee and partner champions</li> <li>• Develop partner performance improvement action plans as needed</li> </ul>
<b>Technical Assistance Provided or Facilitated by CPAA</b>	<ul style="list-style-type: none"> <li>• Use performance improvement action plans, as needed, to monitor project progress</li> <li>• Identify regional champions who implemented a successful program and who are interested in training other organizations</li> <li>• Develop a peer-to-peer training model that works for regional champions and partnering providers</li> <li>• Contract with Qualis Health for partners requiring additional support</li> <li>• Contract with AIMS Center for partners participating in Bi-Directional Care Integration</li> <li>• CCS contract for partners participating in Community-Based Care Coordination (Pathways)</li> </ul>
<b>Methods and Frequency of Sharing Approaches and Lessons Learned</b>	<ul style="list-style-type: none"> <li>• Host regional networking events, facilitate opportunities, encourage dialogue, increase clinical-community linkages, and share lessons-learned and best-practices</li> <li>• Host annual regional Quality Improvement Conference</li> <li>• Establish regular Learning Collaborative meetings to review quality improvement topics, evaluate current quality improvement strategies, identify areas for improvement, and develop new methods of quality improvement and partner management through professional skills building</li> </ul>

**Narrative responses.**

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

**18. General implementation update**

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols:* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.

**Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?**

CPAA monitored partnering provider progress in adoption of policies, procedures, and/or protocols through the Quartering Reporting narrative questions (Appendix H). All MTP Implementation partners were required to report on their progress during Quarter 1 reporting (October 1, 2018 – March 31, 2019 – subsequent reporting will cover a single quarter). To identify progress made in the adoption of policies, procedures, and/or protocols to date, CPAA MTP Implementation Partners responded to: *“Please provide a brief summary of progress made in the adoption of policies, procedures, and/or protocols that support your MTP work, including any challenges faced. If no progress has been made to date, please describe the policies, procedures, and/or protocols your organization aims to initiate in the next 6 months.”* CPAA then reviewed responses from all 50 partners, assessing for trends.

After careful review of all Quarter 1 reports, CPAA determined organizations are at varying levels of adoption of new policies and procedures based on which stage of implementation they were in. Many of the organizations started with review of all internal policies to ensure they were in alignment with specific requirements of the project areas.

Some examples of partner progress in adoption of policies, procedures, and/or protocols include, but are not limited to:

- Conducting new screenings (i.e. depression, blood pressure checks, BMI measurements, One Key Question, LARC same-day insertion)
- Embedding new procedures, screenings, and prescription monitoring into existing EHR
- Bi-directional referral process/referral tracking
- Identifying and developing organization-specific policies, procedures, and/or protocols (i.e. workflows, crisis workflows, assessments, follow-ups, scheduling, telepsychiatry, monitoring patients receiving medication assisted treatment and naloxone, officers carrying and administering naloxone, warm hand-offs/referrals)
- Updating existing policies, procedures, and/or protocols to align with integrated managed care and other Transformation project areas
- Developing protocol for data collection/documentation and metrics
- Standardizing policies, procedures, and/or protocols across clinic sites
- Clarifying/developing new job descriptions that impact new workflows based on adoption of new policies, procedures, and/or protocols
- Developing policies, procedures, and/or protocols for staff and volunteer safety
- Implementing caseload tracker into workflow

**Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.**

Within CPAA’s network of MTP Implementation Partners, there are several examples of partnering providers sharing policies, procedures, and/or protocols.

Some organizations participating in project 2A, Bi-Directional Integration of Care, adapted policies and procedures from physical health/behavioral health partners to meet the combined needs of both health practices, now in an integrated setting. Organizations participating in Bi-Directional Integration of Care also attended CPAA-provided AIMS Center trainings and worked closely with the AIMS Center to improve policies and workflow to support required health screening and registries. Due to overwhelming demand for AIMS Center training participation, CPAA hosted several cohorts of trainings, specific to provider type (i.e., behavioral health agency cohort, primary care cohort, and a pilot pediatric cohort).

Other organizations, who are partnered closely in their MTP work, are working together to share policies, procedures, and/or protocols. For example, two organizations are meeting twice a month to solidify their new referral process and to develop necessary forms and procedures to track those referrals. Several organizations working in 3A, Opioid Response, are sharing internal procedures and policies while new medication assisted treatment (MAT) programs develop their own.

Additional examples of partnering providers sharing policies, procedures, and/or protocols include, but are not limited to:

- Developing initial working procedures/protocols for measuring physical health metrics
- Identifying medical intervention procedures/protocols to be utilized when metrics are outside of normal range
- Developing a Patient Health Metrics Tracking Registry and procedures for use
- Hiring and training staff on the policies and procedures for using the register and coordinating client care between providers.

**Describe any challenges faced by partnering providers in the adoption of policies, procedures and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?**

To monitor challenges faced by partners in the adoption of policies, procedures, and/or protocols, in the Quarter 1 Narrative Report, CPAA asked: *“Please provide a brief summary of progress made in the adoption of policies, procedures, and/or protocols that support your MTP work, including any challenges faced. If no progress has been made to date, please describe the policies, procedures, and/or protocols your organization aims to initiate in the next 6 months.”*

While many partners report that internal policies have been updated to reflect new models of care and workflows, several organizations identified updating policies and procedures as a challenge because they are still early in the implementation phase. The first quarter was spent researching, learning, and networking, resulting in a delay of formally updating policies, procedures, and protocols, specifically when partnering with external agencies.

To support our partnering providers to overcome challenges, and in response to the need for technical assistance highlighted by the Current State Assessment, which CPAA conducted in the spring of 2018, CPAA finalized a contract with the AIMS Center to offer their Bi-Directional Care Integration training program to partners in the region (Appendix I). As previously mentioned, those trainings have been

robustly attended, and in addition to a behavioral health cohort and a primary care cohort, CPAA is piloting a pediatric cohort in the region.

Specific to 3B, Reproductive and Maternal/Child Health, CPAA hosted a full-day training with Power to Decide on One Key Question, which modeled how to talk to clients about their pregnancy intentions and have counseling and resources ready to support those clients, however they answer the question (Appendix J). While healthcare workers are often on a tight schedule when meeting with their clients and patients, the training helped providers brainstorm how to embed One Key Question into their intake or EHR systems to ensure there are standard ways to address client needs.

Another way CPAA is supporting our partners to overcome challenges is by coordinating activities and TA with Comagine Health. After conducting site visits during this reporting period with each of the 50 MTP Implementation Partners, CPAA evaluated which partners needed additional assistance with adoption of policies, procedures, and/or protocols (Appendix K). At the time of reporting, CPAA has connected 6 partners with Comagine Health. These partners are smaller and/or rural organizations and providers that currently lack existing quality improvement strategies and have limited data capacity.

CPAA is also making concerted efforts to support regional transformation of adoption of policies, procedures, and/or protocols by providing trainings and assistance to regional partnering providers, in addition to our network of MTP Implementation Partners. To that end, CPAA hosted a Quality Improvement Conference, which included workshops and hands-on activities for both clinical and community-based organizations to develop policies to increase efficiencies and enhanced systems of care, ways to use more data processes and data presentation, and implement measures for monitoring. CPAA has also moved from project-specific workgroups to a regional Learning Collaborative. At our first event, over 80 participants from around the region learned about trauma-informed care; the Learning Collaborative included workshop sessions on developing policies to increase worker retention and decrease secondary trauma, both of which are crucial for direct-service providers. Upcoming Learning Collaborative topics include harm reduction and bias.

**Describe the key challenges or risks identified in implementing selected transformation strategies, including potential impacts and mitigation strategies for specific transformation project areas or Domain I strategies. Include impacts across projects, as well as within a specific project area.**

To identify key challenges or risks in implementing selected Transformation strategies, CPAA required MTP Implementation Partners to submit quarterly reports, which include the question: *“Describe the key challenges or risks experienced in implementing your selected Transformation projects during this reporting period. Include potential impacts and mitigation strategies for specific Transformation activities. Please be sure to address each project area you’re participating in.”* After careful review of the Quarter 1 reports, CPAA identified several categories of risks and challenges trends when implementing Transformation projects.

One trending risk category across all project areas is limited workforce. As noted in previous SARs, the Implementation Plan, and the Project Plan, workforce shortages continue to be a concern for partners in the CPAA region. Multiple organizations have current openings they are unable to fill due to a lack of qualified applicants. CPAA anticipates this problem will not only persist but continue to grow as all nine ACHs across the state seek to expand the often-specialized workforce necessary to implement MTP

programs, particularly with Integration of Care and Opioid Response both required project areas. Because of this, providers with appropriate licensure and training are in high demand, especially in rural areas, where hiring is already challenging. Regional workforce shortages are compounded by the fact that Medicaid traditionally reimburses at a lower rate than commercial health plans or Medicare. Because of this, fewer providers, in a region already suffering from provider shortages, are accepting Medicaid patients compared to commercial plans. Being on Medicaid is, in itself, a barrier to care and a health equity concern. Providers are uncertain on how to best engage this population while moving forward with value-based care, knowing Medicaid beneficiaries are most vulnerable, have some of the worst health outcomes, and will be difficult to engage in preventative care.

Limited workforce has resulted in providers delaying project implementation due to inability to hire qualified staff or because of staff turnover. If untrained providers are hired, training is expensive and can be slow to schedule. To mitigate this risk, CPAA worked with partners to identify and prioritize training requirements to successfully implement evidence-based interventions, such as the AIMS Center Whole Person Care, One Key Question, and Care Coordination Systems (CCS) training for partners participating in Community CarePort (Pathways). Upcoming intervention-specific trainings include on-going CCS trainings as additional Pathways cohorts come online, long-acting reversible contraception (LARC) training, and buprenorphine waiver training for medication assisted treatment (MAT). Additionally, CPAA is routinely providing regional training opportunities to increase capacity and skills of all providers, in addition to MTP Implementation Partners, such as harm reduction, trauma-informed care, and staff retention.

Another trending risk category for partners across all project areas is lack of regular and deliberate communication between community-based social service organizations and clinical providers. We recognize that health is more than health care, and improving health starts outside the clinic walls and is critical to an innovative Transformation. However, partners reported that establishing partnerships with external organizations throughout the community to support referrals and finding time to solidify the referral process between organizations has been especially challenging. Coordinating schedules to meet and clearly develop the necessary forms and processes to track cross agencies referrals are slow due to competing priorities. To mitigate this risk, as previously discussed, CPAA is routinely providing regional trainings and networking events to introduce partners, facilitate working partnerships, and improve relationships. Additionally, CPAA coordinates and facilitates meetings between partners when appropriate.

As another mitigation strategy, CPAA elected to use and promote HealthBridge.care to support communication and expand referrals between clinical and community-based organizations. HealthBridge creates community-clinical linkages using a secure and HIPAA-compliant public facing website. HealthBridge lists available resources in the area, allowing direct referrals by both providers and clients. CPAA is continuously updating and expanding organizations listed HealthBridge to provide the most accurate and robust list of resources available in our region.

Other implementation challenges and mitigation strategies include, but are not limited to:

- A Domain 1 challenge is upgrading EHRs to support registries, new screenings and workflows, and reporting requirements; this upgrade is necessary and expensive. To mitigate the risk, CPAA offered partners an Integrated Managed Care (IMC) Application for

EHR Enhancement, despite being ineligible to receive incentive funding to support IMC as an on-time adopter (Appendix L). CPAA offered this funding opportunity, up to \$30,000 per organization, to MTP behavioral health agency partners.

- Transformation, by definition, requires change, and change is hard; staff burnout is a challenge across project areas, particularly for smaller, community-based organizations doing large new scopes of work and partners working with multiple ACHs. This is mitigated by CPAA going to great lengths to streamline reporting requirements and minimize administrative burdens on our partners. CPAA is also providing regional trainings, such as CPAA's Learning Collaborative on trauma-informed care, including secondary trauma for workers. The Learning Collaborative also included workshop sessions for regional partners to begin developing policies to encourage workplace wellness and increase staff retention. Ongoing Learning Collaborative regional trainings are being developed for harm reduction, bias, health equity, social determinants of health, and change management. CPAA is also supporting organizations as they implement change at a sustainable pace. This includes allowing modifications to Change Plans and providing additional support as needed/requested. To that end, CPAA is currently developing intervention-specific cohorts, encouraging partners to share best practices, lessons learned, and work together to find solutions to common challenges.
- Specific to project 2B, Care Coordination, Community CarePort (Pathways), challenges include care coordinating agencies (CCAs) setting up their infrastructure and hiring and training new care coordinators. This is especially challenging because the CCAs do not know how successful they will be; outcome-based payments sometimes equate to CCAs expending a lot of time and energy without being paid. To mitigate this risk, CPAA is helping minimize start-up costs by providing the Care Coordination System (CCS) software platform and training to all CCAs. At the time of reporting, the four CCAs throughout the region are serving over 450 Pathways clients, which already exceeds CPAA's 2019 goals. This overwhelming demand for services is especially challenging because each Pathways client has different needs (i.e. some clients are met once a month, while others are met twice a week). To mitigate the risk of not meeting demand for services, six CCAs in Cohort 2 are beginning training and will be coming online by the end of August 2019.
- Specific to project 3A, Opioid Response, challenges include overwhelming demand for services and administrative obstacles. To mitigate the risk of not meeting demand for services, CPAA is working with OARR Alliance to host a second regional Certified Peer Counselor training with an emphasis on substance use disorder (SUD). In May, CPAA piloted the first training for Peers with a focus on SUD at a fortuitous time, as this is a Medicaid-billable service as of July 1, 2019. CPAA is also planning additional waiver trainings for providers, as well as addressing stigma and provider discomfort with MAT through regional educational opportunities, which will build capacity around the region to meet demand. Additionally, some CPAA MTP partners participating in 3A are already pursuing braided funding for additional space in existing clinics and/or mobile clinic sites. To mitigate the risk

of administrative obstacles, including but not limited to patients having access to MAT while incarcerated and after being released from incarceration, CPAA is working with partners and HCA to identify proper coding strategies and streamline the Medicaid reinstatement process for individuals who had their benefits suspended while incarcerated. Additionally, work on innovative, “outside the box” MTP projects, like Lewis County Sheriff’s Office MAT program inside the Lewis County Jail, will help other jails around the state model similar programs.

- Specific to projects 3B, Reproductive and Maternal/Child Health, and 3D, Chronic Disease Prevention and Control, is the challenge of patient buy-in. For 3B, that includes combating parent misinformation about the importance of well-child visits and vaccinations. To mitigate this risk, CPAA is working with partners to develop a norming campaign to share around the region, particularly on social media. Additionally, CPAA is working on setting up an intervention-specific regular call, in this case for pediatrics, so providers can share lessons-learned, best practices, and use each other as resources to find solutions for challenges. For 3D, patient-buy in for evidence-based behavior changing programs, (i.e., CDSM, DPP) is a particular challenge. In the past, patients have signed up for classes and either not attended or not completed the classes. Partners have worked together to co-brand materials (i.e., flyers and tents for waiting and exam rooms) to cue providers and ensure patients make informed decisions and come to behavior changing programs ready to engage (Appendix M). CPAA is encouraging these successful partners to become “provider champions” so other providers will use their successes as a model.

## **19. Regional integrated managed care implementation update**

For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.

CPAA has made progress during this reporting period, moving towards regional integrated managed care. As previously mentioned in the SAR2, there are two regional service areas and corresponding Behavioral Health Organizations (BHOs) in the CPAA region transitioning to IMC in 2020: Great Rivers BHO and Thurston-Mason BHO. While there is a general timeline that lays out transition milestones and stakeholder expectations, each BHO region has different stakeholders and is in a different stage of planning for the transition to IMC.

The Great Rivers BHO region is making progress in developing the early warning system, communications, and provider readiness workgroups. The Great Rivers Interlocal Leadership Structure (ILS) is working with HCA on developing the region’s early warning system. The ILS will focus on collecting data for the required metrics and will consider adding additional metrics later this year. Additionally, the ILS will absorb the communications responsibilities for the region. CPAA will manage and facilitate the provider readiness workgroup. Although the provider readiness workgroup has yet to be convened, CPAA is planning to host the first workgroup by August 31, 2019.

The Thurston-Mason BHO is taking the lead on developing an ILS for their region. As the ILS is developed, it's unclear which entities will be responsible for leading the early warning system, communication, or provider readiness workgroups. CPAA has continued to work closely with Thurston-Mason BHO during the reporting period to determine how we can best support the transition to IMC and what role CPAA will play on the ILS and the different workgroups.

- For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the ACH has identified as it pertains to integrated managed care. What steps has the ACH taken to address these needs?

Behavioral health providers are actively preparing for the transition to IMC by allocating resources, participating in training opportunities, and developing internal infrastructure capabilities. Over the past year, CPAA has collaborated with behavioral health providers to identify a number of training and technical assistance needs, including contracting training, electronic health record implementation/modification, and how best to work with managed care organizations (MCOs). CPAA has taken steps to support provider readiness and address all three of these areas including:

- CPAA hosted Contracting from a Position of Strength, an MCO contracting training led by Adam Falcone, a subject matter expert and attorney (Appendix N).
- In collaboration with all four MCOs in our region, CPAA hosted and coordinated the first of several MCO-BHA forums for behavioral health providers to learn more about IMC and to engage directly with MCOs (Appendix O).
- As previously mentioned, numerous behavioral health providers mentioned EHR implementation as a challenge area. CPAA allocated supplemental funding to agencies that are enhancing or modifying EHRs to improve functionality for MCO billing requirements.
- CPAA contracted with XPIO Health to provide direct in-house technical assistance for behavioral health providers through the end of 2019. XPIO is currently working with five behavioral health partners and has meetings planned with an additional four partners (Appendix P).

### Attestations.

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

	Yes	No
20. 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:		

	Yes	No
<ul style="list-style-type: none"> <li>• Identification of partnering provider candidates for key informant interviews.</li> <li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li> <li>• 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.</li> </ul>	X	

If the ACH checked “No” in item 20 above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

## Section 3. Pay-for-Reporting (P4R) metrics

### Documentation.

#### 21. P4R Metrics (*updated May 2019*)

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.<sup>5</sup> Twice per year, ACHs will request partnering providers respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster. ACHs will gather the responses and report an aggregate summary to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

#### *Related resources and guidance:*

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification she..](#)
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under *ACH pay for reporting metrics*.
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.
- It is HCA’s expectation that ACHs will facilitate participation of practice/clinic sites and CBOs, and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to

<sup>5</sup> For more information about ACH pay for reporting (P4R) metrics, see Measurement Guide Chapter 6 and Appendix K. Link: <https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf>

summarize the number of respondents by provider type for each reporting period.

*Instructions:*

- Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g. count of sites that selected each response option).
- Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the [reporting template](#).

*Format:*

- ACHs submit P4R metric information using the [reporting template](#) provided by the state.

***Submit P4R metric information.***

Please see CPAA.SAR3.P4P Metric Reporting.7.31.19.

# Appendixes

# Appendix A

Dear MTP Implementation Partner,

CPAA is announcing a funding opportunity for MTP Implementation Partners *only*: Application for Infrastructure Funds.

**Application for Infrastructure Funds** is a one-time funding opportunity open only to our MTP Implementation Partners. These funds are meant to help offset MTP project start-up costs. The funding can be used for small, discrete, one-time project costs like medical equipment and supplies, IT equipment, office furniture, etc. **The Infrastructure Funds application will open June 3, 2019, and close July 15, 2019.** Awards will be announced August 1, 2019. [Click this link for more information and to go to the Application for Infrastructure Funds.](#)

If you have questions or concerns, please email [reporting@cpaawa.org](mailto:reporting@cpaawa.org). Write Infrastructure Funds Application Question in the subject line. Questions will be responded to within 3 business days.

Thank you.

Cascade Pacific Action Alliance

# Application for Infrastructure Funds

## Save & Return

Log in

Use an account to return to saved work.

Release: June 3, 2019

Close: July 15, 2019

Announcement of Awards: August 1, 2019

### Introduction:

Cascade Pacific Action Alliance (CPAA) allocated Medicaid Transformation Project (MTP) Domain 1 funding for CPAA Medicaid Transformation Partners to make targeted investments to support approved MTP projects. These funds are designed to offset start-up costs associated with implementing MTP projects.

Infrastructure Funding is a one-time funding opportunity that may be used for small, discrete, one-time project costs including, but is not limited to:

- Minor building modifications
- Medical equipment
- Medical supplies
- IT equipment
- Office furniture
- Health Information Exchange/Technology investments

For example, an organization hires a provider to support Bi-Directional Integration of Care. A storage room will be converted into a treatment room. Infrastructure Funds may be used to offset the cost of required equipment such as a desk, computer, blood pressure monitor, etc.

### Eligibility

**Only CPAA Medicaid Transformation Project Implementation Partners that have a current contract with CPAA may apply.** Funds must be used for targeted investments in projects areas included in the contract. Organizations may only submit one application per organization (as

defined by EIN). \*CHOICE Regional Health Network employees may not apply on behalf of organizations that they support or are affiliated with.

## Available Funding

CPAA allocated a portion of Domain 1 funding for one-time infrastructure costs. If selected, CPAA will make a small, one-time payment (\$2,000 to \$20,000) to offset a portion of project start-up costs.

## Priorities for funding

- Directly impacts an approved MTP project area
- Supports MTP project goals
- Includes braided funding if the total cost is more than the requested amount
- One-time investment

## Application for Funds Instructions

When completing the Application for Infrastructure Funds, your response will be saved when you advance to the next page. You can save your form and return to it later; however, to do so, you must first create an account by following the link on the first page. **CPAA strongly encourages all applicants to create an account.** Please note: If you close your browser before saving or before moving to another page, your input will be lost. If you choose to not create an account, you cannot return to your answers later. To directly log into your own form, use this link (add link to formsite). An invoice for reimbursement or letter of intent to purchase must be included for this application to be considered.

## Questions and Answers

Please direct questions to: [reporting@cpaawa.org](mailto:reporting@cpaawa.org). Please include "Infrastructure Funding Application" in the subject line of your email. Questions will be responded to within 3 business days.

## Evaluation and Selection Criteria

Maximum points may be earned in the following categories:

- **50 points** Narrative description
- **40 points** Connection to project areas
- **10 points** Clarity of supporting documentation

25% Complete

## Applicant Information

**Are you a CPAA Medicaid Transformation Project (MTP) Implementation Partner with a current contract? \***

Yes

No (Unfortunately, only CPAA MTP Partners Are Eligible to Apply)



50% Complete

Organization Name \*

Organization name as recognized by the IRS \*

Employer Identification Number (EIN) \*

Organization Street Address \*

Address Line 2

City \*

State \*

Zip Code \*

Primary Contact Name (First Last): \*

Phone Number of primary contact \*

Email Address of primary contact \*

Organization Type \*

- Clinical (Traditional Medicaid provider)
- Non-Clinical (Non-Traditional Medicaid provider)
- Combined Clinical and Non-Clinical

**CPAA counties in which you operate full-time facilities \***

- Cowlitz
- Grays Harbor
- Lewis
- Mason
- Pacific
- Thurston
- Wahkiakum

**Select the approved project area(s) that funding will support. \* ?**

- Bi-Directional Integration
- Care Coordination (Pathways)
- Chronic Disease Prevention and Control
- Reproductive/Maternal and Child Health
- Opioid Use Public Health Crisis
- Transitional Care

## Questions (scored)

**Provide a brief narrative description of how the money will be spent. \***

Total amount requested: \* 

Will the amount requested cover the total cost of the investment? \*

- Yes - No additional questions
- No - Additional funding from another source will be used.
- No - We have not secured additional funding at this time.

Have you already made the investment? \*

- Yes - You are required to attach an invoice to this application
- No - You are required to attach a letter of intent to this application

Attach an invoice or letter of intent to this application (Max size 10 MB)



## 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

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

## 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](mailto:reporting@cpaawa.org) no later than **October 15, 2018**, for initial feedback and recommendations.

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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](mailto:reporting@cpaawa.org) no later than **November 15, 2018**.

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

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

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<b>Scale and Sustain (Jan 2020-2021)</b>		
<b>Milestones</b>	<b>Target Date</b>	<b>Lead Person</b>

### MTP Transformation Activities

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

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: \_\_\_\_\_

Appendix C:  
Quarterly Reporting  
Instructions and Templates

Dear MTP Implementation Partner,

Attached to this email, you will find three documents:

- **Partner Roster**
- **MTP Quarterly Report, Milestone Report**
- **MTP Quarterly Report, Narrative Report**

The **Partner Roster** lists the most current information we have on your organization. Please verify that the information within this document is correct and email [reporting@cpaawa.org](mailto:reporting@cpaawa.org) if you need to add or change any information.

The **MTP Quarterly Report** is a required report for all MTP Implementation Partners. CPAA will use partner Quarterly Reports to monitor MTP goals and activities, address challenges, and to fulfill ACH-level reporting requirements and earn Transformation dollars for the region. The MTP Quarterly Report consists of two required documents: the **Milestone Report (Excel file)** and the **Narrative Report (Word document)**. The Milestone Report has been prepopulated with milestones occurring during this reporting period from your approved Change Plan. The Narrative Report consists of four questions to help CPAA track progress and capture any Transformation activities not listed as milestones. We made every effort to streamline the tool and reduce the reporting burden on our MTP partners while capturing the necessary information required to successfully administer the Transformation.

This first reporting period covers Quarter 4 2018 through Quarter 1 2019 (October 1, 2018 – March 31, 2019). Subsequent Quarterly Reports will cover a single quarter.

**Completed Quarter 1 reporting is due by 3:00pm on Tuesday, April 30, 2019. Please submit your completed reporting to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) in the original formatting: Excel for the Milestone Report and Word for the Narrative Report.**

All questions must be answered for a report to be complete. Your submission will be reviewed, and if CPAA has any concerns, you will be notified within 2 weeks of submission. Submission and CPAA approval of the Quarterly Report fulfills your organization's reporting requirement for Quarter 1 payment. We anticipate your MTP Quarter 1 payment will be processed through the Financial Executor portal in May of 2019. Delay in reporting may result in loss of funds for the reporting period.

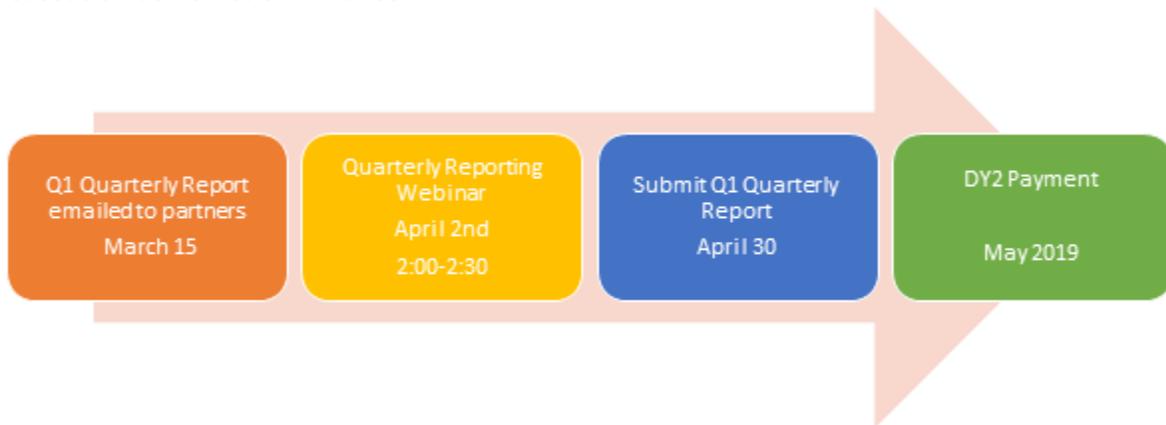
CPAA is hosting a **webinar on Monday, April 2, from 2:00 – 2:30pm**, to answer MTP Quarterly Report questions. You can log into the webinar with this link: <https://zoom.us/j/289577053>. Directors and program managers are also available to answer questions and provide technical assistance in completing your MTP Quarterly Report, and you can email any questions or concerns to [reporting@cpaawa.org](mailto:reporting@cpaawa.org).

Please submit your completed Quarterly Milestone and Narrative Report to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by **3:00pm on Tuesday, April 30, 2019**.

Sincerely,

*Jean Clark*

Jean Clark, Chief Executive Officer  
Cascade Pacific Action Alliance



# Medicaid Transformation Quarterly Report



## Organizational Information

Organization Name	
Primary Contact Name	
Phone Number	
E-mail Address	

## Report Contents

**Must be completed and returned to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by 4/30/2019 using the naming convention MR2019Q1\_ organization name.** Submit your completed Milestones Report in Excel. Please do not alter rows, columns, or formatting. Please submit your completed Narrative Report as a Word document using the naming convention NR2019Q1\_ organizationname.

Your organization's Medicaid Transformation Project (MTP) Quarterly Report is composed of two parts:

- Milestone Report:** has been prepopulated with your organization's final Change Plan milestones. For this reporting period, you will report on milestones with due dates between October 1, 2018, and March 31, 2019 (DY2 Q4- DY3 Q1). Future reports will be prepopulated with self-identified milestones for only one Quarter.
- Narrative Report:** provide additional context and information about your organization's MTP activities.

Both the Milestone Report and Narrative Report must be completed in order to fulfill CPAA's reporting requirements. Receipt of completed reporting will trigger quarterly payment, which will be processed within 30 days. CPAA uses your completed Quarterly Report to monitor MTP goals and activities, address challenges, and to fulfill ACH-level reporting requirements and earn transformation dollars for the region. **If you have any questions or concerns about quarterly reporting, please submit them to the [reporting@cpaawa.org](mailto:reporting@cpaawa.org) prior to 4/30/2019.**

## Instructions for Milestone Report

1. Select the progress indicator:

- Completed** – The milestone has been completed, and the implementation partner is able to provide supporting documentation regarding the completion of the deliverable upon request.
- In Progress** – Actions were taken towards achieving the work step deliverable, but the deliverable has a target end date in the future. The implementation partner is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
- Not Started** – Work step has not been started.
- Needs to be Revised** – Milestone needs to be modified.

2. If the milestone is completed, do not provide notes. For all other progress indicators, write a **brief** description in the notes section (200 characters or less) and provide a new due date using the formula 00/00/00 :

- If in progress, please briefly provide a status update and state any barriers encountered.
- If not started, please identify any barriers encountered, provide a brief description of how you are moving forward, and state the revised due date for the milestone.
- If needs to be revised, provide the new milestone, rationale, and the new date if applicable.

## Instructions for Narrative Report

# Medicaid Transformation Quarterly Report

Choose between options:  
 - Not Started  
 - In progress  
 - Completed  
 - Need to Revise

## Example Report

Intervention	Intervention Description	Milestone	DueDate	Progress	Notes	New Due Date
2A_PC_BH	Primary care to behavioral health	Universal application of the PHQ2 at all primary care clinics by Medical Assistants	12/30/2018	Completed		
2A_PC_BH	Primary care to behavioral health	Identify a registry platform for use across sites	12/31/2018	Completed		
2A_PC_BH	Primary care to behavioral health	Have three staff members complete the AIMS Training	12/31/2018	In Progress	Due to staff turnover 2/3 clinicians are trained. 3rd will be trained once hired	6/28/2019
2A_PC_BH	Primary care to behavioral health	Implementation of a client registry to track PHQ-9 scores for clients that are receiving integrated services	12/31/2018	Not Started	Due to delayed roll out of new registry. Registry is purchased and training/ PHQ-9 tracking begins in April 2019.	7/31/2019
2B_PATH	Care Coordination	Hire three Pathways Care Coordinator	12/31/2018	Need to Revise	to serve patient volume, will stagger onboarding of Coordinators. Hire 2 Pathways Care Coordinators by 5/30/2019	5/30/2019

2A: Bi-Directional Integration of Physical and Behavioral Health  
 2B: Community-Based Care Coordination (Pathways)  
 2C: Transitional Care  
 3A: Opioid Response  
 3B: Reproductive/Maternal and Child Health  
 3D: Chronic Disease Prevention and Control

# Narrative Report



Instructions: Please complete the Narrative Report by responding to each question (350 words or less per question) and submit as a Word document using the naming convention NR2019Q1\_ organizationname.

To fulfill CPAA reporting requirements, both the Narrative Report and the Excel Milestone Report must be completed and emailed to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by 4/30/2019.

Organization	
Primary Contact Name:	
<b>Narrative Questions</b>	
1. Describe the key challenges or risks experienced in implementing your selected Transformation projects during this reporting period. Include potential impacts and mitigation strategies for specific Transformation activities. Please be sure to address each project area you're participating in.	
2. Provide a narrative or list of activities that occurred during the reporting period that support MTP projects but are not listed in the Milestone Report. Please be sure to address each project area you're participating in.	
3. Based on your experience as a MTP partner, what feedback do you have for CPAA to improve how we support partner understanding and success?	
4. Please provide a brief summary of progress made in the adoption of policies, procedures, and/or protocols that support your MTP work, including any challenges faced. If no progress has been made to date, please describe the policies, procedures, and/or protocols your organization aims to initiate in the next 6 months.	

Dear MTP Implementation Partner,

Attached to this email, you will find four documents:

- **Partner Roster**
- **MTP Quarter 2 Reporting Template, Milestone and Metric Report**
- **MTP Quarter 2 Reporting Template, Narrative Report**
- **Metric Definitions**

The **Partner Roster** lists the most current information we have on your organization. Please verify that the information within this document is correct and email [reporting@cpaawa.org](mailto:reporting@cpaawa.org) if you need to add or change any information.

The **MTP Quarterly Report** is a required report for all MTP Implementation Partners. CPAA will use partner Quarterly Reports to monitor MTP goals and activities, address challenges, and to fulfill ACH-level reporting requirements and earn Transformation dollars for the region. The MTP Quarterly Report consists of two required documents: the **Milestone and Metric Reports (Excel file)** and the **Narrative Report (Word document)**. The Milestone and Metric Reports have been prepopulated with milestones occurring during this reporting period from your approved Change Plan and approved Change Plan metrics. The Narrative Report consists of four questions to help CPAA track progress and capture any Transformation activities not listed as milestones. We made every effort to streamline the tool and reduce the reporting burden on our MTP partners while capturing the necessary information required to successfully administer the Transformation.

This reporting period covers Quarter 2 2019 (April 1, 2019 – June 30, 2019).

**Completed Quarter 2 reporting is due on Wednesday, July 31, 2019. Please submit your completed reporting to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) in the original formatting: Excel for the Milestone and Metric Reports and Word for the Narrative Report.**

All narrative questions must be answered for a report to be complete. Submission and CPAA approval of the Quarterly Report fulfills your organization's reporting requirement for Quarter 2 payment. We anticipate your MTP Quarter 2 payment will be processed through the Financial Executor portal in August of 2019. Delay in reporting may result in loss of funds for the reporting period.

CPAA is hosting a **webinar on July 11 at 3:00 pm**, to answer MTP Quarterly Report questions. You can log into the webinar with this link: <https://zoom.us/j/335482990> Directors and program managers are also available to answer questions and provide technical assistance in completing your MTP Quarterly Report, and you can email any questions or concerns to [reporting@cpaawa.org](mailto:reporting@cpaawa.org).

Please submit your completed Quarterly Milestone and Metric Report and Narrative Report to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by **Wednesday, July 31, 2019**.

\*As a reminder, the application for infrastructure funding is still open. [Click this link for more information and to go to the Application for Infrastructure Funds.](#)

Thank you.

Cascade Pacific Action Alliance

# Medicaid Transformation Quarterly Report



## Organizational Information

Organization Name	
Primary Contact Name	
Phone Number	
E-mail Address	

## Report Contents

**All reporting must be completed and returned to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by 7/31/2019.** Submit your final documents in the format that they were sent. Please do not alter rows or columns. Please submit your completed Milestone and Metric Report as an Excel file using the naming convention MR2019Q2\_organization name. Please submit your completed Narrative Report as a Word document using the naming convention NR2019Q2\_organization name.

Your organization's Medicaid Transformation Project (MTP) Quarter 2 Report is composed of three parts:

1. **Milestone Report:** has been prepopulated with your organization's approved Change Plan milestones. For this reporting period, you will report on milestones with due dates between 4/01/2019 - 06/30/2019 (DY3 Q2).
2. **Narrative Report:** provides additional context and information about your organization's MTP activities during the DY3 Q2 reporting period. Please make sure to answer all of the questions.
3. **Metric Report:** has been prepopulated with your organization's approved Change Plan metrics. Metric reporting will be included in Q2 and Q4 reports each year.

All three reports must be completed in order to fulfill CPAA's reporting requirements. Receipt of completed reporting will trigger quarterly payment, which will be processed within 30 days, based on availability of the Financial Executor Portal. CPAA uses your completed Quarterly Report to monitor MTP goals and activities, address challenges, and to fulfill ACH -level reporting requirements and earn transformation dollars for the region. **If you have any questions or concerns about quarterly reporting, please submit them to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by 7/24/2019.**

## Instructions for Milestone Report

The Milestone Report can be found on the second tab of the Excel file.

1. Select the progress indicator:

- **Completed** – The milestone has been completed, and the implementation partner is able to provide supporting documentation regarding the completion of the deliverable upon request.
- **In Progress** – Actions were taken towards achieving the work step deliverable, but the deliverable has a target end date in the future. The implementation partner is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
- **Not Started** – Work step has not been started.
- **Needs to be Revised** – Milestone needs to be modified.

2. If the milestone is completed, do not provide notes. For all other progress indicators, write a **brief** description in the notes section (200 characters or less) and provide a new due date using the formula 00/00/00 :

- If in progress, please briefly provide a status update and state any barriers encountered.
- If not started, please identify any barriers encountered, provide a brief description of how you are moving forward, and state the revised due date for the milestone.
- If needs to be revised, provide the new milestone, rationale, and the new date if applicable.

## Instructions for Narrative Report

1. Please respond to the questions outlined in the narrative report (350 words or less). See Word document for Narrative Report template.

## Example Milestone Report

Choose between options:

- Not Started
- In progress
- Completed
- Need to Revise

# Medicaid Transformation Quarterly Report



Intervention	Intervention Description	Milestone	DueDate	Progress	Notes	New Due Date
2A_PC_BH	Primary care to behavioral health	Universal application of the PHQ2 at all primary care clinics by Medical Assistants	12/30/2018	Completed		
2A_PC_BH	Primary care to behavioral health	Identify a registry platform for use across sites	12/31/2018	Completed		
2A_PC_BH	Primary care to behavioral health	Have three staff members complete the AIMS Training	12/31/2018	In Progress	Due to staff turnover 2/3 clinicians are trained. 3rd will be trained once hired	6/28/2019
2A_PC_BH	Primary care to behavioral health	Implementation of a client registry to track PHQ-9 scores for clients that are receiving integrated services	12/31/2018	Not Started	Due to delayed roll out of new registry. Registry is purchased and training/ PHQ-9 tracking begins in April 2019.	7/31/2019
2B_PATH	Care Coordination	Hire three Pathways Care Coordinator	12/31/2018	Need to Revise	to serve patient volume, will stagger onboarding of Coordinators. Hire 2 Pathways Care Coordinators by 5/30/2019	5/30/2019

2A: Bi-Directional Integration of Physical and Behavioral Health  
 2B: Community-Based Care Coordination (Pathways)  
 2C: Transitional Care  
 3A: Opioid Response  
 3B: Reproductive/Maternal and Child Health  
 3D: Chronic Disease Prevention and Control

## Instructions for Metric Report

The Metric Report can be found on the third tab of the Excel file.

Self-reported baseline and end year targets were recorded for each metric. CAAA requires that you report semi-annually on the progress for each metric prepopulated in your quarterly reports.

1. You are **required to fill in all highlight cells** on the Metric Report tab.
2. If no baseline was recorded when filling out your Change Plan, the cell has been highlighted. If there is a 0, that is the baseline that was given.
3. Please pay close attention to the units for each metric, as indicated in column E (i.e., percentage or number) when populating column F and G in the Metric Report.

If applicable, metrics have been prepopulated for each project area your organization is participating in based on the information in your organization's approved Change Plan. Not all project areas have semi-annual metric reporting; Pathways and Opioid Response have a different metric reporting process.

- If you're participating in Pathways, your metrics will be pulled from the CCS platform. There is no further action required from you at this time.
- If you're participating in Opioid Response, your reporting is on a different timeline and is already complete. There is no further action required from you at this time.

# Narrative Report



Instructions: Please complete the Narrative Report by responding to each question (350 words or less per question) and submit as a Word document using the naming convention NR2019Q2\_ organization name.

To fulfill CPAA reporting requirements, both the Narrative Report and the Excel Milestone and Metric Report must be completed and emailed to reporting@cpaawa.org by 7/31/2019.

Organization	
Primary Contact Name:	
<b>Narrative Questions</b>	
<p>1. Describe the key challenges or risks experienced in implementing your selected Transformation projects during this reporting period (04/01/19 – 06/30/19). Include potential impacts and mitigation strategies for specific Transformation activities. Please be sure to address each project area you’re participating in.</p>	
<p>2. Provide a narrative or list of activities that occurred during the reporting period that support MTP projects but are not listed in the Milestone Report. Please be sure to address each project area you’re participating in.</p>	
<p>3. <i>(If your Q2 report does not have any metrics, you may skip this question)</i>            Did your organization have difficulties reporting on any of the metrics prepopulated in your Q2 Report? If so, please list any of the metrics you had difficulty reporting on and answer the following prompts as it relates to each metric ID.</p> <ul style="list-style-type: none"> <li>• Describe any issues related to reporting on the metric(s) as defined</li> <li>• Identify whether your agency can make changes in data collection or reporting practices prior to the next reporting period to address these issues.</li> <li>• State whether you expect ongoing difficulty reporting on a metric and if yes, provide suggestions on how the metric could be improved to make accurate reporting more feasible.</li> </ul>	
<p>4. Please provide a brief summary of progress made in the adoption of policies, procedures, and/or protocols that support your MTP work, including any challenges faced. If no progress has been made to date, please describe the policies, procedures, and/or protocols your organization aims to initiate in the next six months.</p>	

## 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
<b>Column A</b>	<p><b>Project ID</b>, According to the MEDICAID TRANSFORMATION PROJECT TOOLKIT:            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.            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.            CPAA Projects:            2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation            2B: Community-Based Care Coordination            2C: Transitional Care            3A: Addressing the Opioid Use Public Health Crisis            3B: Reproductive and Maternal and Child Health            3D: Chronic Disease Prevention and Control            More details: <a href="https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf">https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf</a></p>
<b>Column B (hidden)</b>	<b>MetricID</b> , Unduplicated metric code for CPAA internal use. First two digits corresponds to the Project ID, third and fourth digits is an autonumeric by project.
<b>Column C</b>	<b>Sub Category / Intervention</b>
<b>Column D</b>	<b>Short Description [Metric ID]</b> : Measurement description as pre-populated in your Change Plan.
<b>Column E</b>	<b>Measure Description</b> : Detailed description of each measurement.
<b>Column F</b>	<b>Numerator</b> : The upper part of a fraction. The metric which has been counted. (e.g. # of people developed the disease of interest)
<b>Column G</b>	<b>Denominator</b> : 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)
<b>Column H</b>	Initial reporting date: Initial date that the data should be submitted to CPAA using the tool provided.
<b>Column I</b>	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](mailto: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](mailto:reporting@cpaawa.org) no later than **November 15, 2018**.

<b>Intervention by Project</b>	<b>Total</b>
<b>2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation</b>	<b>4</b>
Behavioral health integration in primary care settings	2
Physical health integration in behavioral health settings	2
<b>2B: Community-Based Care Coordination</b>	<b>3</b>
Pathways	3
<b>2C: Transitional Care</b>	<b>10</b>
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
<b>3A: Addressing the Opioid Use Public Health Crisis</b>	<b>10</b>
Opioid Response - CBO	5
Opioid Response - Clinic	4
Opioid Response - Emergency Department	1
<b>3B: Reproductive and Maternal and Child Health</b>	<b>12</b>
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
<b>3D: Chronic Disease Prevention and Control</b>	<b>19</b>
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
<b>Total measures in this document</b>	<b>58</b>

## 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]	<b>Depression Utilization of the PHQ-9 Tool (eCQM 2018)</b> 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]	<b>Depression Remission at Twelve Months (eCQM 2018)</b> 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]	<b>Percentage of Patients with Body Mass Index (BMI) Recorded in EHR</b> 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]	<b>Percentage of Patients with Blood Pressure (BP) Recorded in EHR</b> 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"> <li>•MAT initiation</li> <li>•Take-home naloxone</li> <li>•Our ED does not offer these services</li> <li>•Not applicable. Our site is not an ED.</li> </ul>	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"> <li>•Bree Collaborative guidelines</li> <li>•CDC guidelines</li> <li>•None of the above</li> </ul>	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"> <li>•IntegratedMED calculator</li> <li>•Links to opioid prescribing registries or PDMPs</li> <li>•Automatic flags for co-prescriptions of benzos</li> <li>•None of the above</li> </ul>	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"> <li>•Screeningand treatment for depression/anxiety occurs on site</li> <li>•Screening for depression/anxiety occur on site, patients referred to treatment</li> <li>•Contracting with providers who offer these services</li> <li>•Formalized referral relationship with providers who offer these services (MOUs or similar arrangement)</li> <li>•Informal referral relationship with providers who offer these services</li> <li>•None of the above</li> </ul>	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"> <li>•Medicationsare provided on site</li> <li>•Contracting with providers who offer these services</li> <li>•Formalized referral relationship with providers who offer these services (MOUs or similar arrangement)</li> <li>•Informal referral relationship with providers who offer these services</li> <li>•None of the above</li> </ul>	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"> <li>•Yes</li> <li>•No</li> </ul>	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"> <li>•Yes</li> <li>•No</li> </ul>	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"> <li>•Yes, via warm handoff</li> <li>•Yes, via providing information</li> <li>•No, we provide these services on site</li> <li>•No , we do not refer for another reason</li> </ul>	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"> <li>•Yes, to organize and expand</li> <li>•Yes, to learn about access</li> <li>•No, we did not receive technical assistance</li> </ul>	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"> <li>•Yes,via warm handoff</li> <li>•Yes, via providing information</li> <li>•No, we provide these services on site</li> <li>•No, we do not refer for another reason</li> </ul>	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

## Appendix E

Dear MTP Implementation Partner,

Thank you for completing your MTP Quarterly Report and signing your Year 2 Contract Amendment. CPAA will use Quarterly Reporting to complete our ACH-level reporting requirements to HCA and earn Transformation dollars for the region. We appreciate your timely submission of reporting materials and progress made in the Medicaid Transformation Project.

CPAA has compiled milestone progress from Quarter 1 Milestone Reports to share with our partners as a way of capturing not only the progress each partner is making in the execution of Change Plans but also our progress as a region. Please note the compliance score, which is calculated as the weighted average of completed and in progress milestones divided by the total number of milestones, is an internal measure. Compliance scores are not tied to 2019 funding methodology.

- [your organization] completed \_\_\_ out of \_\_\_ of the self-reported milestones due during Quarter 1 of 2019 and obtained a compliance score of \_\_\_%.
- MTP partners in the CPAA region completed 607 out of 949 of the self-reported milestones due during Quarter 1 of 2019 and obtained an average compliance score of 81.23%.

Just a reminder that you've earned your Year 2 Transformation funding and can use it at your discretion. Year 2 represents the highest overall MTP funding amount CPAA could earn for the region. While future years' funding amounts and methodologies are not yet finalized, CPAA's potential funding decreases in subsequent years of the Transformation, which will result in less funding to distribute to MTP Implementation Partners. Please contact Samantha Tatum, Operations Director, if you have questions or concerns about your MTP payments.

Thank you.

# MTP Performance Monitoring

# 2019

**Cascade Pacific Action Alliance (CPAA)**  
**Semi-Annual Report**  
January 1, 2019 – June 30, 2019

This report highlights the activities of CPAA and its 50 funded Medicaid Transformation Project (MTP) partners implementing interventions in Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum Counties.

## Milestone Progress

During the first reporting period, CPAA's regional partners submitted progress updates on a total of 949 milestones as identified in their change plan. Of the 949, 607 were completed and 253 remain in progress.<sup>1</sup> The regional compliance score below shows our progress towards change plan implementation as a region.

253 In Progress

607 Completed

949 Total

**80.41%**

### Regional Compliance Score

Weighted average of completed and in progress milestones divided by the number of milestones

## Trainings & Events

During the reporting period, 13 trainings and events were held with approximately 596 participants from across the region.



13

Trainings & Events



596

Total Participants

**Harm Reduction**

One Key Question

**Quality Improvement**

**Integrated Managed Care**

Secondary Trauma

**Networking** **Whole Person Care**

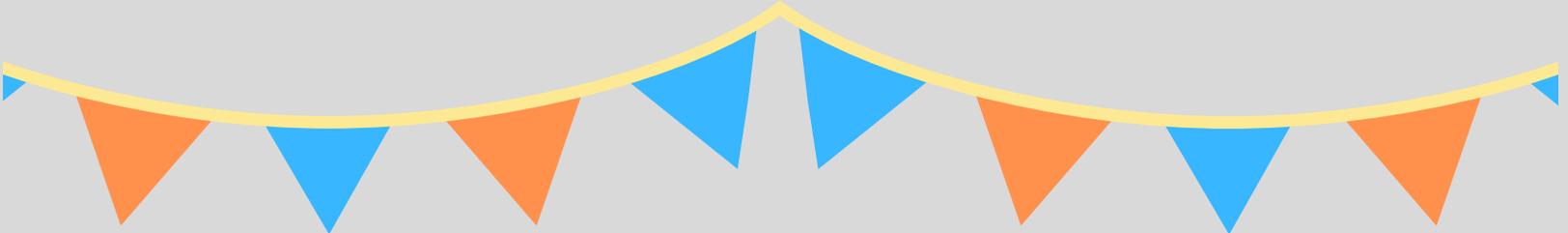
and Staff Retention

**Peer Counseling**

**Opioid Prescribing for Dental Providers**

**Training Highlight:** Through our partnership with the Pacific Mountain Workforce Development Council on the Opioid Use Reduction and Recovery (OURL) Alliance project, the first ever certified peer counselor training was held with a focus on opioid and other substance use disorders.

# Appendix G: Event Materials



*Save the date*

# CPAA NETWORKING EVENT

FEBRUARY 27, 2019



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**11:30 to 3:00 PM**

**Centralia Square Grand Ballroom**

**Join regional partners in conversations about transformation work, ways to collaborate, and learn more about projects in your community. Lunch provided. More Information coming soon.**

**Click here to RSVP.**



Congratulations to the organizations selected to receive funding from Cascade Pacific Action Alliance (CPAA) to host Local Forums!

<i>County</i>	<i>Forum/Organization</i>
<i>Cowlitz</i>	Pathways 2020 Community Health Forum/Pathways 2020
<i>Grays Harbor</i>	Grays Harbor Public Health District No. 1 dba Summit Pacific Medical Center
<i>Lewis</i>	Lewis County Community Health Partnership
<i>Mason</i>	Mason County Health Coalition/Mason General Hospital
<i>Pacific</i>	Pacific County Public Health and Human Services Department
<i>Thurston</i>	Thurston Thrives
<i>Wahkiakum</i>	Wahkiakum Health and Human Services

We are announcing all the successful applicants together to encourage regional camaraderie and a spirit of collaboration. CPAA is looking forward to this new phase of our partnership, and we are excited to work with each of you to transform health care delivery systems.

In the coming weeks, we will be in contact with each of you to discuss next steps, including contracts and registering with the Financial Executor Portal. **Registration in the Financial Executor Portal and executed contracts are required to receive Medicaid Transformation Project (MTP) payments.** Please complete the attached template by February 11, 2019, and return it via email to Megan Moore at [moorem@crhn.org](mailto:moorem@crhn.org). The template provides us with the necessary information to begin contract development and registration in the portal.

**You are invited to CPAA's upcoming Networking Event (February 27) and Quality Improvement Conference (March 21).** The Networking Event will provide an opportunity for partnering providers to come together, share promotional materials, and gain a better understanding of the transformation work being done across the region. The QI Conference will provide learning opportunities for partners across the spectrum of QI implementation. More information about both events will be sent out soon, and we look forward to seeing you there.

Please don't hesitate to contact us with any questions or concerns.

Congratulations again, and thank you for all your hard work.

Sincerely,  
*Jean Clark*  
Jean Clark, CEO

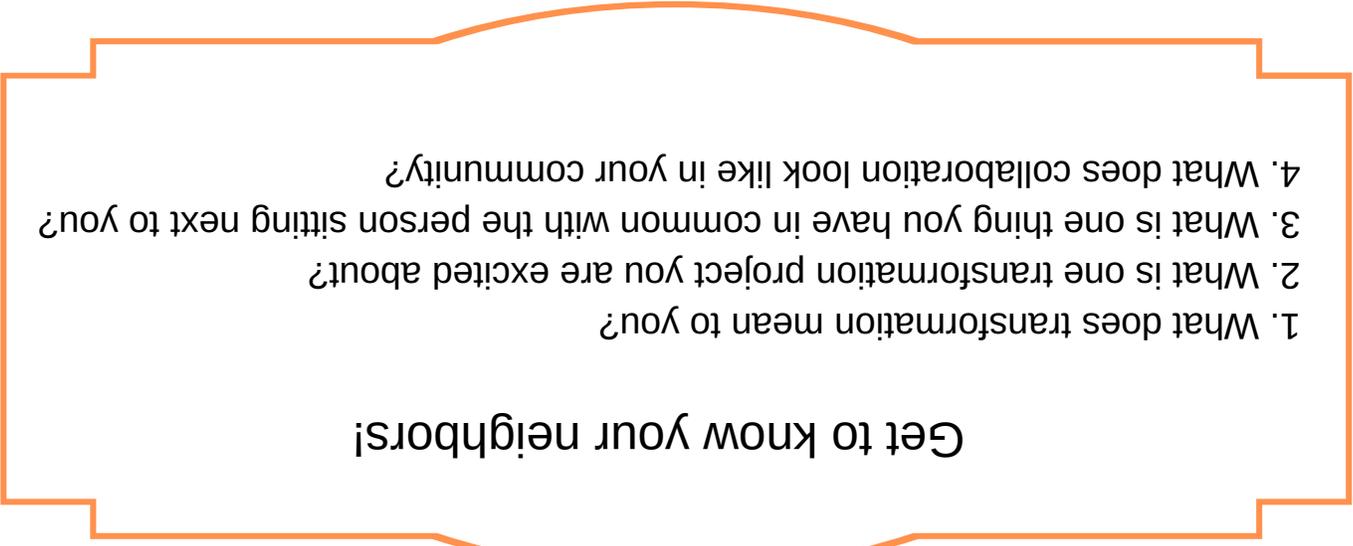


February 27, 2019

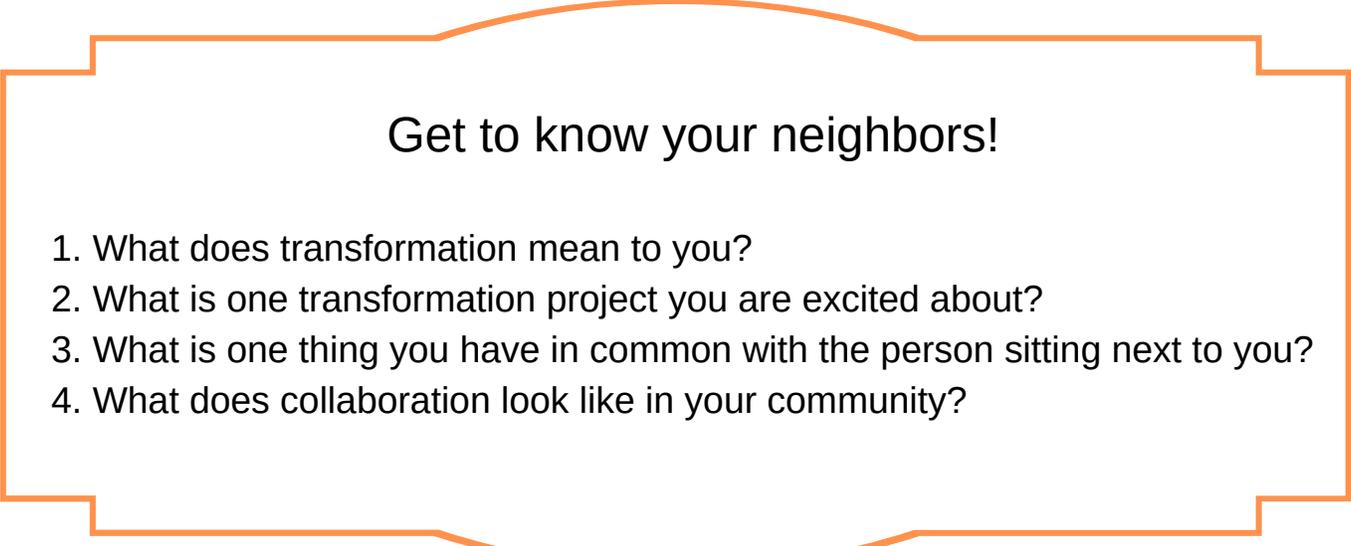
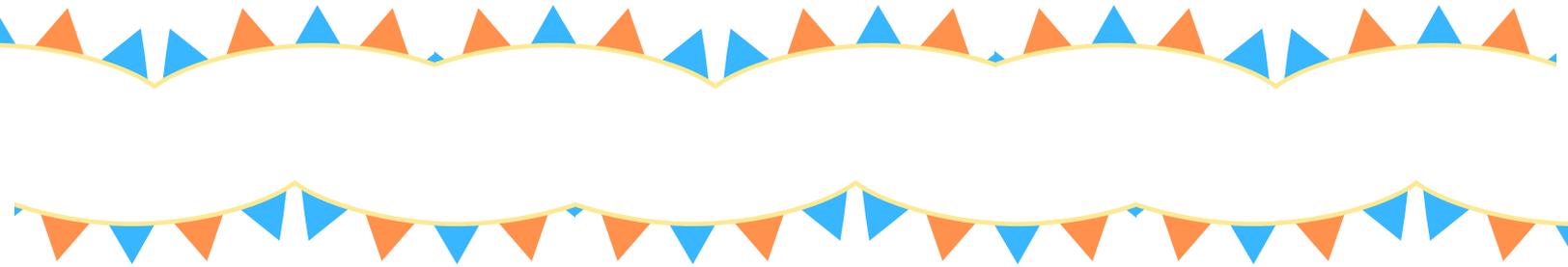
## Networking Event Agenda

Centralia Square Grand Ballroom and Hotel  
202 Centralia College Blvd, Centralia, WA

- |                      |   |
|----------------------|---|
| <b>11:30 – 12:00</b> | <b>Check in</b><br>Sign in, grab your nametag, and drop off any materials you would like to share or display.   |
| <b>12:00 – 12:10</b> | <b>Welcome!</b><br>Jean Clark, Chief Executive Officer, will open the event, highlighting the objectives of the day and sharing organizational updates and news.  |
| <b>12:10 – 12:45</b> | <b>Interactive Lunch</b><br>Strike up a conversation during lunch! Check out the table tents for Transformation-related conversation starters.  |
| <b>12:45– 1:00</b>   | <b>Activity Instructions</b><br>Michael O’Neill, Pathways HUB Program Manager, will provide an overview of the structure of the activity, how to maximize the conversations, and what to expect from participating.   |
| <b>1:00 – 2:30</b>   | <b>Speed Networking</b><br>Follow the timer and refer to the Speed Networking Instructions for helpful discussion prompts.  |
| <b>2:30 – 3:00</b>   | <b>Unstructured Networking</b><br>An opportunity to continue conversations started during the speed networking activity and connect with those you did not have the chance to chat with. This is also an opportunity to: <ul style="list-style-type: none"><li>• Review and add to our <b>interactive calendar</b> featuring upcoming events and important dates in our region.</li><li>• Observe and collect <b>partner resources</b> from around the room.</li><li>• Snap a picture at our <b>photo booth</b> with your regional partners and share on social media #CPAA #TransformingMedicaid #HealthierWA.</li></ul> |
| <b>3:00</b>          | <b>Adjourn</b><br>Bon voyage! Be sure to <b>tell us what you think</b> by completing our event evaluation form and <b>follow up</b> with your connections.  |

- 
1. What does transformation mean to you?
  2. What is one transformation project you are excited about?
  3. What is one thing you have in common with the person sitting next to you?
  4. What does collaboration look like in your community?

## Get to know your neighbors!



## Get to know your neighbors!

1. What does transformation mean to you?
2. What is one transformation project you are excited about?
3. What is one thing you have in common with the person sitting next to you?
4. What does collaboration look like in your community?

YOU'RE INVITED

# Building Community. Advancing Outcomes.

MARCH 21, 2019 9:30-4:30 PM

LACEY COMMUNITY CENTER

CPAA is hosting a conference to share best practices, quality improvement methods, and strategies to improve health outcomes in our region.

Meeting attendees will take away practical methods to improve the safety, timeliness, efficiency, and equity of programs and processes at their organization. The day will include hands on activities, peer to peer sharing, and discussion.



Registration Required. Please email [schroffa@crhn.org](mailto:schroffa@crhn.org)

# Building Community. Advancing Outcomes.

March 21, 2019

9:30 – 4:30

Lacey Community Center, 6729 Pacific Ave SE, Olympia, WA 98503



TIME	TOPIC	PRESENTER
9:30 – 9:40	Welcome and Introduction	Jean Clark, CPAA
9:40 – 10:20	Keynote Address: Empowering Quality Improvement	Rhonda Stewart, Virginia Mason Institute
10:20 – 11:20	Fundamentals of Quality Improvement: Running PDSAs	Trudy Bearden, Qualis Health
11:20 – 11:30	<b>BREAK</b>	
		Moderator: Trudy Bearden, Qualis Health
11:30 – 12:15	Getting to Better Health Outcomes: Using QI and Best Practices Panel Session	Panelists: Sally Sundar, YMCA Jennifer Sipert, Providence Alicia Ferris, Community Youth Services
12:15 – 1:00	<b>NETWORKING LUNCH WITH WELLNESS WALK OPTION</b>	
	Breakout Session 1:	
	<ul style="list-style-type: none"> <li>Continuous Quality Improvement in Office-Based Opioid Treatment: Lessons from a Rural/Semi-Rural Primary Care System</li> <li>Data and Innovation in Rapid Re-Housing</li> </ul>	Albert Carbo, Angie Bland, Anthony Lyon, Peninsula Community Health Services Phil Owen, Sidewalk
1:00 – 2:00	Breakout Session 2:	
	<ul style="list-style-type: none"> <li>Presenting Data Effectively for Quality Improvement</li> </ul>	Nikki Olson, CORE Sarah Bartelmann, CORE
2:00 – 2:10	<b>BREAK</b>	
	Breakout Session 1	
	<ul style="list-style-type: none"> <li>Root Cause Analysis and Just Culture: A Practical Approach to Drive Improvement</li> </ul>	Sheila Yates, Planned Parenthood
2:10 – 3:10	Breakout Session 2	
	<ul style="list-style-type: none"> <li>Improving the Way We Partner with the Community for Change</li> </ul>	Kachina Inman, Healthy Living Collaborative
3:10 – 3:20	<b>BREAK</b>	
3:20 – 4:20	QI World Café – Sharing Quality Improvement Experiences and Creating Connections	Allen Cheadle, Carly Levitz, Creagh Miller, Center for Community Health and Evaluation
4:20 – 4:30	Closing	Christina Mitchell, CPAA

# Building Community. Advancing Outcomes.



## Jean Clark, Cascade Pacific Action Alliance



Jean Clark, RN, BSN, MSN, MBA, brings a 25-year track record of successful leadership in multiple large healthcare organizations and Critical Access Hospitals to her new role as CHOICE Regional Health Network and Cascade Pacific Action Alliance (CPAA) Chief Executive Officer.

In her previous roles in senior leadership for Kindred Healthcare, a Fortune 500 company and the leading provider of post-acute healthcare delivery systems in the United States, Jean has overseen physician enterprise development, clinical quality including patient experience and staff engagement, clinical operations, strategic service line development, consolidation of services, recruitment with retention, and state and national health policy development. Jean is excited to apply her extensive knowledge of hospital systems to the ongoing regional health improvement work at CHOICE and CPAA. She is passionate about addressing social determinants of health and increasing health equity for our most vulnerable populations.

## Rhonda Stewart, Virginia Mason Institute



Rhonda Stewart is a transformation sensei at Virginia Mason Institute. She leads health care leaders across the world in building a lean culture and coaches them to create a solid infrastructure that supports lean implementation and organizational learning while always focusing on patients. Rhonda has led or participated in improvement events in the areas of finance, accounting, payroll, supply chain, analytics, billing, urology, cardiology, radiology, laboratory and PACU/recovery. Prior to joining Virginia Mason Institute, Rhonda was a director in the revenue and performance reporting department at Virginia Mason, immersed in applying lean

methods in the areas of health care accounting, budgeting and analytics. She was in the finance department for 19 years, 12 of them at the manager or director level. Rhonda holds a BA in Accounting from Central Washington University. Rhonda is certified in the Virginia Mason Production System. ®

## Trudy Bearden, Qualis Health



Trudy Bearden serves as Senior Consultant at Qualis Health. Her consulting skills are augmented by her years as a primary care clinician with additional experience in the hospital setting, both of which occurred within residency programs. Having spent many years as a clinic administrator, quality coordinator and transformation team lead, she understands the challenges and competing demands practices face while trying to implement practice transformation changes.

Ms. Bearden provides consulting to sites undergoing medical home practice transformation, building on the Eight Change Concepts for Practice Transformation<sup>1</sup>. Her consulting expertise and passion are focused on improving primary care service delivery both within and beyond the United States. Ms. Bearden works with partners and clients to improve quality, safety and efficiency in ways that include patients in the process and increase joy in the workplace. She has additional expertise in quality improvement, change management, health information technology and optimization, and team dynamics as well as HIPAA, Promoting Interoperability Use and the Quality Payment Program.

Prior to her position at Qualis Health, she served for five years as a clinical manager and clinical instructor at the Idaho State University Family Medicine Residency, where she led the medical home transformation as part of the Safety Net Medical Home Initiative. Before that, she was the PA for the Division of Vascular Surgery at the Yale School of Medicine. She completed the Intermountain Healthcare Advanced Training in Healthcare Delivery Improvement program with Dr. Brent James. Ms. Bearden received a Bachelor of Science degree, *magna cum laude*, in Biological Sciences from Florida State University and a Master of Science in Physician Assistant Studies from the University of New England.

## Alicia Ferris, Community Youth Services



Alicia Ferris is the Chief Clinical Officer of Community Youth Services, a non-profit based in Olympia, Washington that specializes in serving adolescents and young adults through a broad and integrated continuum of care. Alicia has a Masters in Counseling Psychology from Alaska Pacific University and experience working in a range of settings including: juvenile justice, community health clinics, schools, tribal behavioral health centers, and homeless drop-in centers. Tasked with starting up CYS' Integrated Counseling Division she has worked with universities, state agencies, and the legislation to create innovative ways to meet the unique needs of a population that often falls through the cracks.

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<sup>1</sup> Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice*. 2012; 39:241-259.

## Sally Sundar, YMCA of Greater Seattle



Sally Lacy Sundar is the Senior Director of Health Integration and Transformation at both the YMCA of Greater Seattle and the Washington State Alliance of YMCAs. Ms. Sundar holds a master's degree in International Development and Global Health and brings seven years' experience working on multi-sector public health improvement projects in both domestic and international contexts. At the YMCA she established and facilitates the Washington YMCA Clinical Integration Steering Committee. Previously Ms. Sundar worked for the Centers for Disease Control and Prevention (CDC) as a Public Health Associate, stationed in the Richmond City Health District (VA). She also held briefer positions supporting the Health Communications Team in the CDC Country Office during the Ebola epidemic response in Conakry, Guinea.

## Jennifer Sipert, Providence Health and Human Services



Jennifer Sipert is the patient safety manager for Providence at both St. Peter and Centralia hospitals. She has been with Providence for 16 years. Nine of those years was working as a diagnostic sonographer and then she transitioned into Quality and Safety where she has been working for 7 years. Jennifer holds a Masters of Health Sciences from George Washington University in Healthcare Quality and also has attained the CPHQ (Certified Professional in Healthcare Quality) certification. She received her Bachelor of Science degree in Psychology from the University of Oregon and her sonography degree from Bellevue College. She has also volunteered abroad as a Peace Corps volunteer in West Africa in the 1990s and most recently in Haiti where she helped to implement a quality and safety program in the operating room of a rural hospital. The OR staff and physicians had struggled to control a monthly rate of surgical skin burns, and through staff rounding and quality and process improvement efforts, over a one-month period, was able to work with staff and identify the root causes of the skin burns and create and spread an action plan that eliminated skin burns the following month. The OR team in Haiti has been able to sustain those results and at the last check in, had zero burns in the previous six months.

## Albert Carbo, Peninsula Community Health Center



Albert is a clinical pharmacist on the PCHS integrated behavioral health and substance use disorder (BH/SUD) team. He continues to work on improving access to high-quality SUD treatment across the PCHS system via data collection, process improvements, and collaborative community partnerships.

## Angie Bland, Peninsula Community Health Center



Angie is the Integrated Care Program Coordinator overseeing PCHS' integrated BH/SUD team. In this role she provides care coordination between primary care providers, integrated BH/SUD specialists, and external community partners.

## Anthony Lyon, Peninsula Community Health Center



Tony is a physician assistant who has been with PCHS for over 10 years. He is a DATA-waivered provider who recently accepted a post as an associate medical director overseeing PCHS' mobile and emergency department efforts.

## Phil Owen, Sidewalk



Phil Owen is the Executive Director of SideWalk, an Olympia nonprofit on a mission to end homelessness. Phil has served in homeless services for 18 years, including 10 years as a live-in volunteer at Bread and Roses. Recently, he served as a co-chair of the Home Fund, an Olympia ballot initiative to build permanent supportive housing.

## Nikki Olson, CORE



Nikki Olson is the Associate Director of CORE, where she leads CORE's data and learning work, helping support Accountable Communities of Health and other collective impact organizations design and build data systems and infrastructures that allow communities to effectively plan for transformation, target their efforts, and track their impacts. She has also contributed to research projects focusing on outcomes for poor and vulnerable populations and the impact of social determinants of health. Nikki received her Masters in Sociology from Portland State University.

## Sarah Bartelmann, CORE



Sarah Bartelmann is a Development Program Manager at CORE, where she works with Accountable Communities of Health in Washington and California to support their data and measurement needs, and provides policy and measurement consultation for CORE's evaluations and cross-sector data projects. Previously, she was the metrics manager for the Oregon Health Authority, overseeing pay-for-performance programs for Medicaid managed care plan and hospitals. Sarah received her Masters in Public Health from Tulane University.

## Sheila Yates, Planned Parenthood of the Great Northwest and Hawaiian Islands



Sheila Yates, MPH, CPHQ serves as the Vice President of Quality and Risk Management at Planned Parenthood of the Great Northwest and the Hawaiian Island. They operate 27 health centers in Alaska, Idaho, Hawaii and Western Washington. Sheila has over 30 years of experience in health care administration. Prior to coming to Planned Parenthood she was a leader in patient safety, traumatic brain injury and mental health programs in both hospital and ambulatory care settings.

## Center for Community Health and Evaluation

The Center for Community Health and Evaluation (CCH) is part of Kaiser Permanente Washington Health Research Institute. Based in Seattle, Washington, CCH serves foundations and organizations throughout the United States. Our mission is to improve the health of communities with collaborative approaches to planning, assessment, and evaluation ([www.cche.org](http://www.cche.org)). Three CCH Research Associates will be leading the session: Allen Cheadle, Carly Levitz, and Creagh Miller

Thank you to our sponsors!





## Learning Collaborative Agenda

Date: Thursday May 30<sup>th</sup>, 2019; 10:00 – 2:00 PM

Time	Agenda Item
<b>10:00-10:45</b>	Welcome Presentation: Trauma Toxic Stress, & Staff Retention <i>Michael O’Neill, N.E.A.R. Sciences Master Trainer</i> Partner Perspective: Love Overwhelming <i>Chuck Hendrickson, Executive Director</i>
<b>10:45-12:00</b>	Workshop: Imagining a Trauma Informed Workplace <ul style="list-style-type: none"> <li>• Introduction and Framing</li> <li>• Roundtable Discussion Worksheet – PART 1</li> <li>• Roundtable Discussion Worksheet – PART 2</li> </ul>
<b>12:00-12:30</b>	Knowledge Gathering <ul style="list-style-type: none"> <li>• Workshop Report Out</li> <li>• Live Poll Questions</li> <li>• Fill Out Evaluation Form</li> </ul>
<b>12:30-1:00</b>	Lunch
<b>1:00-2:00</b>	Community CarePort Advisory Meeting <ul style="list-style-type: none"> <li>• Discuss connections to today’s Learning Collaborative content</li> <li>• Review Community CarePort HUB Data</li> <li>• Community CarePort Listening Session (Care Coordinator)</li> <li>• Provide input on HUB Development</li> </ul>



# Learning Collaborative

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TRAUMA, TOXIC STRESS, AND STAFF RETENTION

MAY 30, 2019

# Learning Collaborative Orientation

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Michael O'Neill,  
*Community CarePort Program Manager,  
NEAR Sciences Master Trainer*

# Biology of Toxic Stress Overview

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N.E.A.R Sciences describe and quantify the impact of stress and trauma on our lives

N

Neurobiology

E

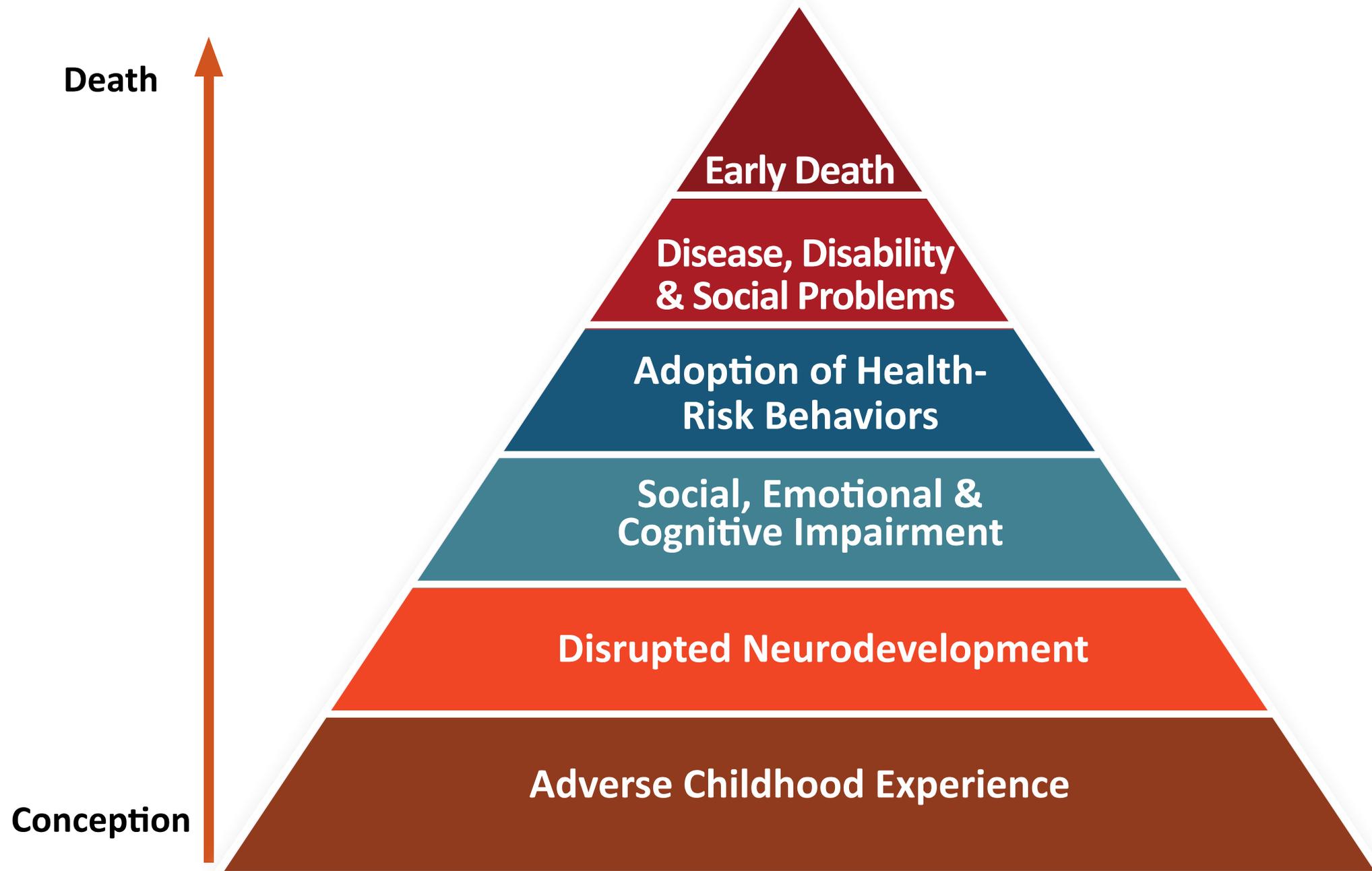
Epigenetics

A

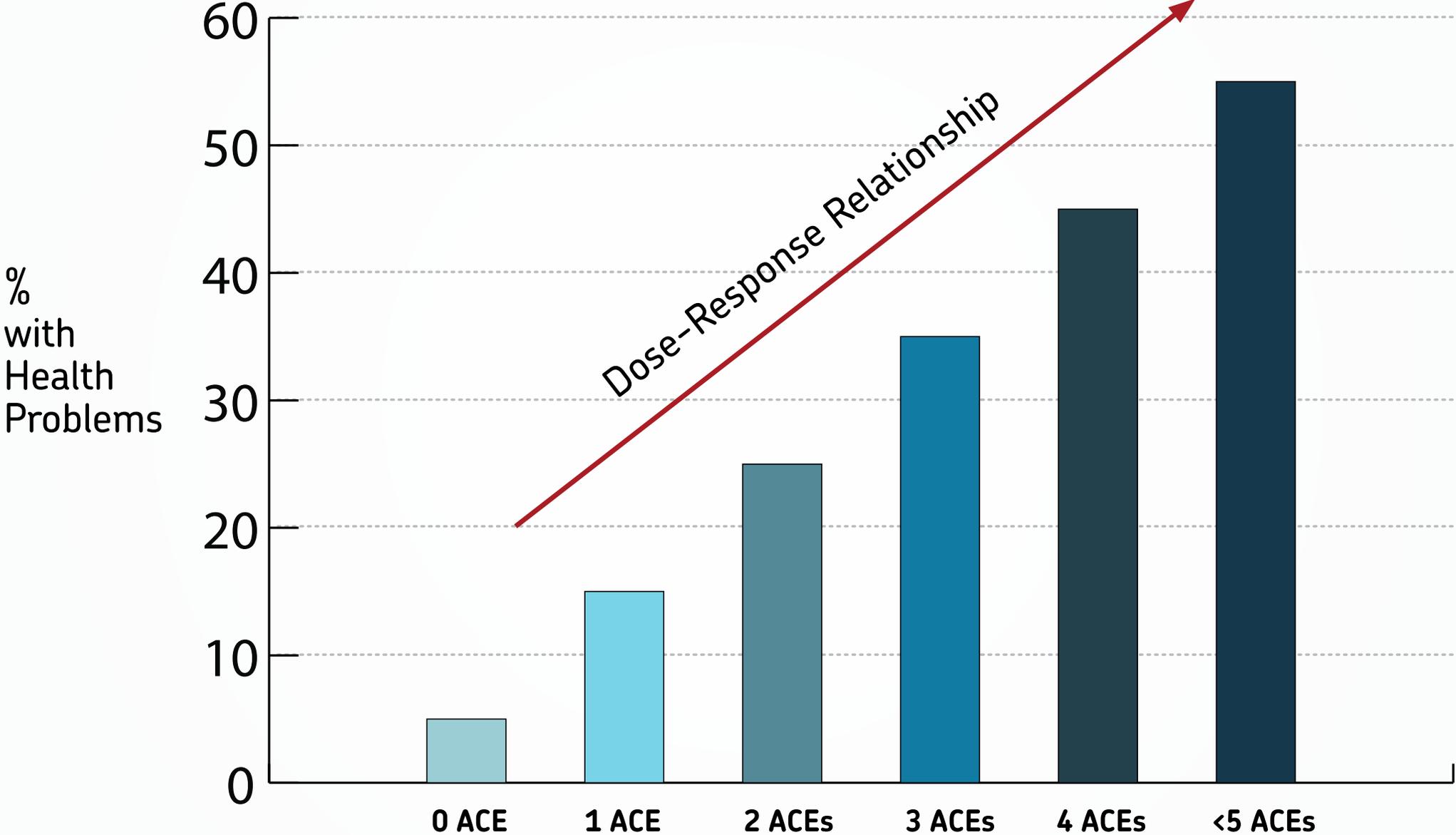
Adverse Childhood Experiences

R

Resilience



# ACE Score and Health Problems



# Outcomes Attributable to ACEs

## Risk

- Smoking
- Heavy drinking
- Obesity
- Risk of AIDS
- Taking painkillers to get high
- Obesity

## Poor Mental Health

- Frequent mental distress
- Sleep disturbances
- Nervousness
- MH problem requiring medication
- Emotional problems restrict activities
- Serious & persistent mental illness

## Health & Social Problems

- Fair or poor health
- Life dissatisfaction
- Health-related limits to quality of life
- Disability that impedes daily functioning
- Don't complete secondary education
- Unemployment
- History of adult homelessness

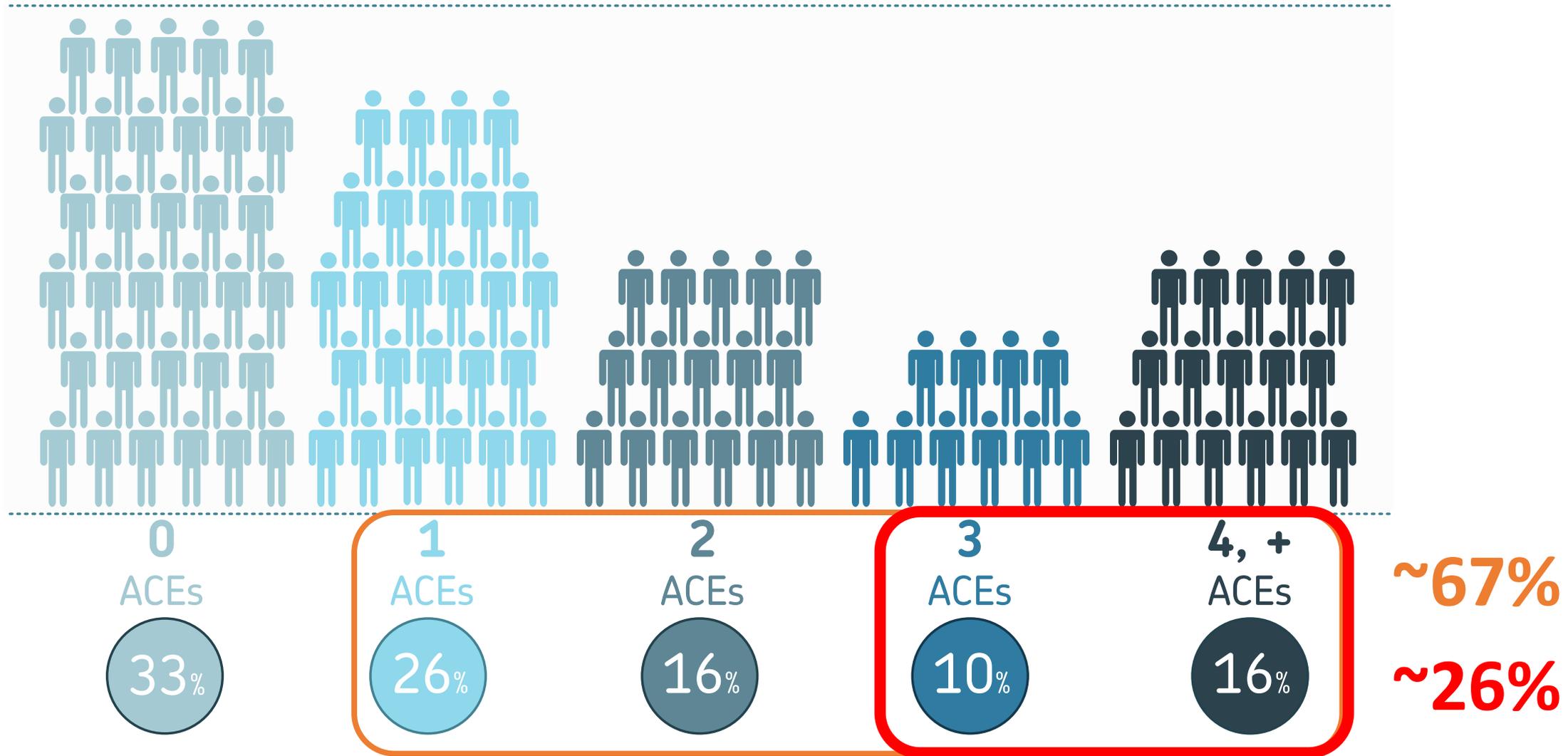
## Prevalent Disease

- Cardiovascular
- Cancer
- Asthma
- Diabetes
- Auto immune
- COPD
- Ischemic heart disease
- Liver disease

## Intergenerational ACE Transmission

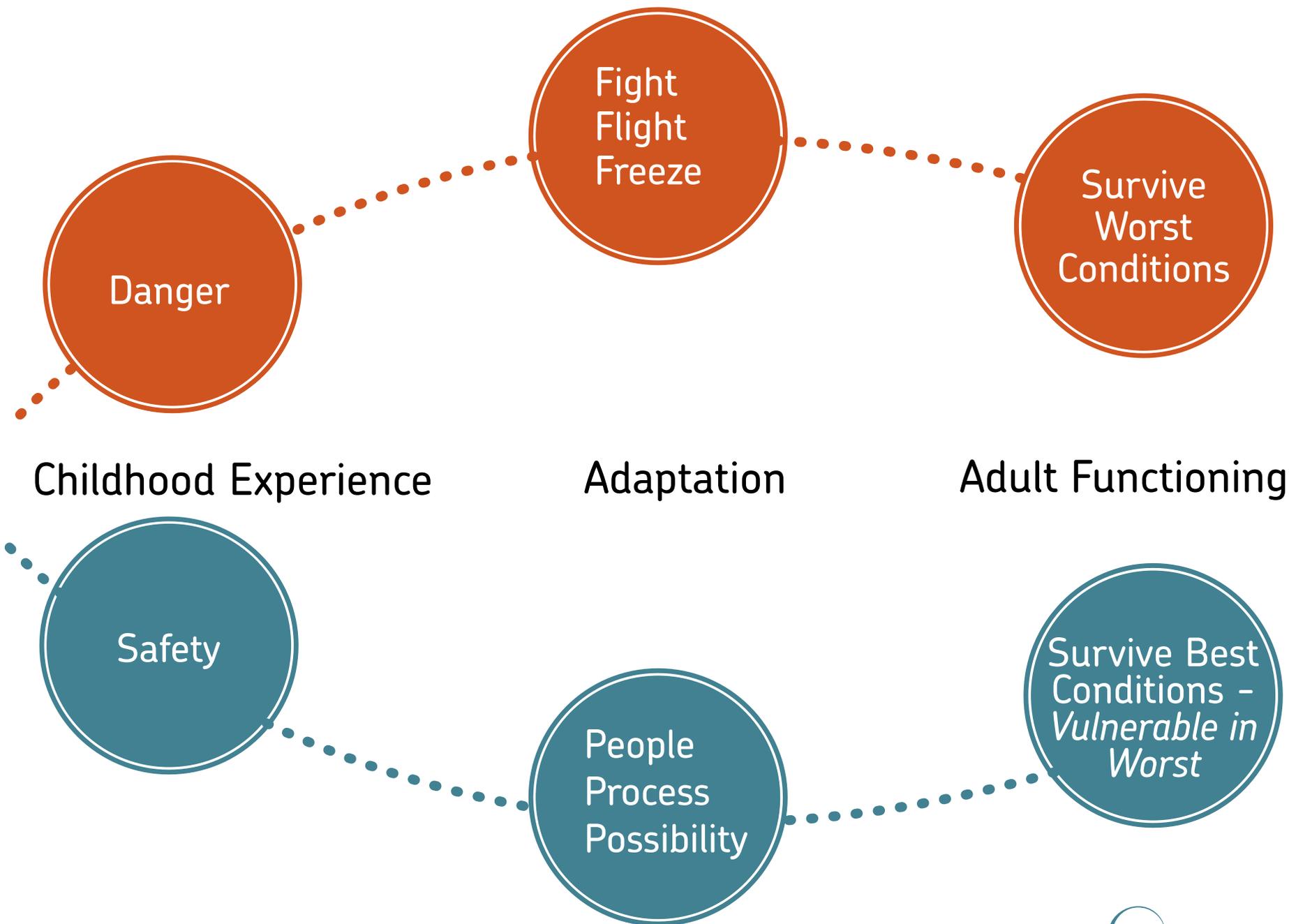
- Mental Illness
- Drugs or Alcohol Problem
- Multiple divorces, separations
- Victim of family violence
- Adult incarceration

# ACE Score = Number of ACE Categories



ACE Scores Reliably Predict Challenges During the Life Course

CONCEPTION



# EFFECTS OF MALTREATMENT

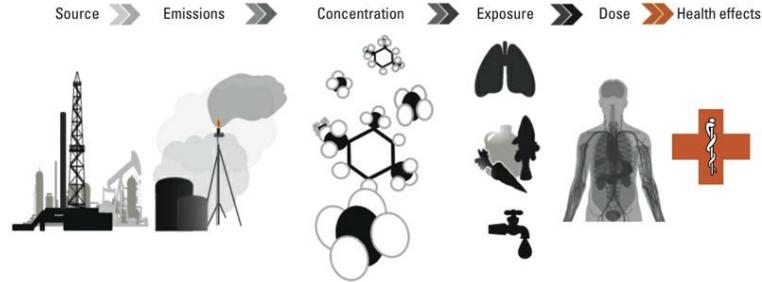


type of maltreatment

GENDER

**A G E**

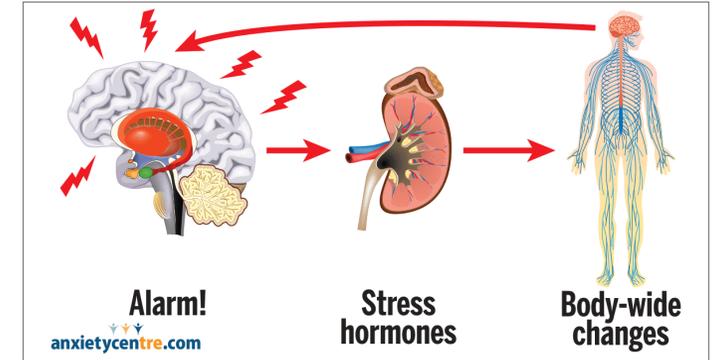
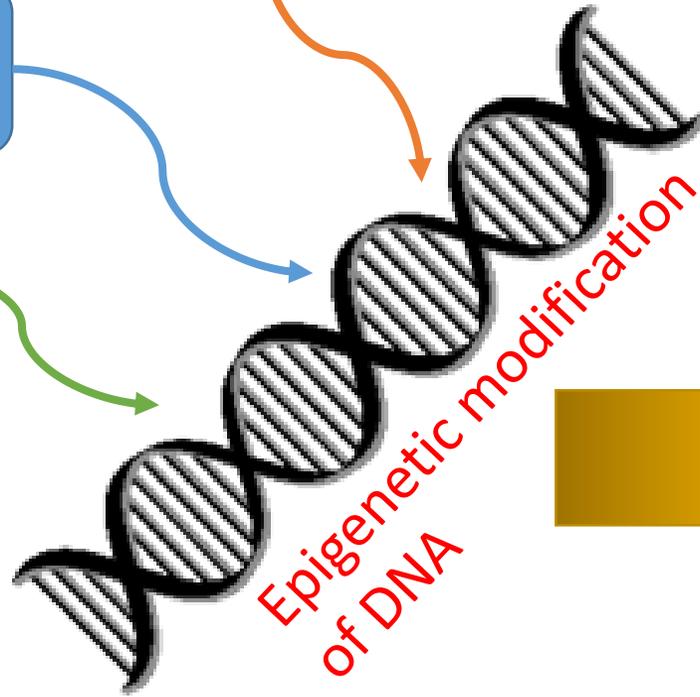
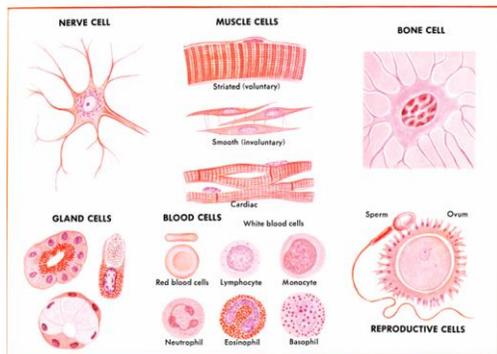
# Dynamic Adaptation of the Genome



Environment

Experiences

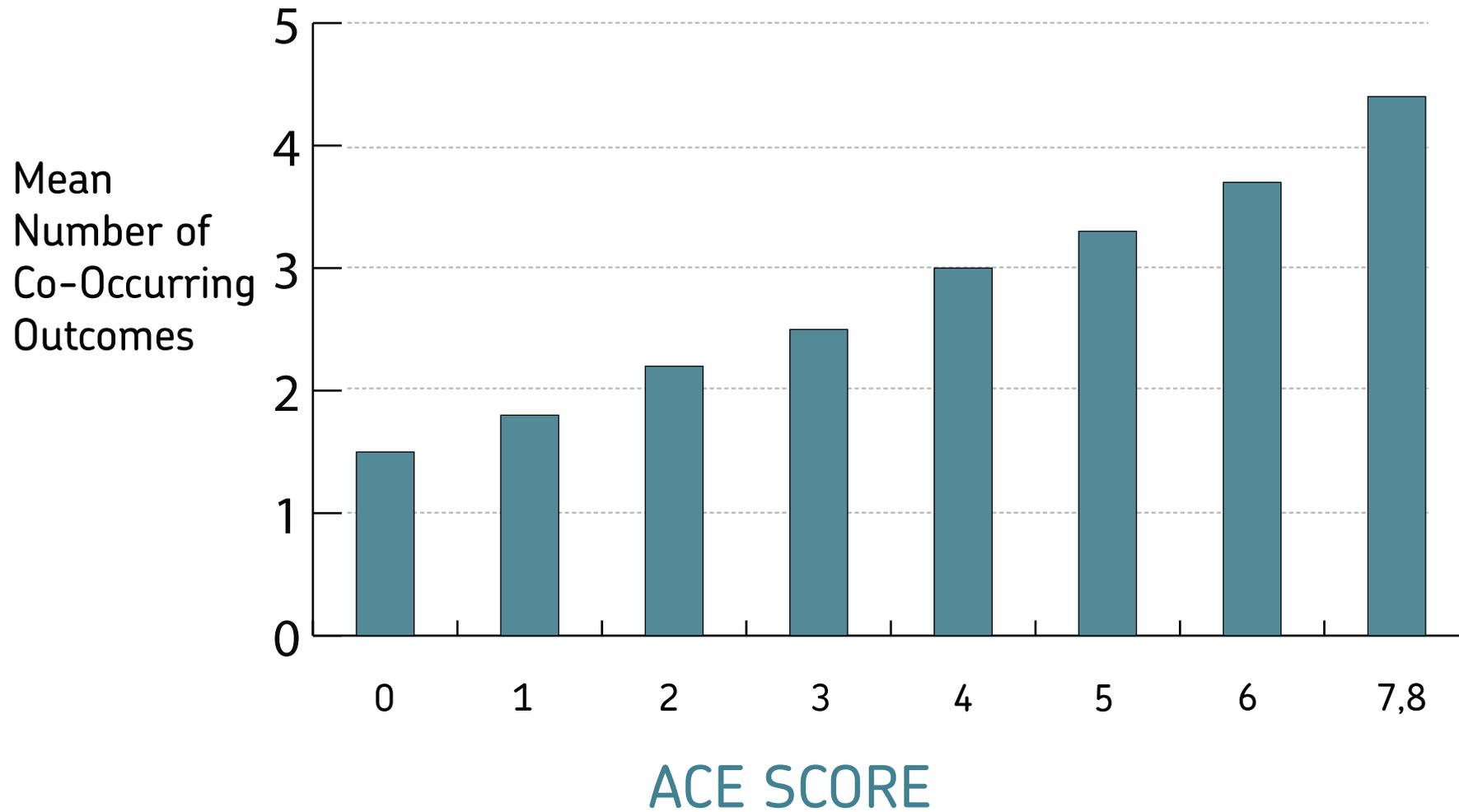
Biology



Phenotype – expression of your genetic code

A blue rounded rectangle containing a stylized illustration of a person's face and the text 'Phenotype – expression of your genetic code'.

# Cumulative Risk Exposure to Whole Population



## Health and Social Problems

panic reactions  
depression  
anxiety  
hallucinations  
sleep disturbances  
severe obesity  
pain  
smoking  
alcoholism  
illicit drug use  
IV drug use  
early intercourse  
promiscuity  
sexual dissatisfaction  
amnesia (childhood)  
high stress  
problems with anger  
perpetrating  
domestic violence

# What is Resilience?

The ability to adapt to or bounce back from stress and difficulty.

## Anyone can be resilient!

But a variety of things can impact the amount of resilience we have to call on at any given time.

## Resilience can be challenged by:

- Adverse Childhood Experiences
- Recent trauma and stress
- Social isolation

## Resilience can be increased!



Positive self image  
Feeling able to make a difference  
Able to read own emotions



Safe, stable, nurturing relationships  
Able to call on others for favors and help



Caring communities that work together  
Cultural and/or faith traditions  
Opportunities to participate

# Key Takeaways from N.E.A.R. Sciences

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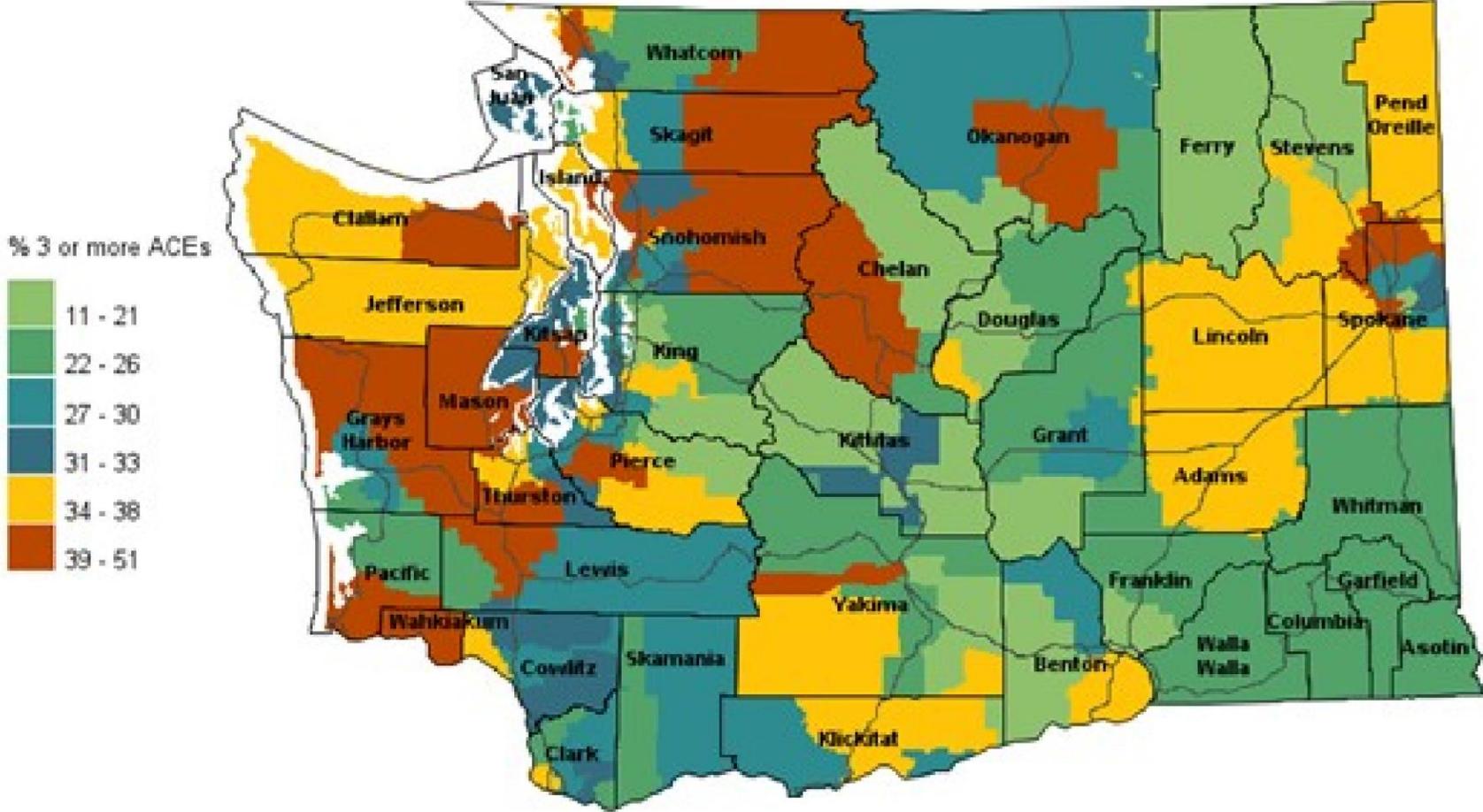
The body has  
natural adaptations to  
toxic stress

ACEs are common

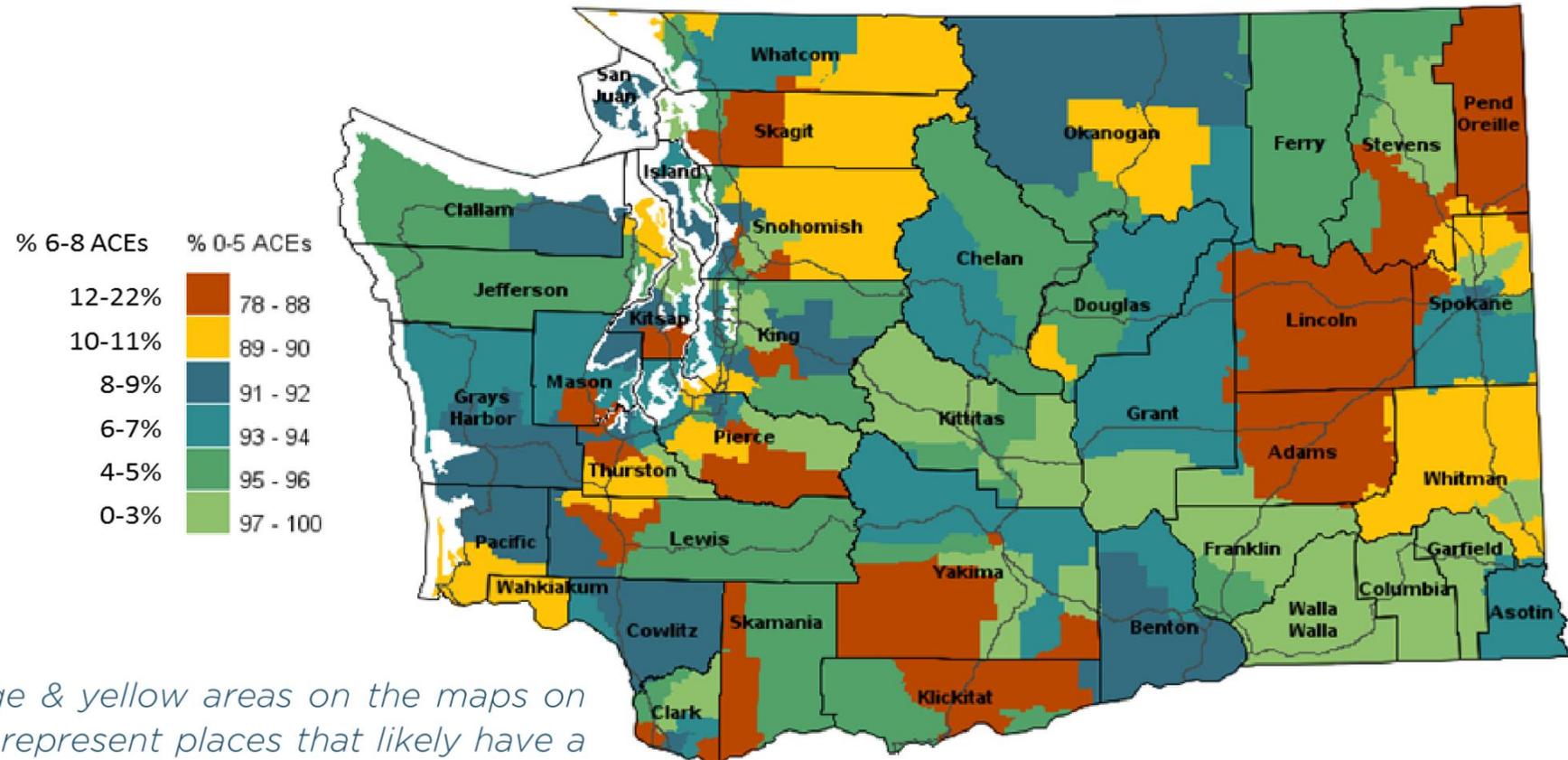
People carry different loads  
of current stressors in their  
life

Resilience factors  
help people reduce  
or prevent negative effects

Population with  $\geq 3$  ACEs, Locales: Ages 18-64

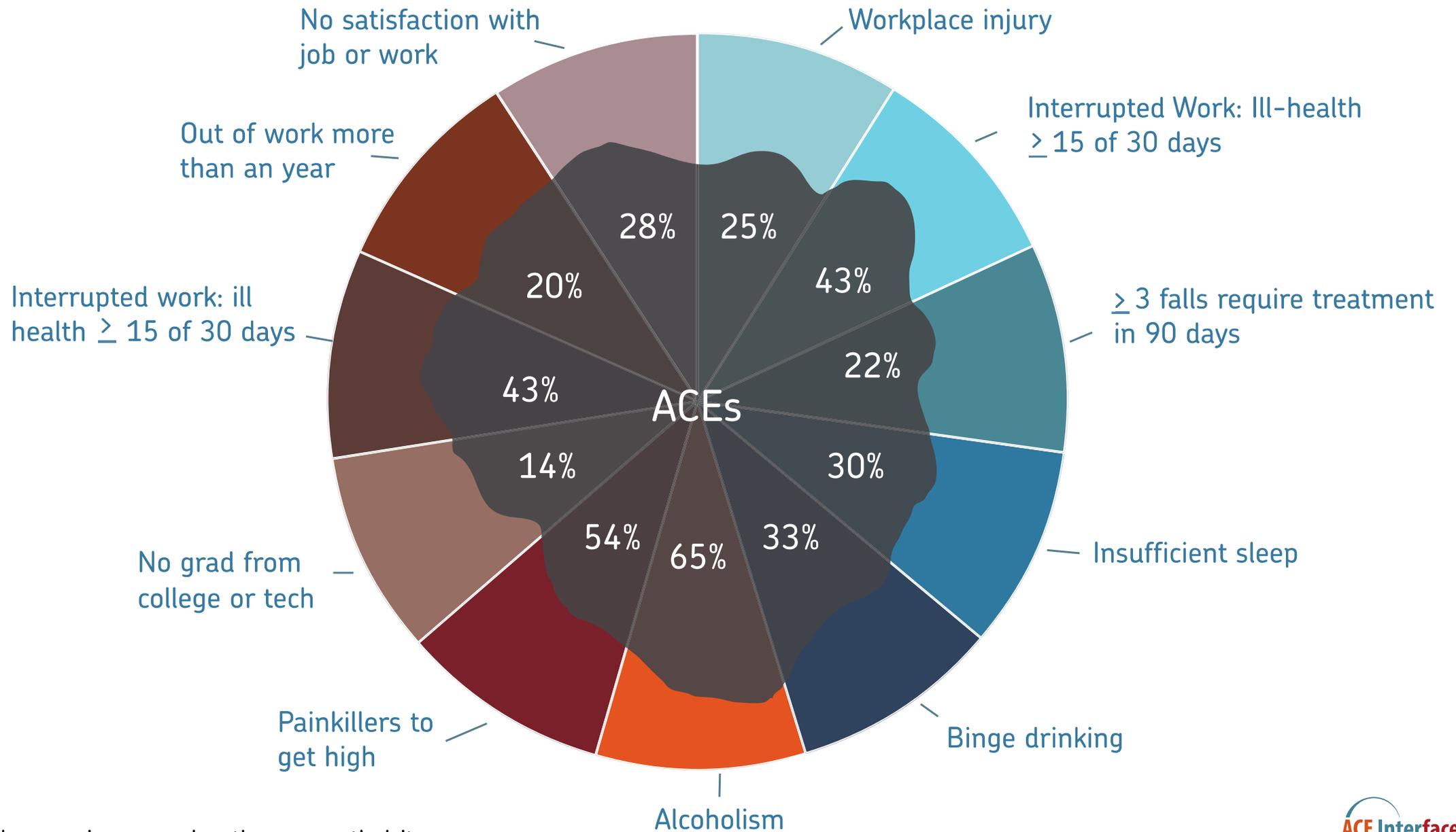


## Population with $\geq 6$ ACEs, Ages 18-64



*The orange & yellow areas on the maps on this page represent places that likely have a high proportion of people with  $\geq 6$  ACEs.*

# Population Attributable Risk



Controls: gender, age, income, education, race-ethnicity

# Secondary Traumatic Stress

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- Comes from exposure to the experiences and stressors that clients face
- Impacts the body in similar ways to first hand exposure to these stressors
- Has effects on employee performance and health

# Burnout

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- Individual
  - Decreased job performance
  - Increased symptoms of physical and behavioral health conditions
- Agency
  - Responding to customer dissatisfaction
  - Increased employee absence
  - Scrambling to cover missed shifts

# The Cost of Turnover

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- Lost productivity from staff that leave and decreased efficiency of staff and supervisors that need to provide coverage
- Cost of hiring
- Cost of training

# Putting it in context

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**Chuck Hendrickson,**

*Executive Director*

**Love Overwhelming**

Love Overwhelming provides a variety of programs that serve homeless individuals. They have continually worked to improve their agency's approach to supervision and support for their employees with a trauma informed lens.

# Being Trauma Informed is an Agency Wide Effort That starts With a Focus On Staff

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- Individual Knowledge and Skills
- Implementing Specific Strategies
- Managing Agency-wide Systems Change

# Individual Practice: Self-care

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# Strategies to consider

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1. Support and encourage employees to practice self-care
2. Use Reflective Supervision practices
3. Establish and reinforce a co-worker agreement to promote healthy staff interactions
4. Enhance HR practices to monitor for impacts of toxic stress on employees and support individuals experiencing difficulties
5. Implement or enhance an employee wellness program

# Change Management

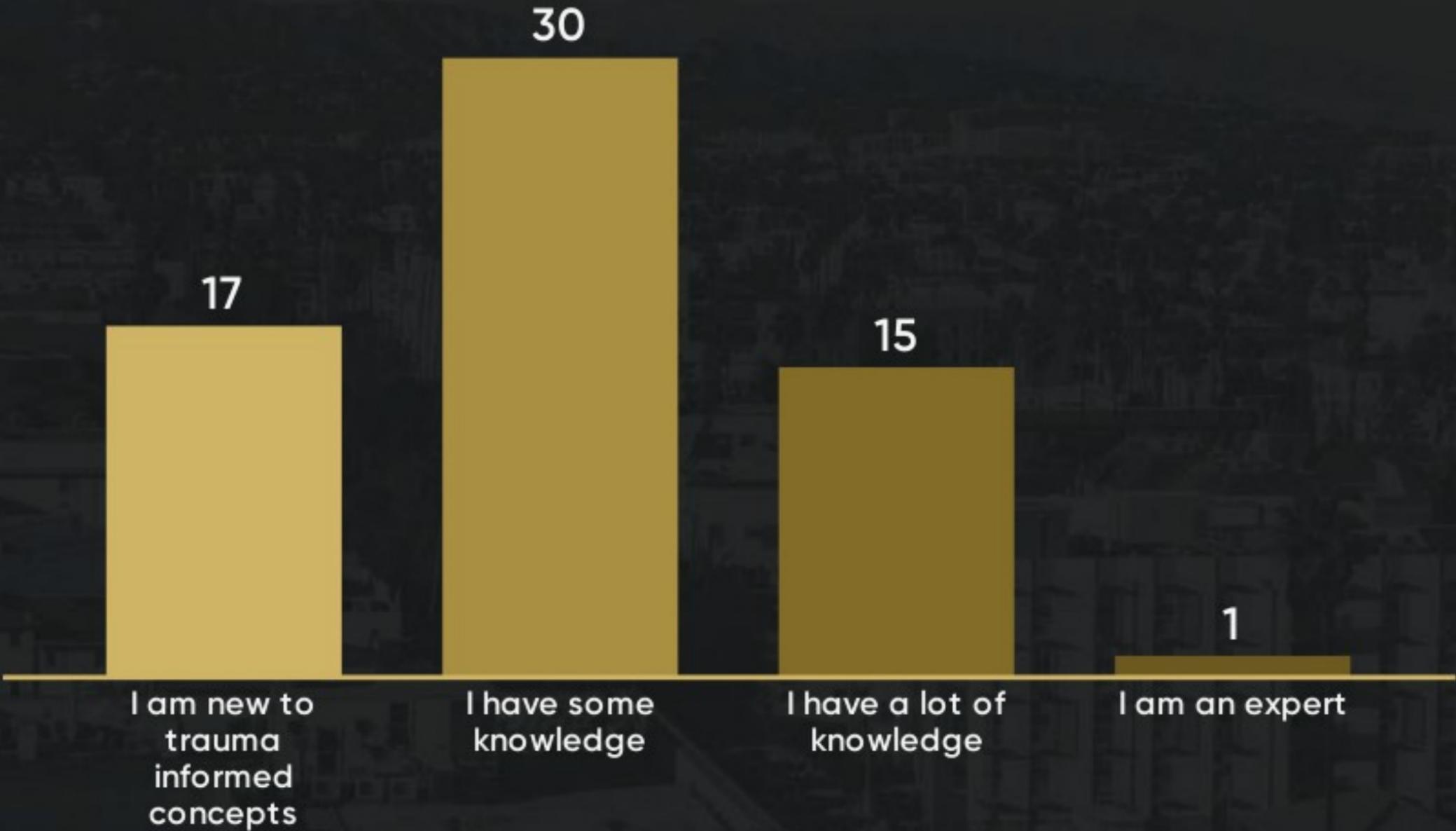
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- Leadership at all levels of your agency
- Dedicated time and internal structures to continually engage with the change process
- Resources and content experts to support effective implementation
- Embrace the uncertainty and look for signs of changes in workplace culture

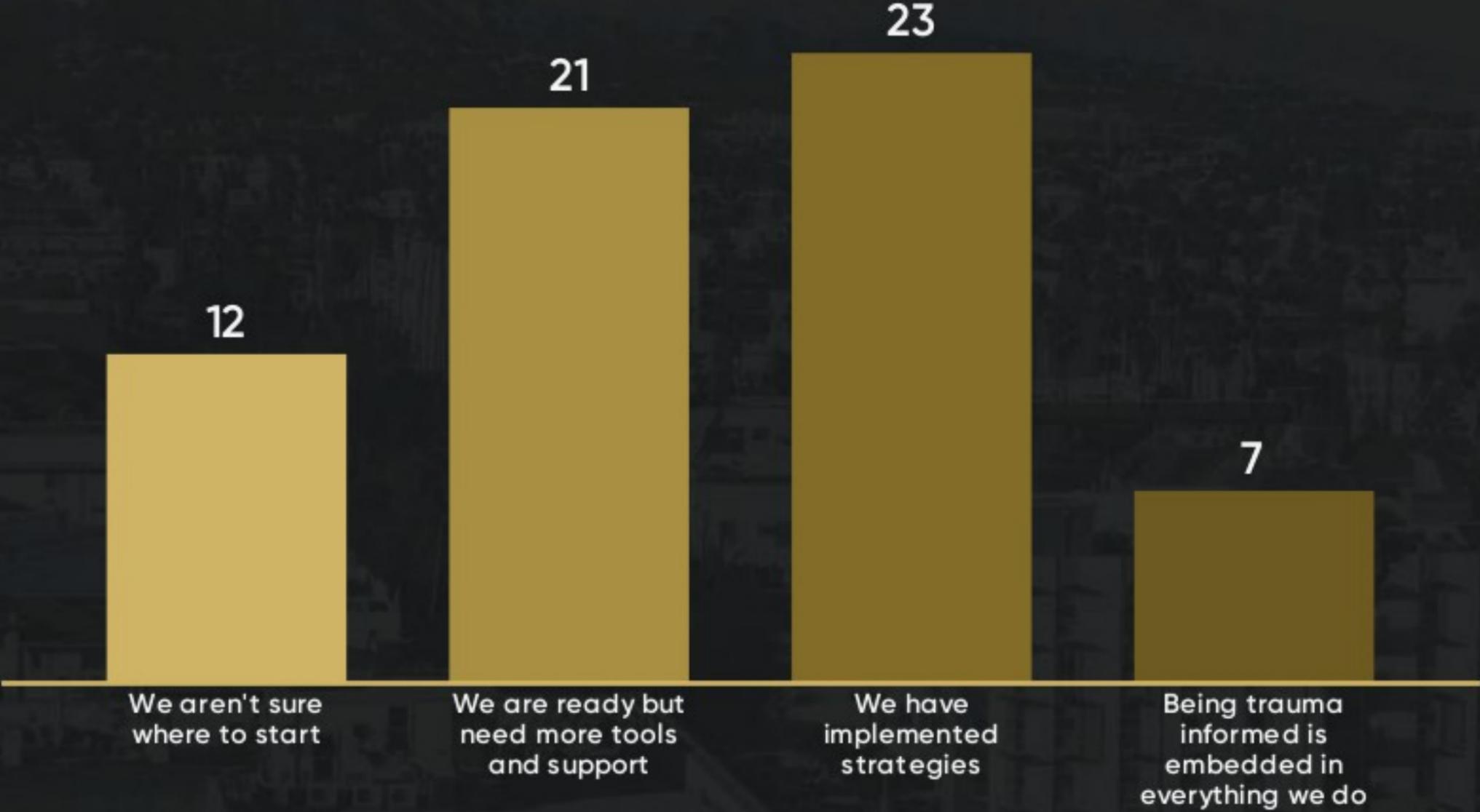
**WE WANT TO KNOW WHAT YOU THINK!**



I have the knowledge to help my agency work on creating and maintaining a trauma informed work environment for staff.



# My agency has leaders ready to take action on trauma informed strategies and systems to support staff.



# What is one thing that stood out from today's presentation?

The talk about self care

Toxic stress

The written tools are very helpful. I can see implementing this process with our staff.

Information on NEAR Sciences

The county statistics for ACEs

Cool brain science!

Reflective supervision

Importance of self care

Overall description of NEAR

# What is one thing that stood out from today's presentation?

The experiences shared by Love Overwhelming

LOVED Michael's presentation. Please send it out to participants!!

Making an action plan

Need commitment from agency leadership.

Real life examples

Staff satisfaction

The need for a trauma informed workplace.

Commitment to all levels of staff. This presentation was not directed at one particular group, but was applicable to any person who attended.

NEAR Sciences

# What is one thing that stood out from today's presentation?

Everyone seems to struggle for time to implement TIC

Aces and how we can address it in the work place

Self care can't just be talked about. We have to model this from leadership and schedule it for staff

Ace statistics

Individual experiences

ACEs in helping professions

How toxic stress effects the brain

To make staff neetings humanizing not just administrative

We need to continue these conversations together!

# What is one thing that stood out from today's presentation?

Leadership modeling it, not just talking about it

Great overview of program

That we aren't the only agency with an overwhelming caseloads in multiple programs.

Washington state statistics on ACES populations

Information re NEAR & brain science

How much past trauma can affect a person especially when there are multiple traumas

N.E.A.R

Importance of putting on your own oxygen mask first.

Epigenetic modification in dna

# What is one thing that stood out from today's presentation?

If we dont take care of us, our staff, we dont have the fuel to invest in other's, cluents... community

How challenging it can be to make changes with limited resources, so sometimes the small things are the best place to start. Intention matters!

what NEAR stands for.

Starts with leadership

The factors that go into epiginetic modification of dna and how that effects our bodies mentally and physically.

Talking about how to implement effective strategies to reduce burnout.

Self care annd training

Michael O'Neil and Chuck Hendrickson delivering a message that needs to be put in practice at a leadership level

Knowledge of presenters

# What is one thing that stood out from today's presentation?

That it is important to invest in the staff to ensure they are happy and fulfilled so there is retention of staff and productivity.

Focusing on the trauma that employees face in and out of the workplace. Helping people through trauma can be as traumatic as dealing with it yourself. Especially if you have similar past experiences.

Promote self care by encouraging staff to take care of themselves, eg leave 10 min early and go to a park or beach to transition.

How much past trauma can affect a person

Leadership buy-in and modeling

Round table discussions

Questioning around my own orgs translation and trickle down of corporate policy. Is there consistency in messaging- if not, where is the breakdown?

Oxygen mask

Initial understanding about the impact of trauma as it relates to workplace success and satisfaction. We must take care of ourselves too!

# What is one thing that stood out from today's presentation?

The percentage of people with Aces. Stories of coworkers really supporting each other.

HRs role can make or break organizations staff perceptionn of culture. For example if there is a positive policy that staff is unaware of, the culture is effected

Greatoverervio

Aces presentation.

The universal need for leadership buy in.

The BARRIES agencies face to be trauma informed.

# What is one thing that stood out from the workshop?

Other agencies barriers

Shared examples

Hearing all the great ideas what other orgs are doing

It was engaging

Great networking with a strong representation of the community

Thinking through concrete examples on how to resolve barriers.

Other

How trauma informed our agency policies already are but that it doesn't always translate well in practice

The variety of work environments and requirements in different agencies

# What is one thing that stood out from the workshop?

The ability to idea share and see through differing lenses

The process was helpful to guide the discussion.

Other organizations are already doing great things in this area. It is great to have the chance to learn from each other.

Engaging conversations about what we can do better as an organization.

Wide range of organizations experiencing similar barriers to implementing actions

I liked drilling down into small a tion steps. Made it tangible

Ideas for improving self-care in the workplace

Integrity

As leadership we need to role model self care to our teams

# What is one thing that stood out from the workshop?

The struggle is real.

Similarities in the barriers and aspirations

Resilience and how this can protect a person with ACEs from detrimental life choices.

How important it is to be trauma informed in the workplace to promote staff happiness and retention.

How even within varied organizations and positions that we all face the same hardships and issues as well as yearn for the same sense of peace and belonging.

Other agency experiences

Breaking everything down into categories helped create some action steps

Really good idea sharing with other providers on how to create more trauma-informed workplaces.

We are all experiencing similar barriers.

# What is one thing that stood out from the workshop?

Shared experiences & knowledge, very helpful.

It was good to hear the others felt the same way

Honest conversations on a topic we don't often have the space to talk about

Hearing the challenges of other agencies with an eye to my own

We may work in different places/ environments but we all share the same challenges.

Commonality of Issues cross multiple systems

Common struggles across organizations and regions

It is important to have champions for employee recognition/support.

In larger orgs there is less ability to leverage policy/procedures to instigate change.

# What is one thing that stood out from the workshop?

Some great ideas on integrating employee wellness support. A survey was suggested to get all employees input on.

How leaders and front staff need to work together to create change

Workforce satisfaction and purpose is key to service delivery

Have parallel people from other orgs come share what they do to promote success.

The table discussion was helpful good ideas on compassion fatigue

Lessons gained from other's experiences - what was beneficial

Good collective group brainstorm ideas.

So many parallel or similar experiences across different organizations.

Lead by example

# What is one thing that stood out from the workshop?

Learning new methods to address staffing issues.

Not just about leadership buy in, but staff buy in as well. We don't think burn out will happen to us.. until it does.

Leadership needs to set the standard. Don't assume you know what's best for someone else in terms of their self care.

We can incorporate a trauma lens into our current work with cultural competence

You must have a plan

We have a long way to go in developing a self care model

We cant help others if we dont take care of ourselves

Similar struggles among us.

Importance of physical space

# What is one thing that stood out from the workshop?

Understanding and acknowledging different perspectives and ideas of others selfcare (what they do, how and why.)

Administrative training

We can all do better

Leadership needs to modeltge concepts in TIC

# What is one action step you will take after this meeting?

Using these tools with our staff

Creating engaging training

Self care accountability

Be a better role model in self-care

I will share out trainings at staff meetings

Bring back some new wellness policies to our org.

Honest conversations with leadership around need for trauma informed practices

Encourage leadership to practice good boundaries.

Share ideas heard with others in workplace

# What is one action step you will take after this meeting?

Work on creating reflective supervision and active listening.

Staff satisfaction is key

Work on improving self care.

Training ideas for department and whole organization

Do more self care for myself and then helping others by sharing what our organization offers

Implement non-education related trainings to support TI workplace management.

Self-care first. Push for policy changes that really focus on how to improve employee mental health - not just policies that look good on paper

Read and share the links of information that was given

Reflective supervision as part of normal check ins

# What is one action step you will take after this meeting?

Great job Michael!!!!

I will Continue to Champion thoughts ideas and practices that benefit the work place in order to build up the positive work culture

Make conscious efforts to be accountable to myself to practice self care both at home and in the work place.

Discussing this training with coworkers who didn't make it

Lead by example and not email staff after hours, on weekends or when on vacation.

Create better boundaries

Reflective supervision.  
Creating a calm and tic office space

Continue to engage in discussions on how to make improvements to our organization.

Modeling healthy boundaries.

# What is one action step you will take after this meeting?

Talk to HR about implementing a training for staff about secondary trauma/self-care and ensuring staff are aware of agency resources available to them at hire and throughout employment.

Continue monthly staff meetings teaching these concepts.

The importance of reflexive supervision

Focus on reflective supervision, know where people are and what feeds them

Changing my behavior/mindset is a starting point while I engage leadership to develop policies and systems.

Be assertive about the importance of trauma support for staff - don't wait for them to ask for support

I can take responsibility as an individual employee to improve and engage in organizational resources

Ask leadership if we can create a survey to get everyone's thoughts on trauma informed care at the work place.

Present concept of ACE's to leadership team. Continue to build on this training.

# What is one action step you will take after this meeting?

Discussing with staff an individualized self care plan for themselves

Training on self care, burn out.

Set specific questions to ask in each supervision to ensure we cover non-administrative issues.

Compassion for staff is good business

Modeling what we are teaching our staff. Focus on the practice use of this methods.

Make time to take a breath and acknowledge that i cant do everything i want to do in my day, therefore come up with a better time management tool of what i can do.

Making trauma-informed care a priority by setting time aside for it.

Every staff member should have an opportunity to self-determine training and education interests and needs

Our self care needs improving

# What is one action step you will take after this meeting?

Encourage individual, personal checkin with staff to avoid unknown trauma related issues.

Self care

Further discussion with leadership and HR. Requests for more trainings in house for all.

Bring this information back to management

Discuss with leadership the importance to invest in lead staff.

Michael is an awesome presente!

Listen to staff frustrations that come up again and again and think about how the organization support folks

Take better care of my staff, flexibility & time for their own self care.

Build a team dedicated to making sure self care is bieng understood and put in play.

# What is one action step you will take after this meeting?

Working on my own self-care so I can be a better model to others around me. It is important to actually unplug when away from the office.

Keep these conversations going

Make an emergency plan for all staff if mental health crisis occur

Provide a variety of free training with CEU's that providers can choose from which interests them.

Better use of technology meetings ( zoom / go to meeting )

Open up communication with staff on self care giving permission to do what it is best for you

No he really is

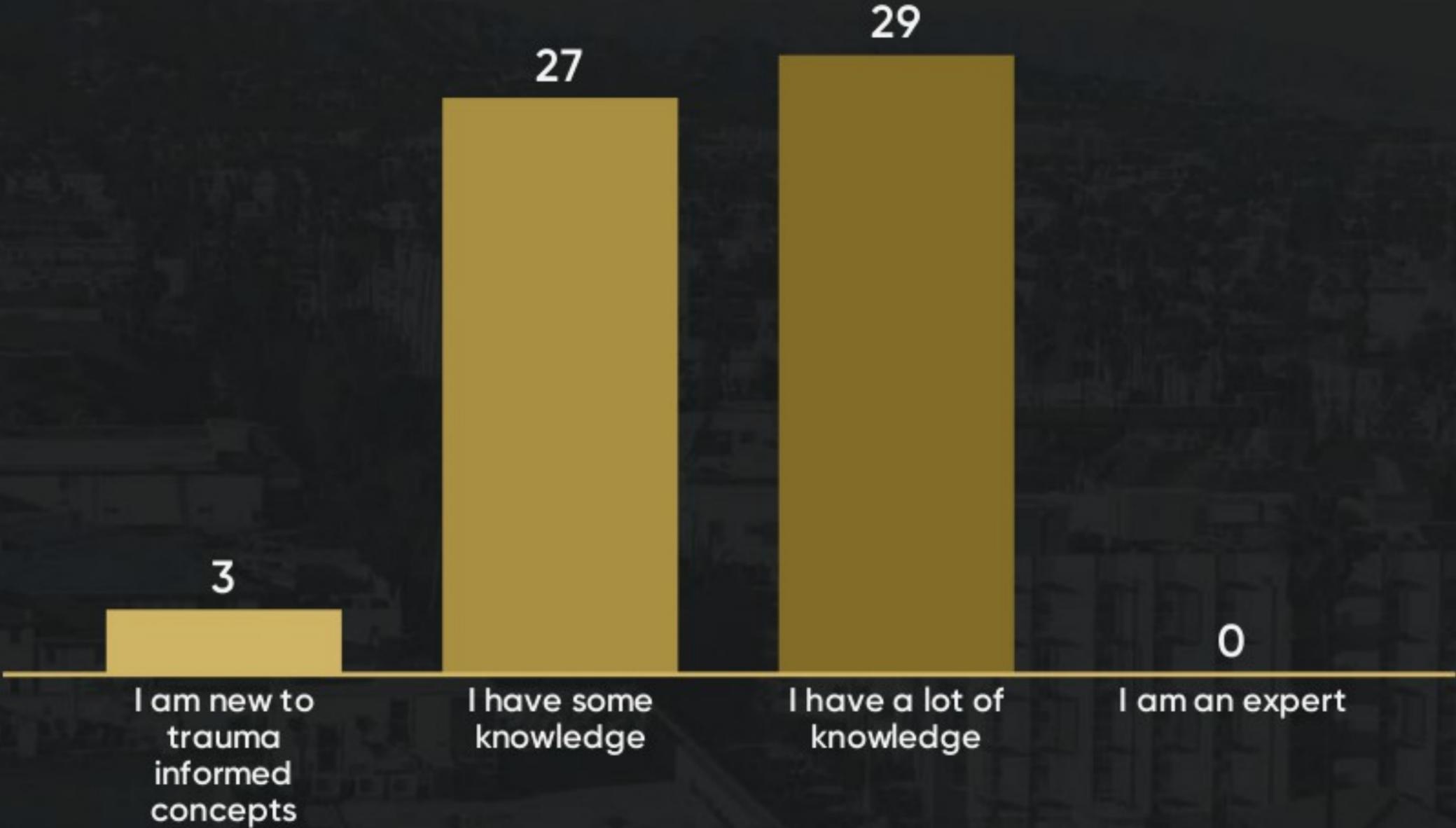
Acknowledge my and others humanity

Using these with the staff

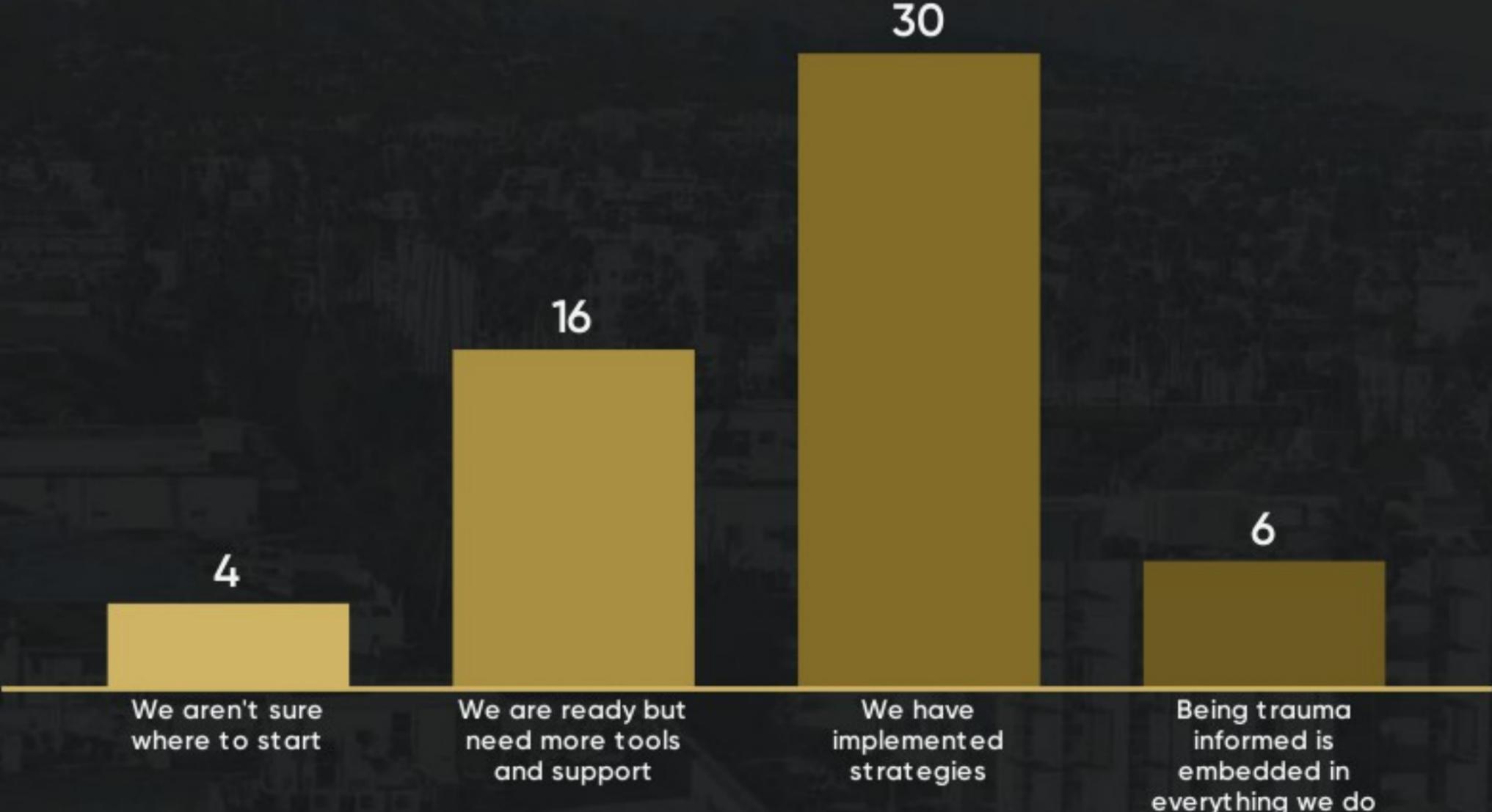
# What is one action step you will take after this meeting?

Meeting staff more regularly discussing self care and burnout

I have the knowledge to help my agency work on creating and maintaining a trauma informed work environment for staff.



# My agency has leaders ready to take action on trauma informed strategies and systems to support staff.



THANK YOU!



# Narrative Report



Instructions: Please complete the Narrative Report by responding to each question (350 words or less per question) and submit as a Word document using the naming convention NR2019Q1\_ organizationname.

To fulfill CPAA reporting requirements, both the Narrative Report and the Excel Milestone Report must be completed and emailed to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) by 4/30/2019.

Organization	
Primary Contact Name:	
<b>Narrative Questions</b>	
1. Describe the key challenges or risks experienced in implementing your selected Transformation projects during this reporting period. Include potential impacts and mitigation strategies for specific Transformation activities. Please be sure to address each project area you're participating in.	
2. Provide a narrative or list of activities that occurred during the reporting period that support MTP projects but are not listed in the Milestone Report. Please be sure to address each project area you're participating in.	
3. Based on your experience as a MTP partner, what feedback do you have for CPAA to improve how we support partner understanding and success?	
4. Please provide a brief summary of progress made in the adoption of policies, procedures, and/or protocols that support your MTP work, including any challenges faced. If no progress has been made to date, please describe the policies, procedures, and/or protocols your organization aims to initiate in the next 6 months.	

## CPAA/AIMS Center Training

### Primary Care in Behavioral Health

Tuesday, May 7, 2019 | Fairfield Inn and Suites, Rochester, WA

#### Agenda

TIME	TOPIC
8:00 – 8:30	Sign-in and Refreshments
8:30 – 9:00	Welcome and Introductions Overview of the Day
9:00 – 9:45	Core Principles and Team Roles in Whole Person Care
9:45 – 10:45	Partnering with Primary Care
<b>10:45 – 11:00</b>	<b>BREAK</b>
11:00 – 12:30	Supporting Medical Care of People with Serious Mental Illness
<b>12:30 - 1:30</b>	<b>LUNCH</b>
1:30 – 2:15	Population Health & Risk Stratification
2:15 – 3:00	Measurement-Based Care: Using a Registry to Improve Client Outcomes
<b>3:00 – 3:15</b>	<b>BREAK</b>
3:15 – 4:30	How Do I Help Clients Get Healthy? Evidence-Based Strategies
4:30 – 4:45	Action Planning Review of the Day
<b>4:45 – 5:00</b>	<b>FEEDBACK &amp; ADJOURN</b>

## Behavioral Health in Primary Care Training

### Tuesday, June 18, 2019

TIME	TOPIC	TARGET AUDIENCE
8:00 – 8:30	Sign-in and Refreshments	All Participants
8:30 – 8:45	Overview of the Day: Welcome and Introductions	All Participants
8:45 – 9:15	Setting the Stage	All Participants
9:15 – 10:15	Engaging Patients in Care	All Participants
<b>10:15 – 10:30</b>	<b>BREAK</b>	
10:30 – 12:00 Breakout Session	Establishing a Diagnosis and Initiating Treatment	BH Providers and Clinical Supervisors
	Operational Coaching: Clinical Workflows, Supervising a Behavioral Health Team in Primary Care, Etc.	Clinic Managers and Operations
<b>12:00 – 1:00</b>	<b>LUNCH</b>	
1:00 – 2:00	Driving Improvement for Patients on Your Caseload: Active Treatment to Target	All Participants
<b>2:00 – 2:15</b>	<b>BREAK</b>	
2:15 – 3:15	Working with Your Psychiatric Consultant: Caseload Review	All Participants
3:15 – 3:30	Introduction to Completing Treatment and Relapse Prevention Planning	All Participants
3:30 – 4:00	Review of the Day	All Participants
<b>4:00 – 4:15</b>	<b>FEEDBACK &amp; ADJOURN</b>	

## One Key Question® Training Agenda

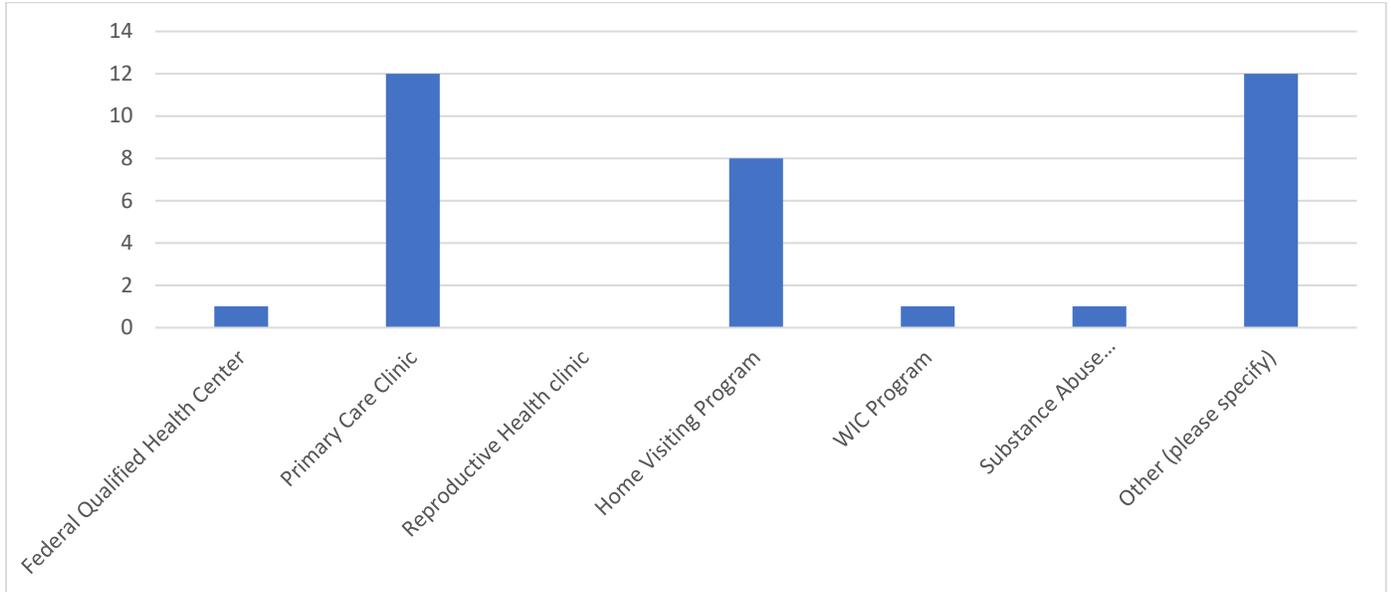
### Cascade Pacific Action Alliance and Power to Decide

June 5, 2019, 8:30 – 3:00 pm

8:00 – 8:30 am	Registration and Breakfast
8:30 – 9:00 am	Welcome and Introductions
9:00 – 10:30 am	Background, Health Equity, and Algorithm <ul style="list-style-type: none"><li>• Background – One Key Question Development and Reasoning for Use</li><li>• Reproductive Autonomy and Pregnancy Desire – Focus on health equity and disparities (short video clip) and history of research and reproductive coercion</li><li>• Algorithm, Protocols, and Fidelity – Deep dive into what to do with each response</li><li>• Reflection Activity: Given the context in which you work (who you work with and what setting), what response will you have the most trouble with and why?</li></ul>
10:30 – 10:40 am	<b>BREAK</b>
10:40 – 11:30 am	Modeling of Protocol <ul style="list-style-type: none"><li>• Trainers model simple role play and attendees practice with the same role play</li><li>• Large group processing/discussion</li></ul>
11:30 – 12:00 am	Unconscious Bias and Values Clarification <ul style="list-style-type: none"><li>• What is Unconscious Bias?</li><li>• Short video</li><li>• Values Clarification activity</li></ul>
12:00 – 12:30 pm	<b>Lunch</b>
12:30 – 1:45 pm	Role Plays <ul style="list-style-type: none"><li>• Attendees will be given more complex scenarios to practice/role play use of One Key Question®</li></ul> Challenges and Solutions Carousel Review <ul style="list-style-type: none"><li>• Listing of potential challenges associated with implementation/workflow</li><li>• Small group work on potential solutions for each challenge</li></ul>
1:45 – 2:30 pm	Implementation – small groups by site <ul style="list-style-type: none"><li>• Workflow</li><li>• Referrals</li></ul>
2:30 – 3:00 pm	Next Steps, Evaluations, and Q&A

## OKQ Training Evaluation (N=43)

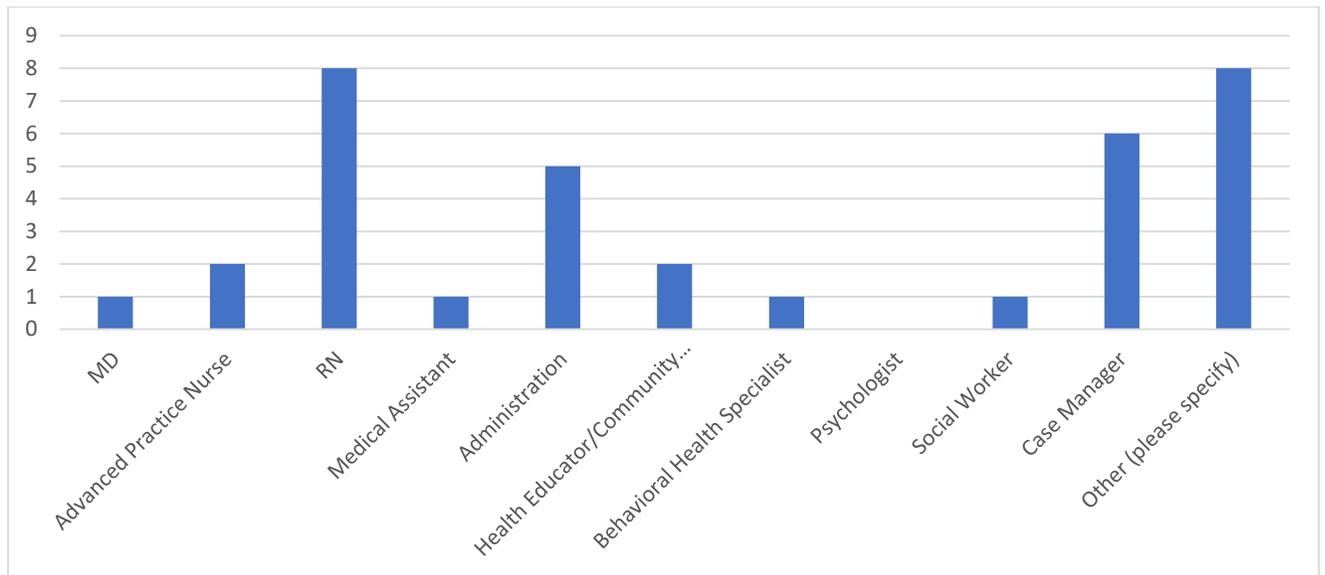
### Agency type:



### Other:

- Women's health clinic
- Public health department
- Hospital
- Community action council (n=2)
- Case management and support
- Hospital-based midwifery practice
- Homeless family services
- Social service office
- Pediatric office
- Hospital owned rural health clinics
- Social services

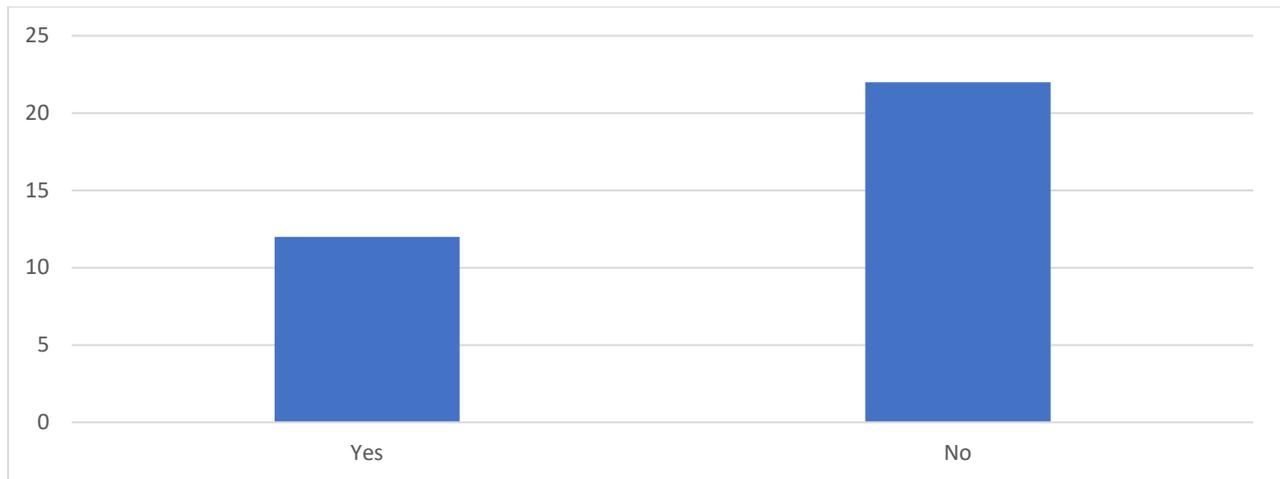
**Position at agency:**



**Other:**

- Certified nurse midwife
- Physician assistant
- Naturopathic physician
- Clinic LPN
- Medical assistant
- Program director
- Nurse manager

### Currently providing pregnancy intention screening at your site?



### If yes, what screening questions and patient answer options are you using?

- Q: Are you planning to get pregnant in the next year? A: Yes/no/maybe
- Q: How do you plan to prevent pregnancy at this time
- Q: Was this a planned pregnancy?
- Q: Would you like to become pregnant in the next year? A: Yes, no, unsure, either way ok, n/a
- Q: Are you planning on having more children
- Q: Are you planning or wanting to become pregnant
- Q: What are your thoughts around birth control options
- Q: Are you pregnant or trying to become pregnant
- Q: Are you planning to have another baby? If so when, if not what method are you using to be sure you get pregnant when you want to
- Q: Do you want to have additional children in the future? Do you have a plan for after your child is born?

**Satisfaction with One Key Question® Training:**

Overall, how satisfied were you with this training? (mean=4.14)

Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied
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The overall purpose of the training was clear (mean=4.51)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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The content of the training met my expectations (mean=4.12)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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The activities were useful in building skills (mean=4.28)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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The presenter(s) showed knowledge of the topic (mean=4.81)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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The teaching methods were effective (mean=4.53)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

The training was well organized (mean=4.51)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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The training was a good use of my time (mean=4.26)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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I feel competent to implement the knowledge and skills that I learned at this training  
(mean=4.21)

Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
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**Confidence Implementing One Key Question®:**

My current level of knowledge of One Key Question and its intended use is:\*

Pre (mean=1.79):

Very Low	Somewhat Low	Somewhat High	Very High
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Post (mean=3.28):

Very Low	Somewhat Low	Somewhat High	Very High
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Ask the One Key Question® and follow the 4-response protocol fidelity\*

Pre (mean=3.00):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Post (mean=4.26):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Clearly articulate and provide a referral when direct care is not an option\*

Pre (mean=3.44):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Post (mean=4.47):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Provide counseling and services in a non-judgmental, unbiased way that supports patient's pregnancy intentions, regardless of their answer

Pre (mean=4.14):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Post (mean=4.53)

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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Provide services that are consistent with One Key Question® code of ethics\*

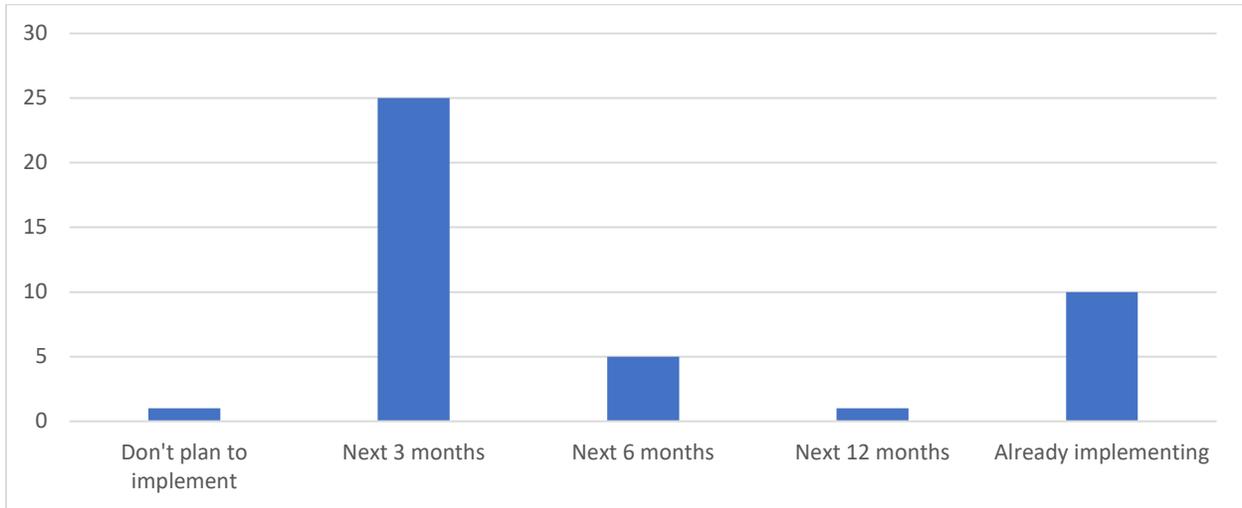
Pre (mean=3.34):

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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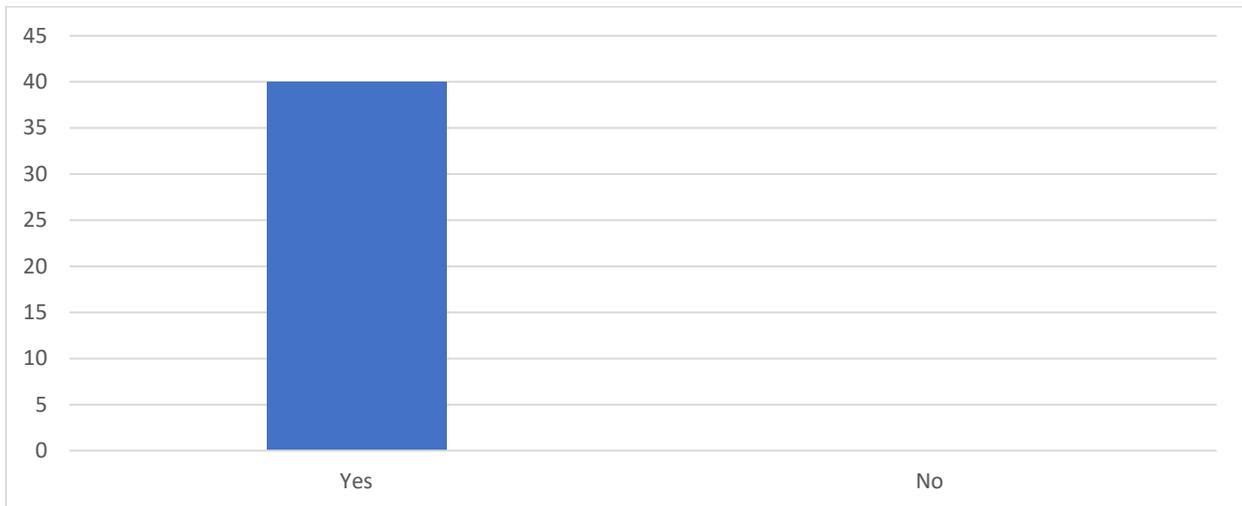
Post (mean=4.62)

Not Confident	Little Confident	Neither	Somewhat Confident	Very Confident
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**When do you plan to implement the material you've learned from this training?**



**Did you learn new information and strategies that you can apply to your work or practice?**



**What topics would you like to have more information on for the post-training webinar?**

- More “ice breakers”, starter phrases, comments on replies to flat out “no, not interested in birth control” or “I don’t like the side effects of the pill” or “I got pregnant on the pill”
- Referral resources in my area for women of this age
- Posters and pamphlets
- Educational tools and handouts for patients and implementation strategies
- Confidentiality with adolescents

- OKQ and STI information
- Targeting this tool to social service agencies vs. clinical and medical providers
- How to have this conversation with transmen and LGBTQ populations
- Discussion about reaching out to males to prevent unplanned/unwanted pregnancies
- Ways to communication options and maybe more handouts
- Patient handouts
- How to implement in a pediatric clinic with post-partum mothers and how to ask OKQ to patients 12/13-19 with parents in the room
- Team implementation and how to overcome staff resistance to change
- Diabetes and pregnancy
- Prevention of pregnancy
- How and what each family planning method protects individuals against unplanned pregnancy
- Specifics regarding each BC method (i.e., use and who are best candidates for various methods) as well as how abortion is entered into the discussion especially within the current political climate
- More information pertinent to WA state
- Pediatric demographics
- Providing information to clients about birth control in a non-clinical setting
- Follow up to ask any questions or address any concerns that arises with implantation and to have the opportunity to learn from the successes and failure of other organizations
- Community programs and available programs
- Types of birth control to handout

**Please include any additional comments you have:**

- Gear more towards home visitors/community health workers not just clinics
- Potential future regret is not a reason to provide a person with their preferred method of birth control. There are few instances of personal choice being denied because of perceived second party's opinion of an outcome other than in women's reproductive health
- The training felt more for medical providers, perhaps have a clinical training session and a non-clinical training session—many of the concerns did not apply to our work
- Most useful was the role play. When I got stuck I was able to gain understanding from group members
- Less group work to keep information presentation on track
- Excellent
- Less role play
- The role play might inspire more conversations if it was designed by pulling a scenario out of a hat and allowing participants to work through the scenario
- I thought it was great
- I don't like the role play

- Please include citations in slideshows. This training was very gender-biased, entirely non-inclusive of nonbinary and trans people that can get pregnant. Providers need to see examples from trainers of use of inclusive language every time they refer to people that can get pregnant. Provider bias against trans folks was not even addressed during the conversation on bias. Do better.
- Send PDF access prior to training so clinics can start using immediately after training (or give website info prior to training if possible)
- Great training, like the activities and variety of ways of learning—love the script and the challenge activity
- I feel like as a country we emphasize individual freedom over community and larger community impact. My one disagreement with this is that I think we need to move to a community minded culture in terms of the number of children being brought into this world, our ecology, ecosystem is suffering because of the over population growth. I think this needs to be a more important as clinicians and social workers
- Great workshop
- I think the demographics should be changed to 15-50. There needs to be more pediatric friendly information and research

Appendix K:  
MTP Partner Site Visit Packet

## Medicaid Transformation

The Medicaid Transformation Project (MTP) 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.

MTP work is led by nine Accountable Communities of Health (ACH), each governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health.

ACHs aim to transform the health system statewide: **better health, better care, and lower costs.**

### 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



### P4P Metrics

MTP Implementation Partners, providers, and community-based organizations in the CPAA region are working together to transform care delivery and improve the state's Pay for Performance (P4P) metrics. **Our combined work to improve our region's P4p metrics culminate in better patient outcomes, healthier communities, and more money** to give to partners for Transformation work.

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

P4P metrics, which are broadly accepted as the standard of care, focus on health conditions that are of significant concern for population health. P4P metrics include, but are not limited to:

- All cause ED visits
- Well-child visits
- Comprehensive diabetes care: A1c testing
- Percent homeless
- Mental health treatment penetration
- Substance use disorder treatment penetration

# CPAA Projects

**Bi-Directional Care Integration** focuses on delivering whole-person care, closing the gap between primary care and behavioral health services, and addressing physical and behavioral health in an integrated system.

Moving into an integrated system means 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. Community CarePort, CPAA's Pathways HUB, 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** coordinates 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 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.

## 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 focus on community-clinical linkages and 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, recovery supports for substance use disorder, regular check-ups and preventative screenings, and transportation to appointments

## Board Members

Chris Bischoff	Wahkiakum County PHHS
Craig Dublanko	Coastal CAP
Danette York	Lewis County PHHS
Dave Windom	Mason County Community Services
Denise Walker	Confederated Tribes of the Chehalis
Dian Cooper	Cowlitz Family Health Center
Emmett Schuster	Willapa Harbor Hospital
Frank Wolfe	Thurston/Mason BHO
Harishiem Ross	Sea Mar
Jon Tunheim	TC Prosecuting Attorney's Office
Karolyn Holden	Grays Harbor PHHS
Kat Latet	Community Health Plan of WA
Laurie Tebo	Behavioral Health Resources
Mary Goelz	Pacific County PHHS
Michelle Richburg	Consumer Representative
Mike Hickman	ESD 113
Steve Clark	Valley View Health Center
Tom Jenson	Grays Harbor Community Hospital
Winfried Danke	Providence

## Contact Information

Jean Clark, CEO

Address: 1217 4<sup>th</sup> Ave E, Olympia, WA 98506

Email: [info@cpaawa.org](mailto:info@cpaawa.org)

Phone: 360-539-7576

## CPAA Support & Comagine Health Coaching

A primary function of Cascade Pacific Action Alliance (CPAA) ACH is to support partners in successful implementation of Medicaid Transformation projects. CPAA can provide a number of services, which are outlined below. If you are interested in receiving support from CPAA or coaching assistance from Comagine Health (formerly Qualis Health), please send a request to [reporting@cpaawa.org](mailto:reporting@cpaawa.org) including your organization's name, project area(s), a point of contact, and a brief description of your request.

### Trainings & Peer Learning

Providing presentations on specific topics, coordinating professional trainings, and connecting with peers in a learning community.



### Coaching with Comagine Health

In-house support to build capacity for practice transformation (e.g., workflow workshops, optimization of EHR reporting).



CPAA  
Support

### Project Management Support

Helping partners initiate, plan, execute, and complete work to achieve specific transformation goals and objectives.



### Partner Connections

Supporting the formation of strategic, collaborative relationships between organizations to work towards shared goals and objectives.



# CPAA Reporting Timeline



Q1/Q3

Milestone Reports and Narrative Report Due

Q2/Q4

Milestone Reports, Narrative Report, and Metric Progress Reporting



**Partner List**

Organization	City	Lead Contact	Email	2A	2B	2C	3A	3B	3D	Total
				Bidirectional Care	Pathways	Transitional Care	Opioid Response	Maternal, Child Health	Chronic Disease	
ANSWERS	Gig Harbor	Karla Cain	karlacain@answerscounseling.org	X				X		2
Area Agency on Aging	Vancouver	Kelli Sweet	sweetka@dshs.wa.gov						X	1
BHR	Olympia	Tiffany Buchanan	tbuchanan@bhr.org	X						1
Capital Recovery	Olympia	Lucinde Grande	cgrande@pioneerfamilypractice.com			X	X			2
Cascade Mental Health	Olympia	Matt Patten	pattenm@cascadementalhealth.org	X						1
CCAP	Aberdeen	Craig Dublanko	craigd@coastalcap.org		X	X				2
Child & Adolescent Clinic	Olympia	Phyllis Cavens	pcavens@candac.com	X				X	X	3
Child Care Action Council	Aberdeen	Fran Williams	Fran@ccacwa.org					X		1
Columbia Wellness	Lacey	Kristin McWain	Kristin.mcwain@columbiawell.org				X			1
Community Action Council	Lacey	Kristin York	kirsteny@caclmt.org		X					1
Community Youth Services	Olympia	Alicia Ferris	aferris@communityyouthservices.org	X						1
Confederated Tribes Chehalis	Oakville	NA					X			1
Consejo Counseling	Shelton	Mario Parades	marioparedes@consejocounseling.org	X			X			2
CORE Health	Longview	Sara Harper	sarahh@choblv.org	X		X	X			3
Cowlitz Family Health	Longview	Dian Cooper	dcooper@cfamhc.org	X			X			2
Cowlitz Indian Tribe	longview	NA		X						1
ESD 113	Tumwater	Mike Hickman	mhickman@esd113.org					X		1
Gather Church	Centralia	Cole Meckle	cmeckle@gmail.com		X		X			2
Grays Harbor Hospital	Aberdeen	Melanie Brandt	mbrandt@ghcares.org	X		X	X	X	X	5
Kaiser Foundation	Portland	Elizabeth Spinning	elizabeth.a.spinning@kp.org	X			X			2
Lewis CCHS (Valley View)	Chehalis	Heidi Zipperer	hzipperer@vvhc.org			X			X	2
Lewis County Sherrif Dept	Chehalis	Chris Sweet	chris.sweet@lewiscountywa.gov				X			1
Lifeline Connections	Vancouver	Joe Foster	jfoster@lifelineconnections.org		X		X			2
Lower Columbia CAPS	Longview	Melissa Taylor	melissat@lowercolumbiacap.org		X	X			X	3
Mason County Public Health	Shelton	Lydia Bucheit	lydiab@co.mason.wa.us				X			1
Mason General Hospital	Shelton	Terri Gushee	tgushee@masongeneral.com	X	X	X	X	X	X	6
Morton General Hospital	Morton	Vicky Brown	VBrown@myarborhealth.org	X						1
Nisqually Indian Tribes	Olympia	NA					X			1
NW Pediatric	Centralia	Jennifer Polley	japolley55@gmail.com	X		X		X		3
Ocean Beach Hospital	Ilwaco	Brenda Slagle	bslagle@oceanbeachhospital.com						X	1
Olympia Pediatrics	Olympia	Janelle Tiegs	janellet@olypeds.com	X						1
Pacific County PH	South Bend	Mary Goelz	mgoelz@co.pacific.wa.us				X			1

PeaceHealth	Longview	Liz Cattin	lcattin@peacehealth.org			X	X		X	3
Pediatric Associates	Olympia	Beth Harvey	betheharvey@comcast.net	X		X	X	X	X	5
Peninsula Community Health	Bremerton	Jennifer Kreidler Moss	jkreidler@pchsweb.org	X	X	X	X	X	X	6
Physicians of SW WA	Olympia	Cheryl Moses	CherylM@PSWIPA.com		X	X				2
Planned Parenthood	Seattle	Lisa Humes- Schulz	lisa.humes-schulz@ppgnhi.org					X		1
Providence	Olympia	Andrea Corona	Andrea.Corona@providence.org	X		X	X		X	4
Quinault Indian Nation	Quinault	NA		X						1
SeaMar	Seattle	Tabitha Gross	TabithaGross@seamarchc.org	X	X	X		X	X	5
Shoalwater Bay Tribe	Tokeland	NA		X						1
Skokomish Indian Tribe	Skokomish	NA		X						1
Squaxin Island Tribe	Shelton	NA		X						1
Summit Pacific Medical	Elma	Tammy Moore	tammym@sp-mc.org	X	X	X	X	X	X	6
Thurston County PH	Olympia	Liz Davis	liz.davis@co.thurston.wa.us				X	X	X	3
Wahkiakum HHS	Cathlamet	Chris Bischoff	bischoffc@co.wahkiakum.wa.us	X				X		2
Willapa BH	Long Beach	Adam Marquis	marquisa@willapabh.org	X						1
Youth and Family Link	Longview	Coorie Dow	cdow@linkprogram.org		X	X		X		3
YWCA of Olympia	Olympia	Hillary Soens	hsoens@ywcaofolympia.org				X	X		2



## Partner Intervention Goals

Organization	Intervention	Smart Goal
ANSWERS	Integrating Primary Care into Behavioral Health	Develop partnerships in Grays, Lewis, Mason & Thurston counties involving Off-Site-Enhanced Collaboration Integrating Primary Care into Behavioral Health
ANSWERS	One Key Question	Implement OKQ increasing percentage of enrolled patients who are screened
Area Agency on Aging	Chronic Disease Self Management	Sustain two Chronic Disease Self -Management Workshops each year of the demonstration and increase the number of clients completing the course
Area Agency on Aging	Paramedicine	Decrease the percentage of high utilizers of the Emergency Medical Services (EMS) system by providing wrap around services that promote chronic disease self-management and address social determinants of health.
BHR	Integrating Primary Care into Behavioral Health	Develop and maintain a bi-directional referral process with Valley View Health Center in Olympia that ensures clients from both organizations are appropriately referred for services when pre-defined metrics indicate such a referral is necessary
Capital Recovery	Increased MAT referral and capacity	Increase the total number of clinic patients who have received MAT education and been dispensed buprenorphine at least once.
Capital Recovery	Increased MAT referral	Increase the total number of clinic patients who were referred from a syringe exchange.
Capital Recovery	Increased MAT capacity	Increase the number of waived prescribers who have treated patients at the Olympia Bupe Clinic.
Capital Recovery	Increased MAT referral and capacity	Increase the number of patients who have been referred to a long-term buprenorphine prescriber and who have been dispensed buprenorphine prescribed by that provider at least once.
Capital Recovery	Screening and support services	Increase the number of clinic patients referred to behavioral health providers and confirmed as having attained initial contact as a patient
Capital Recovery	Opioid Recovery Support	Increase the total number of clinic patients who have met with peer recovery staff and created an individual recovery plan
Capital Recovery	Overdose Prevention	Increase the number of naloxone kits distributed to clinic patients.
Capital Recovery	Patient Navigator	Implement peer patient navigators to increase the number of clinic patients who meet with a peer recovery coach within 7 days of either discharge from a hospital/ED or release from a criminal justice setting
Cascade Mental Health	Integrating Primary Care into Behavioral Health	Improve the tracking of key vitals in chronically mentally ill adults (Intensive CM) as per metrics defined below. Increase the percentage of clients with primary care appointments within the last six months. Decrease clients using tobacco or tobacco related products.
CCAP	Care Coordination	Ensure work as a Care Coordinating Agency is financially sustainable and capable of serving 150 clients
CCAP	SDoH	Provide temporary housing, caregiving, and nurse delegated care to homeless individuals to decrease the percentage of patients who have to be readmitted into hospital or ED within 90 days
Child & Adolescent Clinic	Bright Futures	Implement monthly monitoring of Molina well child visit rate data and provide necessary outreach to patients
Child & Adolescent Clinic	Enriched Medical Home	Implement Pre-Manage and monthly monitoring of Molina data to decrease ED utilization of Molina patients with asthma using care plans and team based care.
Child & Adolescent Clinic	Integrating Behavioral Health into Primary Care	Implement Patient Centered Medical Home model of Behavioral Health care including elements of the Collaborative Care model and Bree Collaborative Standards to serve Medicaid pediatric patients with major depression or dysthymia
Child & Adolescent Clinic	One Key Question	Implement "One Key Question" and chlamydia screening to serve sexually active females age 12-20 years resulting in improvement over baseline of documented pregnancy intention response and chlamydia screen.
Child Care Action Council	Parents as Teachers	Increase outreach and recruitment efforts to acquire full caseload capacity while implementing PAT per fidelity
Columbia Wellness	Prevention Education	Increase the percent of community members who participate in education campaigns surrounding MAT services and naloxone use and distribution by providing open-access education groups and opportunities and tracking data around attendance.
Columbia Wellness	Safe Prescribing Practices	Increase the percent of CW Medical Staff who participate in training and education and adherence to PMP and Washington State prescribing guidelines
Columbia Wellness	Increased MAT referral and capacity	Increase the number of referrals from syringe exchange programs, increase the number of waived-prescribers within CW, and increase CW coordination of care with behavioral health providers.
Columbia Wellness	Overdose Prevention	Increase education and distribution of naloxone kits to clients who present with an OUD.
Community Action Council	Care Coordination	Ensure work as a Care Coordinating Agency is financially sustainable and capable of serving 2021 target caseload clients.
Community Youth Services	Integrating Primary Care into Behavioral Health	Enhance collaboration with medical providers in order to improve medical screening and prevention/intervention of medical conditions for youth receiving behavioral health services at CYS

Community Youth Services	Integrating Primary Care into Behavioral Health	Co-located Enhanced care in order to improve access to medical care and engagement in services for youth receiving behavioral health services at CYS
Community Youth Services	Integrating Primary Care into Behavioral Health	Co-located Integrated Care to improve physical health outcomes; as evidenced by fully integrated care teams onsite, utilizing evidence and research-based practices to provide low-barrier, trauma-informed, holistic care to Transitional Age Youth.
Confederated Tribes Chehalis	Screening and support services	Increase the number of patients who receive SUDS screening
Confederated Tribes Chehalis	Increased MAT referral and capacity	Increase access to MAT or other evidence based treatment
Confederated Tribes Chehalis	Opioid Recovery Support	Increase access to recovery supports including traditional healing practices for those of OUD and SUD
Consejo Counseling	Safe Prescribing Practices	Consejo will have adopted and implemented the Bree Guidelines.
Consejo Counseling	Screening and support services	Increase SBIRT screening for all enrolled Mental Health clients
Consejo Counseling	Integrating Primary Care into Behavioral Health	Establish primary care services at Consejo's behavioral health facility through a partnership with Peninsula Community Health Services
Consejo Counseling	Overdose Prevention	Hire peer Counselor, case managers and care coordinators to serve MAT clients.
Consejo Counseling	Overdose Prevention	Increase the percent of Consejo Behavioral Health Clients with MAT history and needs will receive Peer Counseling and Recovery
CORE Health	Prevention Education	Increase opioid abuse prevention education efforts targeted at youth and increase the number of clients receiving education
CORE Health	Safe Prescribing Practices	Incorporate opioid abuse prevention monitoring into all prescribing within CORE, increasing the amount of prescriber clients to be monitored
CORE Health	Integrating Primary Care into Behavioral Health	Increase physical health screenings. Establish care coordination with primary care providers (PCPs), sharing client information and care plans according to an established schedule/procedure
CORE Health	Non Emergency Medical Transport	Make non-emergency medical transport available for eligible clients increasing the number of clients served.
CORE Health	Opioid Recovery Support	CORE Health will increase engagement of clients in Opioid Use Disorder support services
CORE Health	Overdose Prevention	Increase enrollment of eligible CORE clients in need of MAT services (including education and linkage)
CORE Health	Patient Navigator	Implement Patient Navigator role, increasing the percentage of patients who are connected with needed services (such as primary care, mental health, SUD, employment, housing, and psychiatric prescription) within 7 days of discharge from institutions such as jails/prisons, inpatient psychiatric agencies, and emergency departments
CORE Health	SDoH	Provide services to address social determinants of health at a Social Support Center, increasing the number of clients served at the Center.
Cowlitz Family Health	Safe Prescribing Practices	All FHC providers will be made aware of alternative treatments to opiate prescribing during the first quarter of 2019 and given the WA State guidelines for prescribing opiates. 0% of chronic pain patients will be on chronic opiates of greater than or equivalent to 100 MEDD
Cowlitz Family Health	Increased MAT referral and capacity	FHC will see new MAT patients with a referral to treatment and or support group.
Cowlitz Family Health	Integrating Behavioral Health into Primary Care	FHC will gather and analyze depression data to inform staff training in bi-directional integration with the goal of achieving depression remission by January 2021.
Cowlitz Family Health	Overdose Prevention	FHC providers will offer to provide an add-on prescription for naloxone (if the patient has health insurance that covers it) or will provide a naloxone rescue kit with each opioid prescriptions greater than or equal to 50 morphine equivalent daily dose (MEDD)
Cowlitz Indian Tribe	Integrating Behavioral Health into Primary Care	Implement the five core principles of collaborative care. Implement universal behavioral health screening using the PHQ-9, screening tool.
ESD 113	School Based Health Centers	By the 2021 Target, two School Based Health Centers will be operational in the CPAA region, and providing clinical services to Medicaid eligible children/youth
Gather Church	Increased MAT referral	Increase the number of partnerships with MAT and behavioral health providers to refer clients
Gather Church	Care Coordination	Hire 3-5 care coordinators (caseload 35), to work with homeless, underhoused, SUD, behavioral, and low-income clients, connecting them with appropriate social and health services.
Gather Church	Overdose Prevention	Increase distribution of Narcan kits to heroin users and partner agencies by educating the community, publicizing its availability, connecting with agencies that work with at-risk populations, and attending recovery events in Lewis County.
Gather Church	Overdose Prevention	Increase the number of individuals with access to recovery supports through partnerships and care coordination
Grays Harbor Hospital	Safe Prescribing Practices	Reduce the number of patients on chronic opioids greater than 50 MED
Grays Harbor Hospital	Safe Prescribing Practices	Increase regular behavioral health screening of COT patients
Grays Harbor Hospital	Safe Prescribing Practices	Increase the number of primary care providers enrolled in the PDMP
Grays Harbor Hospital	Increased MAT referral	Increase the number of patients referred for MAT
Grays Harbor Hospital	Care Transition Intervention	Increase the number of enrolled individuals in the Transitional Care Program
Grays Harbor Hospital	Long Acting Reversible Contraception	Increase education on LARCs provided to women of child bearing age

Grays Harbor Hospital	Long Acting Reversible Contraception	Increase same day access to insertion/removal of LARCs by increasing the number of providers trained
Grays Harbor Hospital	Million Hearts Campaign	Incorporate Million Hearts metrics in to care management program and improve percentage of blood pressure control, statin therapy , and smoking assessment with or without treatment
Grays Harbor Hospital	One Key Question	Increase the number of women screened for pregnancy intentions at primary care visits
Grays Harbor Hospital	Overdose Prevention	Increase co-prescribing of naloxone for patients receiving greater than 50 MED, in accordance of AMDG guidelines
Kaiser Foundation	Safe Prescribing Practices	Expand Opioid Use Improvement (PIP) Plan to increase the number of CPAA counties
Kaiser Foundation	Safe Prescribing Practices	Reduce Patients with a high Morphine Equivalent Dose (MED) >90 mg
Kaiser Foundation	Safe Prescribing Practices	Reduce Rate of patients Prescribed Concomitant Opioids Plus Benzodiazepines (PMPM x1,000)
Kaiser Foundation	Safe Prescribing Practices	Establish policy and process to implement WA Opioid attestation requirements
Kaiser Foundation	Increased MAT capacity	Increase the number of waived physicians
Kaiser Foundation	Increased MAT referral and capacity	Implement Hub and Spoke Model Office Based Opioid Treatment Program (OBOT) for Medicaid members in Cowlitz County
Kaiser Foundation	Increased MAT capacity	Develop sustainable payment model to support integrated OBOT program; determine scope of practice to maintenance only patients that will not need concurrent monitored addiction treatment
Kaiser Foundation	Increased MAT capacity	Development of Multi-Year Transformational Plan to evaluate expansion of currently offered MH and SUD services to Medicaid members in
Kaiser Foundation	Integrating Behavioral Health into Primary Care	Improve identification of members with depression and ensure adequate treatments for those patients.
Kaiser Foundation	Integrating Behavioral Health into Primary Care	Integrate Primary Care with Behavioral Health Consultants (BHC) to support ongoing management of behavioral health conditions within primary care
Kaiser Foundation	Overdose Prevention	Increased prescribing and access to Naloxone
Kaiser Foundation	Overdose Prevention	Establish Care pathway for patients needing recovery support within primary care (tied to goals in 3A Treatment)
Kaiser Foundation	Overdose Prevention	Support increased access to peer supports for KPNW members
Lewis CCHS (Valley View)	Patient Navigator	Utilize the role of Patient Navigator to increase the percentage of patients who are contacted and connected with the appropriate level of care within 7 days of a hospital discharge
Lewis CCHS (Valley View)	Wagners Chronic Care Model	Increase compliance of 3 month diabetic checks in completed by diabetes cohort
Lewis County Sheriff Dept	Increased MAT referral and capacity	Offer buprenorphine treatment to all individuals who demonstrate active opiate withdrawal after being booked into the Lewis County Jail. Increase the number of individuals referred to buprenorphine treatment upon release from incarceration in Lewis County Jail.
Lewis County Sheriff Dept	Opioid Recovery Support	Lewis County Jail will increase the individuals who are connected to buprenorphine treatment upon release from incarceration. Increase the percent of buprenorphine inducted individuals who receive a substance use treatment assessment (ASAM) prior to their release.
Lifeline Connections	Screening and support services	Reduce opioid misuse among individuals receiving medication-assisted treatment (MAT) one year after treatment begins.
Lifeline Connections	Increased MAT referral and capacity	Increase the number of patients who receive low-barrier buprenorphine treatment
Lifeline Connections	Care Coordination	Care coordinators for individuals receiving treatment for behavioral health services will take steps to initiate care coordination with primary care providers
Lifeline Connections	Opioid Recovery Support	Increase the number of individuals with Opioid Use Disorder who report improved overall health and six months or greater long-term recovery.
Lifeline Connections	Overdose Prevention	Increase distribution of and education about naloxone and access to recovery supports of individuals who seek treatment for opioid use disorder in three rural counties.
Lower Columbia CAPS	Care Coordination	Increase the number of people enrolled in the Pathways HUB and identify approaches that will help sustain the program.
Lower Columbia CAPS	Patient Navigator	Lower 30-day hospital readmissions rates among hospitalized patients who are experiencing homelessness by providing recuperative care, community health education, and housing navigation/stabilization services.
Lower Columbia CAPS	SDoH	Lower Columbia CAP will develop a Community Food Systems Plan and connect sustainable sources of healthy food to low income individuals
Lower Columbia CAPS	SDoH	Lower Columbia CAP will increase the number of households receiving nutritional services (cooking classes, supplemental foods, and/or Food Farmacy)
Mason County Public Health	Prevention Education	Increase offered educational materials of mobile outreach individuals.
Mason County Public Health	Increased MAT referral and capacity	Mobile outreach staff will have increased the percent of referrals to the Opioid Treatment Network, MAT services and Behavioral Health for psychosocial care through our mobile outreach program
Mason County Public Health	Overdose Prevention	Increase naloxone kit distribution through the Substance Use Mobile Outreach
Mason County Public Health	Overdose Prevention	Increase engagement for heroin users about overdose prevention and provide them with naloxone kits through mobile outreach

Mason County Public Health	Overdose Prevention	Mobile outreach staff will have increased the percent of individuals referred to recovery support services
Mason General Hospital	Safe Prescribing Practices	Increase the number of providers enrolled in the WPMP
Mason General Hospital	Screening and support services	Use of SBIRT will increase among all patients in the clinic setting
Mason General Hospital	Bright Futures	Develop the ability to track, report, and provide follow-up to ensure children seen at the pediatric or family practice clinics have the recommended well child visits.
Mason General Hospital	Care Coordination	Implement a comprehensive Pathways Program and successfully enroll patients identified. Program will achieve financial sustainability by 2021.
Mason General Hospital	Diabetes Prevention Program	Increase the number of patients who are enrolled into Diabetes Prevention Program from
Mason General Hospital	Integrating Behavioral Health into Primary Care	Increase behavioral health screenings (Medicaid patients) using the PHQ-2, PHQ-9 & GAD-7 screening tools
Mason General Hospital	Integrating Behavioral Health into Primary Care	Medicaid patients receiving treatment for depression will achieve depression remission rates
Mason General Hospital	Integrating Behavioral Health into Primary Care	Implement core principles of the collaborative care model
Mason General Hospital	Long Acting Reversible Contraception	Provide postpartum LARC before hospital discharge for all patients who desire the option.
Mason General Hospital	Million Hearts Campaign	Incorporate Million Heart metrics in to care management program and improve percentage of blood control for patient .
Mason General Hospital	One Key Question	Have the One Key Question integrated into our ambulatory EMR, as a field that allows data extraction, and women system wide ages 14-40 have OKQ proactively addressed.
Mason General Hospital	Overdose Prevention	Increase educational opportunities around prescribing naloxone with all high dose opioid prescriptions
Mason General Hospital	SDoH	Develop and provide education about reproductive choices and family planning in the primary languages of our patients from Guatemala.
Mason General Hospital	Transitional Care Model	Implement program to identify at risk ED/hospital discharge patients and successfully enrol those identified in TCM case management program.
Morton General Hospital	Integrating Behavioral Health into Primary Care	X patients will complete a PHQ9 screening tool in our clinic patient population.
Morton General Hospital	Integrating Behavioral Health into Primary Care	Achieve set remission rate patient population clinic wide by the end of the transformation.
Nisqually Indian Tribes	Increased MAT referral and capacity	Develop and implement a sustainable and equitable integrated and holistic MAT program to work in coordination with SUDS and primary care through staff training, service delivery, and data tracking.
NW Pediatric	Bright Futures	Increase the % of children with a minimum of 6 well-child visits at 15 months
NW Pediatric	Integrating Behavioral Health into Primary Care	Develop and implement a patient registry that tracks patients with the identified behavioral health issue (to be determined) with a specific metric (to be identified-ex: PHQ-A).
NW Pediatric	Long Acting Reversible Contraception	Schedule and implement training for LARC insertion/removal, specifically implants (Nexplanon)
NW Pediatric	Patient Navigator	Utilize the patient navigator to decrease the ED utilization of our medicaid patient
Ocean Beach Hospital	Chronic Disease Self Management	Increase annual CDSMP workshops
Ocean Beach Hospital	Diabetes Prevention Program	Increase annual DPP workshops
Olympia Pediatrics	Integrating Behavioral Health into Primary Care	Implement core principles of the collaborative care model to serve all of patients >11 years old with a PHQ-9 score >10 resulting in remission
Pacific County PH	Safe Prescribing Practices	Increase the number of providers in Pacific County enrolled in the state prescription monitoring program and implement PDMP.
Pacific County PH	Increased MAT capacity	Increase number of prescribers who have and use the DATA 2000 waiver along the OUD continuum of care (ER, Jail, Treatment, and Primary Care)
Pacific County PH	Screening and support services	Implement BNI-ED (SBIRT) (induction of MAT, referral/warm hand-off to treatment) at the Willapa Harbor and Ocean Beach Hospitals
Pacific County PH	Screening and support services	Implement BNI- Jail (SBIRT) (induction of MAT, referral/warm hand-off to treatment) in the Pacific County jail
Pacific County PH	Increased MAT referral	Increase number of referrals, from BNI-ED and BNI-Jail (SBIRT), to local outpatient Hub & Spoke network
Pacific County PH	Opioid Recovery Support	Implement Recovery Treatment Self Help (RTSH) by providers in Pacific County
Pacific County PH	Overdose Prevention	Implement naloxone distribution to individuals with OUD or who present with overdose symptoms at Ocean Beach Hospital & Willapa Harbor Hospital
Pacific County PH	Overdose Prevention	Implement naloxone distribution for individuals with OUD upon release from Pacific County Jail
Pacific County PH	Overdose Prevention	Implement naloxone distribution directly to individuals with OUD and other concerned citizens via law enforcement, treatment agencies, and other social service providers
PeaceHealth	Safe Prescribing Practices	Develop and implement internal tools to prevent unnecessary prescription of opioids, monitoring of prescribing practices following Washington State prescribing guidelines and participate in WA State PDMP
PeaceHealth	Increased MAT referral	Develop one or more formal local partnership with MAT provider and/or Behavior Health provider to support easy access to OUD treatment with on-site hospital assessment and care coordination of treatment placement
PeaceHealth	Diabetes Prevention Program	Medicaid patients referred to the YMCA DPP program encouraged to participate in either DPP or Weight Loss Programs

PeaceHealth	Non Emergency Medical Transport	Provide patients at high risk for re-admission to the hospital who are malnourished and food insecure with transitional food supply and community resources to meet nutritional needs. Decrease readmission rate of the selected population
PeaceHealth	Overdose Prevention	Implement program to make Naloxone available without prescription in the ED and Outpatient Pharmacy
Pediatric Associates	Safe Prescribing Practices	Ensure adequate screening for substance use disorder in all 12-18 year olds. Train all providers in appropriate prescribing using state guidelines, and support of families in recovery and treatment with our mental health team.
Pediatric Associates	Increased MAT referral	Connect patients to Dr. Grande at Pioneer Family Medicine for direct referral for MAT.
Pediatric Associates	Bright Futures	Improve % of children with 6 well visits at 15 months
Pediatric Associates	ED Hospital Registry	Integrate Premanage into the clinic to track ED utilization and direct follow up within 7 days to increase follow up
Pediatric Associates	Enriched Medical Home	Continue to support health home care coordination, integrated behavioral health, community connections, patient family engagement and team huddles as a primary care medical home. Provide health home care coordination.
Pediatric Associates	Integrating Behavioral Health into Primary Care	Integrate full time Masters level behavioral health provider into South Sound Pediatrics and develop depression registry to formally follow up and track patient's treatment and improvement with PHQ-9
Pediatric Associates	Long Acting Reversible Contraception	Have rapid access for all patients who desire LARC.
Pediatric Associates	One Key Question	Increase the number of sexually active patients that are screened for chlamydia and that we address pregnancy planning with patients
Peninsula Community Health	Safe Prescribing Practices	Reduce the percentage of detours from the prescribing protocol
Peninsula Community Health	Increased MAT capacity	Maintain the number of waived prescribers at PCHS
Peninsula Community Health	Care Coordination	Train a community health worker in the use of pathways to pilot engagement with patients and community partners using this methodology.
Peninsula Community Health	Chronic Disease Self Management	Increase the annual number of Chronic Disease Self -Management Workshops, targeting populations of at risk individuals with chronic conditions and mental health conditions.
Peninsula Community Health	Integrating Behavioral Health into Primary Care	Mentor and coach partners on integrated behavioral health quarterly
Peninsula Community Health	Long Acting Reversible Contraception	Ensure long acting reversible contraception insertion and removal is available at (currently five) medical office location with more than 2 FTE of providers
Peninsula Community Health	Non Emergency Medical Transport	Increase the number of annual patients who have a food insecurity screening
Peninsula Community Health	One Key Question	Screen women for pregnancy intention
Peninsula Community Health	Overdose Prevention	Maintain naloxone co-prescribing for all PCHS patients with opioid use disorder.
Peninsula Community Health	Patient Navigator	Increase the percentage of patients who have a primary care visit within 30 days after being seen in the emergency room
Peninsula Community Health	School Based Health Centers	Start a school based health center and ramp up utilization to become financially self-sustaining
Physicians of SW WA	Care Coordination	Clients enrolled in the Pathways Project will complete implemented pathway within 180 days from enrollment within budget goals for financial stability to participate in program
Physicians of SW WA	INTERACT4.0	Decrease the percentage of avoidable emergency department utilization of patients as defined as those leading to a discharge home
Planned Parenthood	Long Acting Reversible Contraception	Planned Parenthood patients in the CPAA region will have access to centralized internal referral clinic in Olympia for complicated insertions and removals of long-acting reversible contraception.
Planned Parenthood	One Key Question	X% of Women aged 15—44 will have a documented response to pregnancy intention screening.
Planned Parenthood	One Key Question	X% of Women aged 16—24 with a documented visit will have received a chlamydia screening.
Providence	Increased MAT capacity	Increase active, waived Providence Medical Group primary care providers
Providence	Safe Prescribing Practices	Increase adherence to Opioid Safe Prescribing Pathway and Washington State Prescribing Rules by all Providence Medical Group primary care clinic providers
Providence	Integrating Behavioral Health into Primary Care	Expand integrated behavioral health services of all Providence Medical Group primary care clinics
Providence	Patient Navigator	Optimize current transitional care management to high-risk patients while increasing offering of additional case management of identified top utilizers per year
Providence	Wagners Chronic Care Model	Increase the number of unique patients with diabetes engaged in clinical case management
Quinault Indian Nation	Integrating Behavioral Health into Primary Care	Implement the five core principles of collaborative care, implement universal behavioral health screening using the PHQ-9, screening tool.
SeaMar	2C_SMHET	The Health Engagement Teams will work to reduce All Cause Readmission to Inpatient Hospital Care within 30 days rates by from approximately
SeaMar	Care Coordination	Sea Mar will develop and implement the Pathways program in a fiscally sustainable manner in Grays Harbor and Thurston Counties
SeaMar	Chronic Disease Self Management	Increase number of chronic disease workshops
SeaMar	Integrating Behavioral Health into Primary Care	Increase the percent of individuals receiving a depression screening, and increase the percent of patients in primary care that receive behavioral health services

SeaMar	Integrating Primary Care into Behavioral Health	By 2021, BH specialty providers will apply a universal interpretation of BMI and blood pressure screenings to help individuals manage chronic conditions by using behavioral health interventions
SeaMar	Parents as Teachers	MSS Community Health Workers in CPAA Region will conduct home visits as appropriate for MSS-enrolled pregnant women and their children (0-1 yr old)
Shoalwater Bay Tribe	Integrating Behavioral Health into Primary Care	Implement the five core principles of collaborative care. Implement universal behavioral health screening using the PHQ-9, screening tool.
Skokomish Indian Tribe	Care Coordination	Ensure Pathways care coordination services are financially sustainable and capable of serving a caseload of 20 clients per Care Coordinator.
Squaxin Island Tribe	Integrating Behavioral Health into Primary Care	Implement the five core principles of collaborative care. Implement universal behavioral health screening using the PHQ-9, screening tool.
Summit Pacific Medical	Safe Prescribing Practices	Develop and implement provider education and clinical practice standards for opioid alternatives, treatment and education for medical staff with adherence to standards and protocols.
Summit Pacific Medical	Increased MAT referral and capacity	Provide access to MAT for referred patients receiving referral from community partners, including Emergency Departments, Urgent Cares, Primary Care and Syringe Exchange.
Summit Pacific Medical	SDoH	Summit Pacific Medical Center will implement the Summit Care model to eligible Medicaid individuals with chronic co-morbidities.
Summit Pacific Medical	Bright Futures	Increase the % of children obtaining 6 or more well child visits by the age of 15 months
Summit Pacific Medical	Care Coordination	Summit Pacific Medical Center will fully adopt the Pathways Model, with three care coordinators.
Summit Pacific Medical	Integrating Behavioral Health into Primary Care	Increase the annual percentage of Depression screenings
Summit Pacific Medical	One Key Question	Using the One Key Question model, screen women age 15-44 years of age if a pregnancy is planned in the next 12 months.
Summit Pacific Medical	Overdose Prevention	Establish and implement Naloxone protocols to provide prescriptions and/or distribution to patients with high dose opioid Rx and patients presenting in the ED for an opioid OD.
Summit Pacific Medical	Transitional Care Model	Summit Pacific Medical Center will expand high risk screenings for patients accessing hospital services, and will enroll identified patients in a Transitional Care Model
Thurston County PH	Increased MAT referral	Increase the percentage of all MAT providers in Thurston County that Thurston County Public Health & Social Services Syringe Services Program has a formalized referral process with
Thurston County PH	Increased MAT referral	Maintain the percentage of all MAT providers in Thurston County that Thurston County Public Health & Social Services Syringe Services Program has a formalized referral process with
Thurston County PH	Chronic Disease Self Management	Increase the annual capacity in Thurston County to hold increased CDSMP Workshops reaching more participants
Thurston County PH	Nurse Family Partnership	Combine MTP funds with other new funding to expand NFP program by one Nurse Home Visitor FTE to serve increased families in the tri county region
Thurston County PH	Overdose Prevention	Increase access to naloxone by increasing staffing of the Thurston County Syringe Services Program
Wahkiakum HHS	Integrating Primary Care into Behavioral Health	Collect BP and BMI readings of behavioral health patients.
Wahkiakum HHS	School Based Health Centers	Provide services to medicaid students at the school
Willapa BH	Integrating Primary Care into Behavioral Health	Implement universal behavioral health screening using the PHQ-9, GAD-7, and SBIRT screening tools as well as BMI and BP screenings
Willapa BH	Integrating Primary Care into Behavioral Health	Increase behavioral health screening using the PHQ-9 screening tool patient panel to 85% by 1/1/2020.
Willapa BH	Integrating Primary Care into Behavioral Health	X% of patients receiving treatment for depression will achieve depression remission.
Willapa BH	Integrating Primary Care into Behavioral Health	Implement the core principles of collaborative care including co-located primary care services or building a BHA's own primary care onsite.
Youth and Family Link	Care Coordination	Increase number of clients served
Youth and Family Link	Non Emergency Medical Transport	Increase number of clients served annually
Youth and Family Link	One Key Question	Increase the number patients screened for OKQ
Youth and Family Link	SDoH	Increase number of clients served annually
YWCA of Olympia	Prevention Education	Increase the number of youth accessing teen substance abuse prevention programming per year through incorporating one curriculum module into all Girls Council Peer Support Groups (Girls Circle) that is specifically focused on teen substance use disorder prevention.
YWCA of Olympia	Screening and support services	Increase the number of youth assessed for opioid use on intake and refer who screen in through a warm hand off to the following services when applicable
YWCA of Olympia	One Key Question	Include screening for pregnancy intention and sexual activity into Girls Council intake process and screening.

## 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]	<b>Depression Utilization of the PHQ-9 Tool (eCQM 2018)</b> 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]	<b>Depression Remission at Twelve Months (eCQM 2018)</b> 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]	<b>Percentage of Patients with Body Mass Index (BMI) Recorded in EHR</b> 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]	<b>Percentage of Patients with Blood Pressure (BP) Recorded in EHR</b> 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 Department	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?	<input type="text" value="Drop Down Box"/>	<ul style="list-style-type: none"> <li>•MAT initiation</li> <li>•Take-home naloxone</li> <li>•Our ED does not offer these services</li> <li>•Not applicable. Our site is not an ED.</li> </ul>	7/31/2019

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
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 •Bree Collaborative guidelines •CDC guidelines •None of the above	7/31/2019
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	•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	•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	•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	•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	•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	•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	•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"> <li>•Yes, via warm handoff</li> <li>•Yes, via providing information</li> <li>•No, we provide these services on site</li> <li>•No, we do not refer for another reason</li> </ul>	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

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
3D	Implement Chronic Disease Self-Management Program	# of clients/patients who completed course [3D03]	Number of clients/patients who completed course			7/31/2019
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

Project	Sub Category / Intervention	Short Description [Metric ID]	Measure Description:	Numerator	Denominator	Initial reporting
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
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

## What is Community CarePort?

We provide "Care Traffic Control" to break down silos, coordinate care, and improve health. Our Care Coordinators work individually with clients to identify risk factors from all aspects of a client's life. The Care Coordinators help clients access the services they need including healthcare, housing services, education, employment, and more.

## Care Coordinating Agencies

Care Coordinating Agencies are chosen by client preference, location, and other specific needs. Our current Care Coordinating Agencies are listed below by county.

### **Cowlitz**

- Love Overwhelming
- Youth and Family LINK
- Lower Columbia CAP

### **Grays Harbor**

- Coastal CAP
- SeaMar

### **Lewis**

- Community Action Council

### **Mason**

- Community Action Council
- Peninsula Community Health Services

### **Pacific**

- Coastal CAP

### **Thurston**

- Community Action Council
- SeaMar

### **Wahkiakum**

- Lower Columbia CAP



*Your port of  
entry to all the  
systems of care*

To refer a client, call:  
800-662-2499

# Pre-referral Checklist

Our priority population include those that can answer yes to all three of these questions:

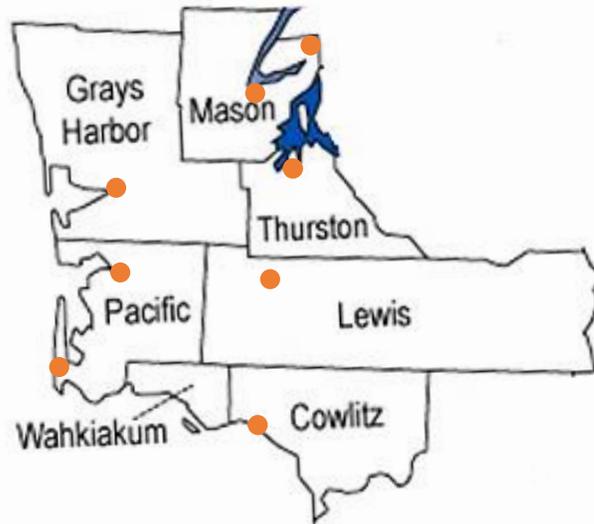
1. Does the person have a **behavioral health concern**?
  - Mental health
  - Substance use
2. Is there an **additional concern**?
  - Pregnancy
  - Chronic disease
  - Co-occurring behavioral health
3. Are there **additional risk factors**?
  - Housing insecurity
  - Recent release from hospital
  - Frequent need to use 911

Any person that can answer yes to these questions is eligible to work with a Care Coordinator.

To refer a client, please call  
**800-662-2499**



We serve clients in 7 counties through a network of Care Coordinating Agencies



For more information on  
Community CarePort

 [www.cpaawa.org](http://www.cpaawa.org)

 800-662-2499

 [oneillm@crhn.org](mailto:oneillm@crhn.org)

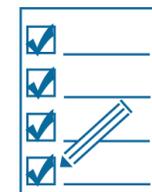
# How the Community CarePort Hub Works



Clients connect with Community CarePort by calling the referral line or being referred by someone else



The Hub assigns the client to a Care Coordinating Agency



Care Coordinators help the client prioritize goals, access services, and become more engaged in their own wellbeing



### **Integrated Managed Care (IMC) Application for Electronic Health Record (EHR) Enhancement**

As part of the Medicaid Transformation Project, CPAA is required to transition to IMC by January 2020. Successful completion of this transition will require substantial coordination and collaboration between HCA, BHOs, MCOs, county administrators, and behavioral health agencies. CPAA is a designated on-time adopter of IMC, and therefore was ineligible to receive incentive funding to support the IMC transition. In an effort to support behavioral health agencies, CPAA recognizes the importance of this transition and allocated funding for the purpose of helping offset the cost of purchasing a new EHR or upgrading an existing system for behavioral health agencies. This incentive is currently only open to CPAA Medicaid Transformation BHA Partners and is designed to complement other sources of funding and your own investments. CPAA will reimburse costs up to \$30,000 per organization. If you are awarded funding, CPAA will follow up with your point of contact to allocate payment.

Please complete the following to request EHR financial support and attach a record of your purchase(s) or a quote from the EHR vendor. All information is required.

Organization Name:

Primary Contact:

Phone:

Title:

Email:

Are you a Medicaid Transformation partner? Yes      No

What EHR do you currently use or which one are you transitioning to?

Provide a short narrative on how you will spend the money. (250-word max)

How will this funding help support your transition to IMC? (250-word max)

Are you receiving funding from another source for this purpose? Yes      No

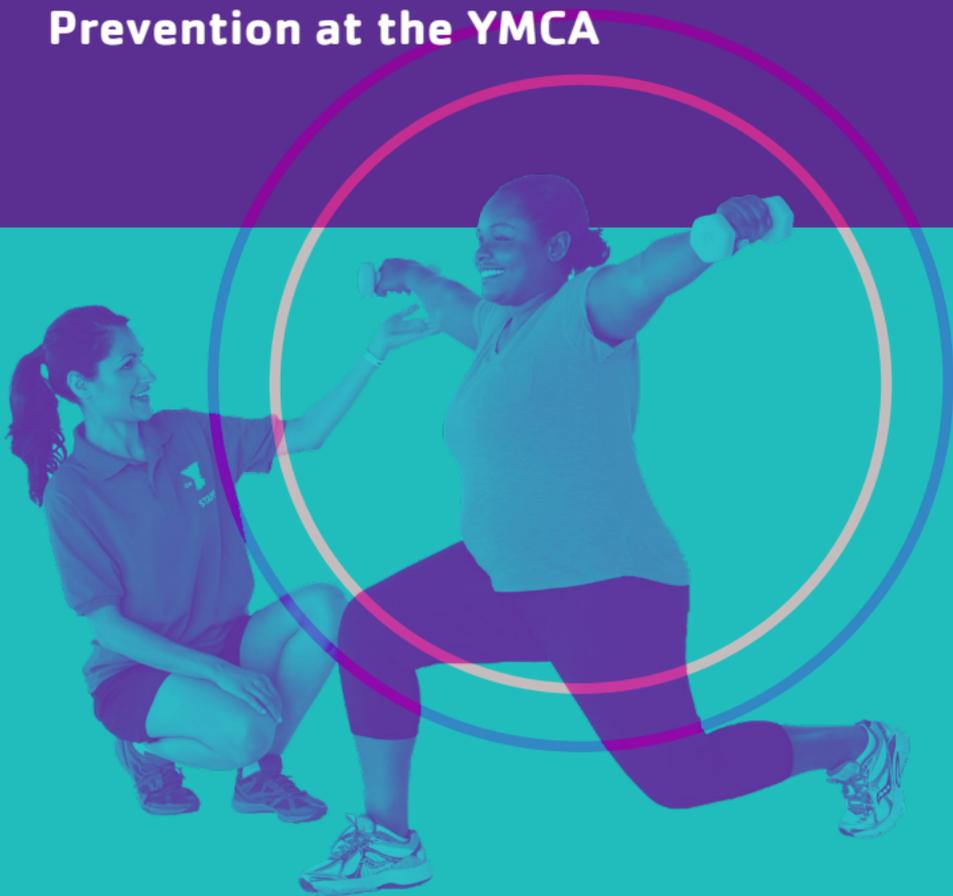
If yes, please describe your additional funding source(s).

Appendix M:  
Co-Branded Patient Materials

# LIVE WELL LONGER



## Chronic Disease Prevention at the YMCA



### THE YMCA IS YOUR PARTNER IN HEALTH

Nearly 50% of adults and 30% of youth in the United States experience one or more chronic diseases, including: diabetes, obesity, heart disease, asthma and cancer. These are conditions which can significantly limit quality of life and place a huge financial strain on individuals and families.

PeaceHealth has partnered with the YMCA to help individuals prevent and manage chronic disease. The Y offers evidence-based programs to manage weight, prevent diabetes and work towards routines that will help you live your healthiest life.

## YMCA DIABETES PREVENTION PROGRAM

Did you know that more than 1 in 3 adults have prediabetes? This program helps adults diagnosed with prediabetes reduce their risk of developing type 2 diabetes. Prediabetes can be reversed through losing modest amount of weight and increasing physical activity. Participants work with a trained lifestyle coach and peers to learn how to implement small, sustainable changes to diet, physical activity, and other behaviors like stress and sleep. Participants meet weekly for four months, followed by regular follow-up sessions over the remainder of the year.

## YMCA WEIGHT LOSS PROGRAM

Any adult seeking support in reaching goals related to balanced eating, physical activity, lifestyle behavior changes, and positive psychology will benefit from the YMCA Weight Loss Program. This non-prescriptive program helps individuals define and pursue their own action plans. Group discussion, sharing and learning are combined with an evidence-based curriculum over weekly meetings for 3 months. This program is a good choice for anyone wanting to prevent or manage a chronic condition associated with body weight, such as diabetes, hypertension, or arthritis.

## MORE SUPPORT AT THE Y

There are a variety of other ways the Y can support your journey to improving your health, no matter where you're starting from. We'll find an option that meets your priorities and works for your lifestyle.

To enroll, you can either ask your health care provider to make a referral to the YMCA on your behalf, or you can call the YMCA directly using the information below. If your doctor refers you, you can expect a call from a YMCA Care Coordination Staff Member to discuss program options and set up a time for an in-person appointment.

**To contact the YMCA directly  
(a clinical referral is not required):**

**Call us at: (360) 423-4770 and ask for David Maes  
Or email [ChronicDiseasePrevention@longviewymca.org](mailto:ChronicDiseasePrevention@longviewymca.org)**



PeaceHealth



**Managed Care Contracting from a Position of Strength!**

AGENDA	
8:00 am to 9:00 am	Breakfast and Registration
9:00 am to 10:30 am	<b>PART 1</b> <b>Step 1: Prepare for Managed Care Contracting</b> <ul style="list-style-type: none"> <li>▪ Contracting Strategy: Find Your Advantage</li> <li>▪ Assessing Regulatory Leverage</li> <li>▪ Assessing Market Power</li> <li>▪ Assessing Timing Leverage</li> <li>▪ Competing on Value</li> <li>▪ Value-Based Payment Methodologies</li> </ul>
10:30 am to 10:45 am	Break
10:45 am to 12:00 pm	<b>Step 2: Evaluate Managed Care Contracts</b> <ul style="list-style-type: none"> <li>▪ Contract Review Team</li> <li>▪ MCO Operational Performance</li> <li>▪ MCO Financial Stability</li> <li>▪ How to Read a Contract</li> <li>▪ Prioritizing Issues</li> </ul> <b>Step 3: Negotiate Managed Care Contracts</b> <ul style="list-style-type: none"> <li>▪ Understanding Negotiation</li> <li>▪ Negotiation Logistics</li> <li>▪ Bargaining over Positions vs. Interests</li> <li>▪ Negotiating Tips</li> <li>▪ Bottom Line Decisions</li> </ul>
12:00 pm to 1:00 pm	Lunch
1:00 pm to 2:15 pm	<b>PART 2</b> <b>Key Terms and Legal Protections</b> <ul style="list-style-type: none"> <li>▪ Scope of Services vs. Covered Services</li> <li>▪ Timing Claiming Rules</li> <li>▪ Prompt Payment and Denied Claims</li> <li>▪ Overpayment Recoupments (and Underpayments)</li> <li>▪ All Product Clauses</li> <li>▪ Cost-Sharing Provisions</li> <li>▪ Regulatory Penalties</li> <li>▪ Access and Appointment Standards</li> <li>▪ Licensure Requirements</li> <li>▪ Credentialing and Delegated Credentialing</li> <li>▪ Prior Authorization / Utilization Review</li> </ul>
2:15 pm to 2:30 pm	Break

2:30 pm to 3:00 pm	<b><i>Key Terms and Legal Protections</i></b> <ul style="list-style-type: none"><li>▪ Contract Term</li><li>▪ Termination Provisions</li><li>▪ Amendments</li><li>▪ Insurance</li><li>▪ Indemnification</li><li>▪ Compensation Exhibits</li><li>▪ Regulatory Appendices</li></ul>
3:00 pm to 4:00 pm	<b>PART 3</b> <b><i>Participating or Forming Provider Networks</i></b> <ul style="list-style-type: none"><li>▪ Types of Provider Networks (e.g. IPAs)</li><li>▪ Accountable Care Organizations</li><li>▪ Federal Antitrust Law</li><li>▪ Financial Risk-Sharing Arrangements</li><li>▪ Clinically Integrated Networks (CINs)</li><li>▪ Messenger Model Arrangements</li></ul>

# MCO & BHA Forum

## Great Rivers and Thurston-Mason

Co-Hosted By:



# Agenda

- ▶ IMC Overview
  - ▶ Background
  - ▶ Provider Readiness Timeliness
- ▶ MCO Overviews
- ▶ Partnering with MCOs
  - ▶ Credentialing & Rosters
  - ▶ Claims & Billing
  - ▶ Provider Readiness Assessments
- ▶ Lunch
- ▶ Q&A and Future Planning
  - ▶ Initiate regional FAQ
  - ▶ Discuss MCO Symposium

# Integrated Managed Care Overview



# Integrated Managed Care Background

- ▶ State legislation directed the Health Care Authority to integrate the care delivery and purchasing of physical and behavioral health care for Medicaid statewide by 2020.
- ▶ Southwest WA (Clark and Skamania Counties) was the only “early adopter” and implemented April 1, 2016.
- ▶ North Central opted to implement integrated care January 1, 2018.
- ▶ Pierce, Greater Columbia and Spokane regions implemented January 1, 2019.
- ▶ North Sound will implement July 1, 2019.
- ▶ The last three regions, Great Rivers, Thurston-Mason and Salish, will implement January 1, 2020.

# Managed Care Organizations by Region

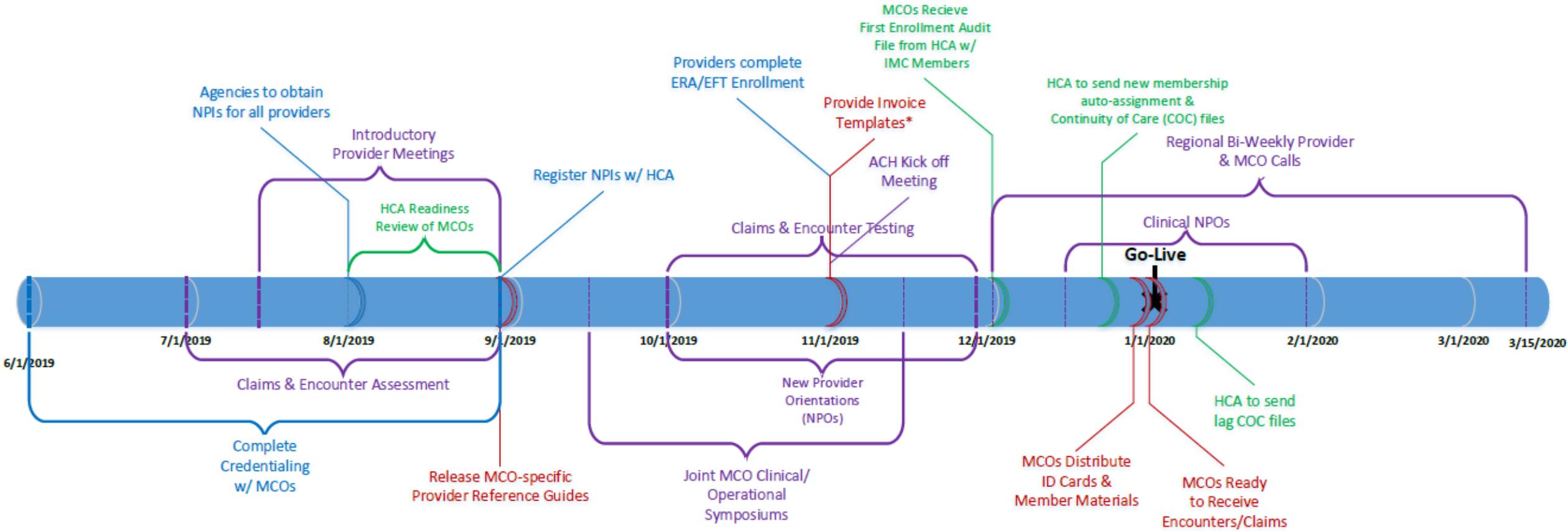
Managed care region	Amerigroup	Community Health Plan	Coordinated Care	Molina Healthcare	United Healthcare
<b>As of January 2019</b>					
Greater Columbia	●	●	●	●	
King	●	●	●	●	●
North Central	●		●	●	
Pierce	●		●	●	●
Spokane	●	●		●	
Southwest	●	●		●	
<b>As of July 2019</b>					
North Sound	●	●	●	●	●
<b>Coming January 2020</b>					
Thurston-Mason	●			●	●
Great Rivers	●			●	●
Salish	●			●	●



\*Apple Health Foster Care is a statewide program, provided through Apple Health Core Connections (Coordinated Care of Washington).

# Provider Readiness Timeline

## What to Expect Between Now and Go-Live 1/1/2020



### Color Key:

Green: HCA tasks

Red: MCO tasks

Blue: Provider tasks

Purple: Provider & MCO collaboration

\* May not apply to all plans

# MCO Overviews





An Anthem Company



## People Come First

Amerigroup focuses on improving health and wellness one member at a time, by doing the right thing for every member every time. We engage and support members and their families to be active participants in their case and to help them make healthy, informed decisions.



## Whole Person Care

Integration is at the heart of our philosophy and approach to the coordination of benefits and services. Our person-centered model helps members access the full array of comprehensive high-quality services and supports they need.



## Getting Results

Amerigroup seeks out new and better ways to improve member health outcomes, quality of life, and access to high quality, cost-efficient care and services. We achieve positive outcomes for members and generate value for states through our innovative approaches.



### Amerigroup in Washington:

- ▶ We help provide access to health care for over 187,000 Amerigroup members statewide
- ▶ Apple Health
- ▶ Integrated Managed Care: one of two statewide MCOs
- ▶ Behavioral Health Services Only
- ▶ Foundational Community Supports
- ▶ Dental (July 1, 2019)
- ▶ Achieved over 80% VBP arrangements
- ▶ Multicultural Healthcare Distinction from NCQA

### Provider Network:

- ▶ Over 65,000 providers
- ▶ Over 120 Hospitals
- ▶ 24 Community Health Centers with over 200 locations



# Value Added Benefits:

## A Whole Person Health Focus

- ▶ Peer Support Specialist registration and renewal payment
- ▶ No-cost eyeglasses up to \$100 annually for members 21-64
- ▶ GED test payment
- ▶ Acupuncture
- ▶ No-cost sports physicals for members 7-18
- ▶ No-cost Boys & Girls Club membership
- ▶ \$50 gas card for non-medical transportation to access social services
- ▶ Taking Care of Baby and Me program



## coordinated care™

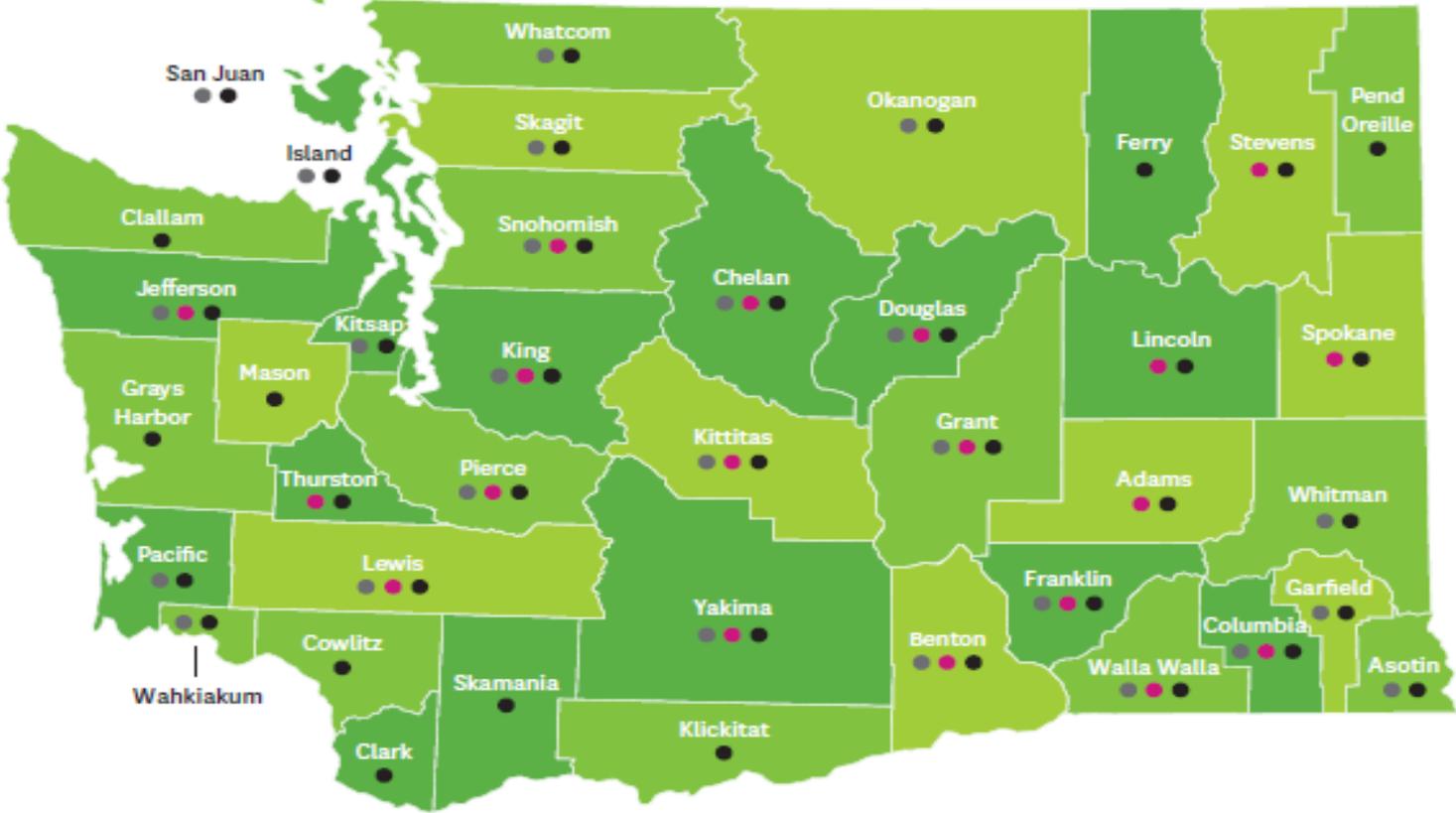
**Mission Statement:** To be the highest quality health plan in Washington, and the health plan of choice for members and providers

- 
- ▶ Serving over 250,000 Washingtonians
    - ▶ Medicaid
    - ▶ Foster Care
    - ▶ Health Benefit Exchange
  - ▶ First MCO to integrate a state-wide population
  - ▶ 2018 DSHS Practice Transformation Award
  - ▶ NCQA Accredited as COMMENDABLE
  - ▶ Community Education Commitment

# Coordinated Care: We've Got You Covered



2019 Coordinated Care Network



- Washington Apple Health
- Ambetter from Coordinated Care
- Apple Health Core Connections (foster care)



ANSWERS WHEN I NEED THEM.

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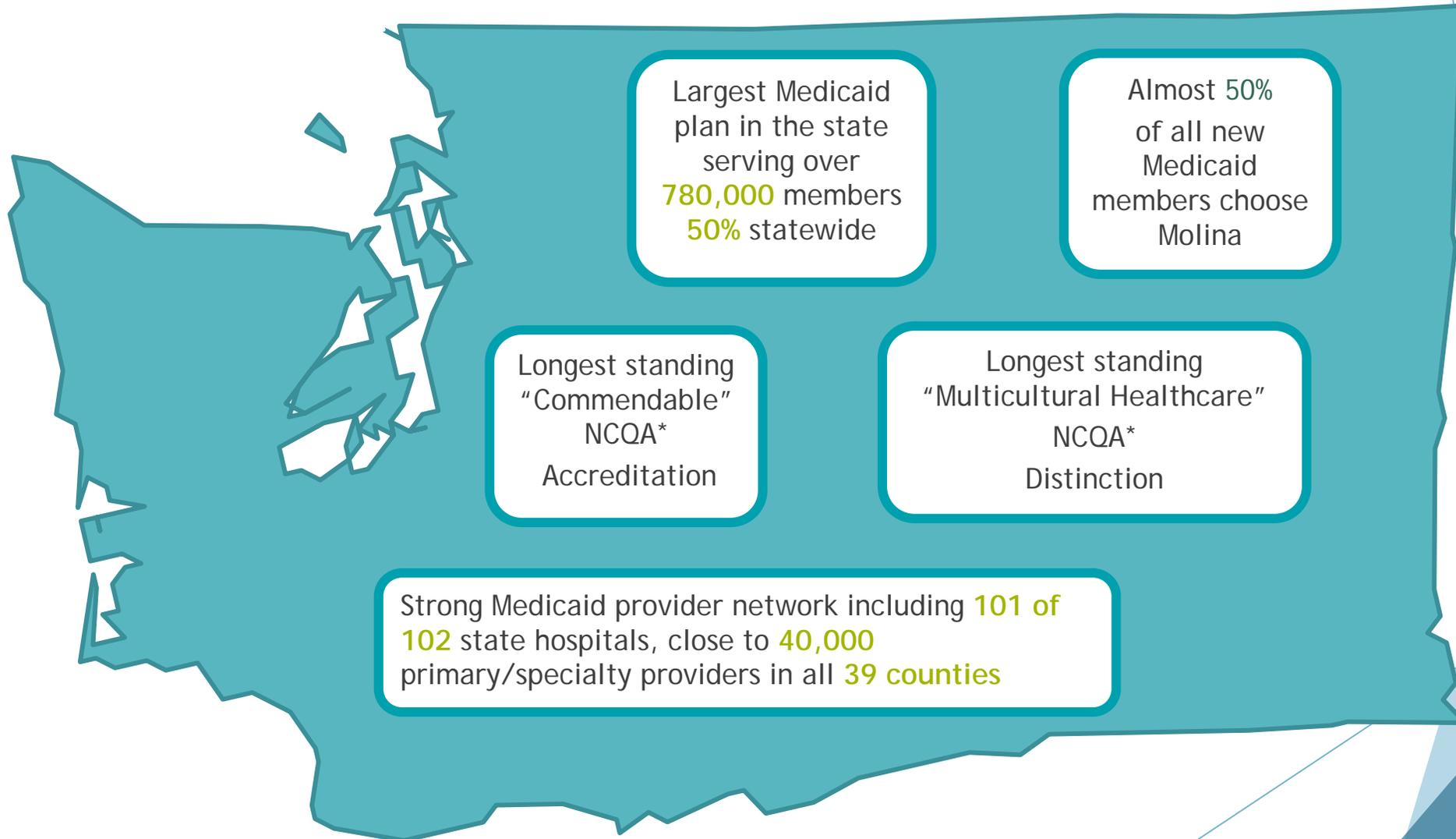


## Value-Added Member Benefits

- ▶ **Earn Rewards:** Complete preventive exams to earn dollar rewards
- ▶ **Start Smart for Your Baby®:** Includes prenatal and postpartum support, education, home monitoring for high-risk pregnancies, no-cost breast pump and no-cost car seat.
- ▶ **Safelink:** No-cost cell phone with 1,000 minutes per month and unlimited texting for qualifying members. Access to our staff and 24/7 Nurse Advice line do not count toward monthly minutes.
- ▶ **Care Management:** Advocates supporting members dealing with diseases, behavioral/mental health, connecting to community resources and removing barriers to achieving better health.
- ▶ **Online Member Account & App:** View rewards balance, change your PCP, complete forms, send secure messages or view/request ID cards
- ▶ **Boys and Girls Club Membership:** no-cost annual membership for 6-18 year-olds to participating clubs, where they can exercise, practice healthy habits and build lifelong friendships.

# Molina Healthcare of Washington

Our Mission: To provide quality healthcare to people receiving government assistance



# Molina Healthcare of Washington

Leading the way to whole person care

## Integrated Managed Care

- Selected (with the highest score) to launch IMC in all 10 Washington regions
- Eight years of integrated care experience with HCA's WMIP pilot in Snohomish county
- Third year of experience in SW WA, serving over 85,000 IMC members
- Currently serving well over 50% of all IMC members statewide



## Local and Personal Member Support

- Lead organization for the Health Home program
- Close to 900 employees including remote and community-based staff who live and work in the communities they serve
- Community Engagement, Supportive Housing and Supported Employment

# Molina Healthcare of Washington

## Value-Added Member Benefits

### HealthinHand App and MyMolina.com

Download our HealthinHand App to quickly:

- Find a doctor or clinic near you
- Connect to our Virtual Urgent Care Clinic
- See your ID card
- Change your provider
- See your health information anytime
- Find community services that provide extra help to families
- And more!

If you prefer, you can also visit MyMolina.com, our secure member website to complete your health assessment, request a case manager, and more.

Sign up today!



### Get Connected! Free Cell Phone

If you do not have a smartphone and would like one, you may be eligible for a free phone, data and text messaging through a federal program called SafeLink.

Apply at [safelinkwireless.com](http://safelinkwireless.com).

### Virtual Urgent Care

Talk or video chat with a provider 24/7 from your **phone, tablet or computer**. No appointment needed. Virtual care doctors and nurse practitioners can treat minor conditions like:

- Colds
- Pink eye
- Rashes
- and more!
- Ear pain

We can help in your language.

Visit [wavirtualcare.molinahealthcare.com](http://wavirtualcare.molinahealthcare.com) or call (844) 870-6821, TTY 711. For emergencies call 911.



### amazon prime

#### Get 90 days of Amazon Prime - on us!

Molina Medicaid members can get Amazon Prime for 90 days at no cost.

- Fast, free shipping
- Special discounts
- Health goods
- Stream movies, TV shows and music

Visit [MolinaHealthcare.com/Amazon](http://MolinaHealthcare.com/Amazon)

### Amazon Gift Cards NEW Health Rewards Program

Get important health screenings and earn Amazon gift cards!

Ways to get Amazon gift cards include:

- Well-child exams
  - Immunizations for children
  - Breast cancer screenings
  - Pregnancy care
  - Diabetes management
- You can earn up to \$200 in total rewards every 12 months.

### Health Programs

#### Weight Watchers®

Get support to reach weight loss goals. Available to qualifying members 18 years and older.



#### Motherhood Matters® Pregnancy Program

Learn how to have a healthy pregnancy and the services available to you.



#### Text4baby

Sign up for free text messages on baby care at [text4baby.org](http://text4baby.org)



#### Stop Smoking Program

Kick the habit through one-on-one counseling and education.



#### Women's Health

Get resources on ways to stay healthy like wellness exams, important screenings and maternity care.



And More!

# UHC in Washington

- ▶ UnitedHealthcare Community Plan serves 175,000 Washington Apple Health members.
- ▶ We serve 31,000 Dual Special Needs Plan members, making us the largest DSNP plan in the state
- ▶ We are the second largest plan in Western WA
- ▶ We serve on the Accountable Communities of Health, where we support mutual goals around health in housing programs, jail transitions, behavioral health integration and maternal-child health programs, and work collaborative with our MCO partners
- ▶ We have a long-standing partnerships with safety net providers, including Community Health Centers, low income housing and supportive service providers
- ▶ We are implementing Integrated Managed Care in King, Pierce and the North Sound for a 2019 start and in 2020 for the remaining regions



# Value-Added Benefits - UnitedHealthcare

-  Quit For Life<sup>®</sup> program.
-  Member Rewards for Well-Child, Screenings.
-  Extra pregnancy support and rewards for moms.
-  Support for complex conditions.
-  Youth programs with free Boys & Girls Club memberships, Sesame Street<sup>™</sup> and youth grants.
-  Sports physicals.
-  UnitedHealthcare On My Way for teen engagement on health and life.



**Healthy First Steps<sup>®</sup>**  
For your baby and for you.

# UHC Focus on Social Determinants

UHC Focus on Social Determinants of health into its clinical model, collaboration strategies and outreach priorities.



Providing reliable access to food could **save over \$215** per member per month in health care costs.



Creating safe, affordable housing can **reduce** health care costs **by over \$350** per member per month.



Supporting the completion of high school can **decrease** health care costs **by over \$140** per member per month.

# Partnering with MCOs



# Credentialing & Rosters



# IMC Credentialing

Behavioral Health Agencies (BHA's) delivering BH services in the State of Washington as part of Integrated Managed Care are credentialed according to NCQA requirements and MCO credentialing policies and procedures.

- ▶ All MCOs credential IMC BHAs at the facility level.

Category/Scenario	Facility Contract (CMHA, SUD Agency)
Individual Practitioner Credentialing Required?	<ul style="list-style-type: none"><li>• No (Facility-based non-licensed)</li><li>• Yes (Licensed, certified or registered with the state of WA who practice independently)</li></ul>
Facility/Location Credentialing Required?	Yes
What type of Application is required?	Facility Application (with supporting licensure)
Are practitioner rosters required?	Yes (for provider directory when appropriate, member care/referral, claims processing)
Re-credentialing Schedule	3 years / 36 months (or sooner if required by state law)

# IMC Credentialing

- ▶ Important Notes about credentialing:
  - ▶ **Time sensitive**: Credentialing is the one of the first and most critical steps to ensuring IMC go-live readiness. Failure to complete credentialing early enough can result in downstream delays to: portal access, loading providers into MCO systems, claims testing, and payment.
  - ▶ **Multiple Locations**: Credentialing applications must include *each* licensed location.
  - ▶ **New locations**: New locations must be credentialed with MCOs. MCOs should also be notified of location closures.

# Credentialing Process & Inquiries

All MCOs utilize ProviderSource (OneHealthPort) and CAQH as primary credentialing sources for individual provider credentialing. Facility credentialing applications vary by MCO. Credentialing materials and inquiries may be submitted as follows for each MCO.

Entity	Contact Email
Amerigroup	<a href="mailto:WACredentialing@Amerigroup.com">WACredentialing@Amerigroup.com</a>
Coordinated Care	<a href="mailto:Contracting@CoordinatedCareHealth.com">Contracting@CoordinatedCareHealth.com</a>
Molina Healthcare	<a href="mailto:MHWProviderContracting@MolinaHealthcare.com">MHWProviderContracting@MolinaHealthcare.com</a>
UnitedHealthcare Community Plan	<a href="mailto:waimc@optum.com">waimc@optum.com</a>

# What You Need to Know About NPIs

There is a two-step process related to NPIs:

1. Obtain NPIs for individual providers

- ▶ All providers (all levels, including unlicensed providers) that provide direct, encounterable care to members must obtain an NPI number to report as the servicing/rendering provider on claims.
- ▶ Exceptions are identified in IMC SERI and HCA NPI Q&A about NPIs - where HCA and MCOs are allowing a provider to use the billing provider information in the rendering provider fields. If the provider's situation is not identified as an exception, they should assume the actual rendering provider needs an NPI and needs it registered with HCA. (Exception example: Freestanding E&T billed with Billing Provider NPI.)

2. Enroll individual providers NPIs with HCA to obtain an HCA ProviderOne ID number.

- ▶ More detail on this process on the next slide.

# HCA ProviderOne ID

BHAs must ensure that all individual providers have an HCA ProviderOne ID or enroll as a 'non-billing' provider (if he/she does not wish to serve fee for service Medicaid clients) but each provider must have an active NPI number with the HCA to bill independently.

- ▶ 42 CFR 438.602(b) requires all BHA providers to be enrolled by 1/1/2019.
- ▶ Both Organizations (Type 1) and Individuals (Type 2) NPI's need to be registered.
- ▶ Requirements and Instructions on enrollment can be found on HCA's website:  
<http://www.hca.wa.gov/enroll-as-a-provider>

Lack of compliance with this HCA requirement could impact claims payment, so please ensure you are properly registered and obtain the ProviderOne ID!

# Rosters

- ▶ When agencies are credentialed at the facility level, we are reliant on provider rosters to ensure our systems are up-to-date.
- ▶ MCOs have established a common roster template for all providers to use in order to streamline processes.
- ▶ Updated rosters should be sent to MCOs on a regular basis to ensure systems are up-to-date. Failure to send timely roster updates can result in incorrect payments or denials.
- ▶ Allow approximately 30-45 days for roster updates to be processed prior to submitting claims to avoid denials and re-work.

# Reporting Provider Changes/Updates

Providers must give notice at least 60 days in advance of any provider changes such as:

- Provider Terms
- Provider Adds/Updates
- Tax ID Changes
- Group and/or Individual NPI
- Billing and/or Pay to addresses
- Clinic locations (where services are rendered)

Please submit rosters and any other changes/updates to:

MCO	Email Address
Amerigroup	<a href="mailto:waopsrequest@amerigroup.com">waopsrequest@amerigroup.com</a>
Coordinated Care	<a href="mailto:Contracting@CoordinatedCareHealth.com">Contracting@CoordinatedCareHealth.com</a>
Molina Healthcare	<a href="mailto:MHWProviderInfo@MolinaHealthcare.com">MHWProviderInfo@MolinaHealthcare.com</a>
United	<a href="mailto:WAIMC@Optum.com">WAIMC@Optum.com</a>

# Claims & Encounters



# Claim and Encounter Process Flow



Provider submits Claim/Encounter one of the following ways

EDI through Clearinghouse (preferred method)

Submitted via MCO web portal

Paper claim mailed to MCO

Claim Encounter goes through upfront claim edits for HIPAA compliance

Claim passes to the MCO system

ACCEPT

REJECT

Not entered in to the MCO system and Clearing house communicates rejection to provider

ACCEPT

REJECT

Portal/Paper Rejections come from MCO to provider

Accepted claims are entered into the MCO system for processing: Payments/ Denials are communicated through EOPs (paper/web portal) and 835 (clearinghouse)

# Provider Readiness Assessments





# LUNCH!

Thanks, Cascade Pacific Action Alliance!

# Q&A and Future Planning



# MCO Website Links

Entity	Website Link
Amerigroup	<a href="https://providers.amerigroup.com/WA">https://providers.amerigroup.com/WA</a>
Coordinated Care	<a href="http://www.coordinatedcarehealth.com/providers.html">www.coordinatedcarehealth.com/providers.html</a>
Molina Healthcare	<a href="http://www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx">www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx</a>
UnitedHealthcare Community Plan	<a href="http://www.uhcprovider.com/communityplan">www.uhcprovider.com/communityplan</a>

# Helpful Links

## ▶ Provider Manuals

### ▶ Amerigroup:

[https://providers.amerigroup.com/ProviderDocuments/WAWA\\_Provider\\_Manual.pdf](https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf)

### ▶ Coordinated Care: <https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html>

### ▶ Molina Healthcare:

<http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman.aspx>

### ▶ UnitedHealthcare Community Plan:

<https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/stateAddendums/waIMC-NetworkManual.pdf>

## ▶ WISE Manual- <https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf>

## ▶ SERI: <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri>

## ▶ HCA Billing Guides: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>

*Thank you for joining us today.*





## IMC Readiness Project



### Project Notes

<b>Date:</b>	Wednesday, 5/15/19
<b>Time:</b>	11:30 AM Pacific
<b>Location:</b>	GoToMeeting
<b>Purpose:</b>	Project Kick Off
<b>Attendees:</b>	Kyle Roesler, Adam Bullian, Traci Crowder

Agenda Item	Notes
Project Scope	<ul style="list-style-type: none"> <li>• Technical assistance to CPAA partner agencies to prepare for transition to integrated managed care January 1, 2020</li> <li>• Start with 7 agencies who voiced interest in technical assistance but communicate to all 12 agencies</li> <li>• \$150,000 divided among 12 agencies, or 7 if other 5 choose not to participate</li> </ul>
Deliverables	<ul style="list-style-type: none"> <li>• Initial Findings Report containing agency readiness assessment results</li> <li>• Final Findings Report containing summary of readiness activities and results</li> <li>• Monthly Status Reports</li> <li>• Project Plan</li> </ul>
Project Team	<ul style="list-style-type: none"> <li>• CPAA Team <ul style="list-style-type: none"> <li>○ Project Lead: Kyle Roesler – Program Manager, Bi-Directional Care Integration</li> <li>○ Christina Mitchell, Clinical Director</li> <li>○ Samantha Tatum and Christine Haywood, Operations – invoices and contracts</li> </ul> </li> <li>• Xpio Team <ul style="list-style-type: none"> <li>○ Project Lead: Adam Bullian</li> <li>○ Traci Crowder, Julie Gavrliko, Tracy Ivey</li> </ul> </li> </ul>
Project Activities	<ul style="list-style-type: none"> <li>• Xpio introduction to Behavioral Health Agencies (BHAs) <ul style="list-style-type: none"> <li>○ Kyle to send BHA contact information</li> </ul> </li> <li>• Xpio BHA kick off meetings</li> <li>• BHA Readiness Assessments and results</li> <li>• BHA IMC Implementation Plans</li> </ul>

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## Appendix P

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- Routine BHA project meetings
  - BHA/MCO Introductory Symposium in CPAA region last week – all CPAA partners attended
    - Will be other symposiums throughout the rest of this year – not yet scheduled
  - Deadlines for MCO contracting is July 15
  - Routine project check in call – half hour – monthly
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|-----------------------|--|
| Project Communication | <ul style="list-style-type: none"><li>• Xpio to coordinate monthly half hour project check in call with CPAA</li><li>• Send invoices to Samantha and Christina H., copy Kyle</li><li>• Copy Kyle, Adam, Traci on all email communication</li></ul> |
|-----------------------|--|
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|------------|---|
| Next Steps | <ul style="list-style-type: none"><li>• Kyle to send agency contact information</li><li>• Xpio draft an introductory email – send to Kyle to review before sending</li><li>• Xpio set up time to meet with agencies and conduct readiness assessment</li><li>• Xpio create IMC implementation plans (project plans) for each agency identifying tasks they need to complete before January</li><li>• Xpio to coordinate routine project calls with agencies and CPAA in order to complete project tasks</li></ul> |
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**Healthier Washington Medicaid Transformation  
 Accountable Communities of Health  
 Semi-Annual Report 3 Assessment  
 Reporting Period: January 1 to June 30, 2019**

**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.SAR3.RFI.Date”
- If the question applies to any attachments, please respond with an **updated** attachment. The naming convention should be as follows: “REVISED ACH Name.SAR3 Attachment Name”

**Section 1: ACH Organizational Updates**

**Question 9 – Key staff position changes:** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use bold italicized font to highlight changes to key staff positions during the reporting period. If applicable, attach or insert current organizational chart.

1. **Independent Assessor Question:** It is noted your Program Director's last day was June 28th, 2019. Please state if this position will be filled and if there will be any changes in the responsibilities for this position. How are the responsibilities of this position being completed until such time as the position is filled?

Because the Program Director’s last day occurred so late in the reporting period, a full and complete staffing update will be included in Cascade Pacific Action Alliance’s (CPAA) SAR4. For the remaining four days of this reporting period, the Clinical Programs Director absorbed Programs Director duties.

Name	Position	Role
*Christina Mitchell	Clinical Programs Director	Provides oversight of the Care Integration, Opioid, Chronic Disease, and Transitional Care programs. <b><i>*Absorbs duties of Program Director June 27 – June 30</i></b>



Name	Position	Role
*Jennifer Brackeen	Program Director	Provides oversight of Pathways, Reproductive and Maternal/Child Health and the Youth Marijuana Prevention and Education program. <i>*Last day June 26</i>

**Section 2: Project Implementation Status Update**

**Question 15 - Implementation work plan:** The ACH must submit an updated implementation plan reflecting progress made during the reporting period. The updated implementation plan must clearly indicate progress made during the reporting period.

2. **Independent Assessor Question:** For Project 3D, Stage 1 work step "Draft and regularly update effective communication tools for the region (website communication, newsletter, and one-pager)" is listed with a status of "Complete, Deliverable Met" for DY2 Q3, however the IP Work Step Status Legend shows this item as "Not Started" for DY2 Q4, DY3 Q1 and DY3 Q2. Please further clarify what regular updates of effective communication tools (website communication, newsletter, and one-pager) means.

CPAA made an error in not changing the status to "Complete, Deliverable Met" for this reporting period. Website, newsletters, and other communication tools were up-to-date and utilized during the reporting period.

3. **Independent Assessor Question:** For Project 2A, there are 4 work steps listed with a completion date of no later than DY3 Q2 that have an IP Work Step Status of "Not Started". These work steps are:
  - a. Review guidelines, policies, and procedures with the 2A work group (Row 68)
  - b. Provide targeted technical assistance for 2A partners to address quality concerns as indicated in quarterly metric reports. This TA could come from 2A Program Manager or external consultants as needed depending on organizational need. (Row 78)
  - c. Establish regular meeting times, at least monthly, to review quality improvement topics (Row 79)
  - d. Use performance improvement action plans, as needed, to monitor care integration progress (Row 80).



No Notes were provided to explain the delay in completing these work steps. Please provide the rationale for why each of these work steps remains "Not Started" and your plan to complete these work steps.

CPAA made an error in not changing the statuses to "Complete, Deliverable Met" for this reporting period. Guidelines, policies, and procedures were reviewed. Targeted technical assistance was provided. Regular meeting times were established. Performance improvement action plans were available, as needed, to monitor care integration progress.

**Question 17 – Quality improvement strategy update:** The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and IA apprised of quality improvement activities and findings. ACHs may determine the format to convey this information.

Semi-annual updates should demonstrate that the ACH has insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided by the ACH to partnering providers to promote achievement of transformation outcomes and objectives.

Through these updates, ACHs are expected to report developments over the reporting period, such as: 1) modifications to the ACH's quality improvement strategy, 2) summary of findings, adjustments, and lessons learned, 3) support provided to partnering providers to make adjustments to transformation approaches, 4) identified best practices on transformation approaches.

4. **Independent Assessor Question:** CPAA noted that Change Plans will be a public facing document to increase transparency, collaboration, and shared learning. Please advise where these plans are available online and include the website link.

Appendix B, which is the *original* Change Plan template released to MTP Implementation Partners, states that all Change Plans will be public-facing documents. Change Plans continue to be living, working documents, both for the partners and CPAA; since that original template release, CPAA has reconsidered making the Change Plans public-facing documents based on partner feedback. While partner Change Plans are not private documents, they are not available to the general public online.

5. **Independent Assessor Question:** CPAA noted one of the QI activities is to "Test new quality improvement methods with partnering providers." Please provide additional detail



on what these new quality improvement methods are and how you are working with your partners to test them.

As noted in both the SAR2 and the SAR3, CPAA requires all MTP Implementation Partners, including tribes and community-based organizations, to complete quarterly reporting based on approved Change Plans, which detail partners' Transformation work. CPAA is keenly aware that overly burdensome reporting would present a challenge, particularly for smaller, nontraditional, community-based social service providers; thus, CPAA's goal is to place minimal reporting requirements on partnering providers while providing CPAA effective performance monitoring.

For the Change Plan template and both Quarter 1 and Quarter 2 reporting templates, CPAA staff diligently worked to draft concise templates that sufficiently captured all the necessary information without being overly burdensome for organizations to complete. Once an internal draft template was completed, 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 templates were satisfactory for each provider setting. After receiving feedback from the different types of organizations and partners, CPAA made the requested adjustments to the templates (e.g., Change Plans are no longer public-facing documents).

CPAA will continue to solicit feedback from partners regarding all areas of ACH activity, including but not limited to, reporting, meetings, and shared learnings, and utilize this process of multi-sector "testing" and adapt as necessary. Partners have frequently noted they appreciate being given the opportunity to provide feedback, as well as CPAA's responsive efforts to incorporate said feedback. This process also ensures CPAA is providing appropriate and effective partner support and facilitating regional transformation.

**6. *Independent Assessor Question:*** It is noted in your report that you encourage providers to share lessons learned. How does this fit into CPAA's quality improvement strategy? How are lessons learned tracked? How is it decided if the lessons learned will be communicated to the larger stakeholder group, and if so, how are they communicated?

CPAA learned, from soliciting multi-sector partner feedback and evaluating event surveys, that providers wanted more opportunities to network and share lessons learned outside their typical "silos" of information. With that goal in mind, as stated in the SAR3, CPAA transitioned project-specific workgroups to a larger, bi-monthly Regional Learning Collaborative. During this reporting period, CPAA also hosted a Quality Improvement Conference and a MTP Networking Event. These larger, regional



events include time in the agenda for partners to network and discuss their ongoing Transformation work. This allows partners to see themselves in the larger goal of regional transformation and encourages new community-clinical linkages.

More specifically, the QI Conference and Learning Collaborative featured partners sharing their “success stories” as presenters, on panels, and in Q&A sessions. For example, the Executive Director of Love Overwhelming, one of CPAA’s MTP partners, was asked by the Care Coordination Program Manager to speak at a Learning Collaborative on toxic stress and staff retention. He shared insights on strategies to relieve workplace stress as a direct-service provider. The workshop session at the Learning Collaborative gave participants a hands-on opportunity to strategize improvements for their work environments and applying a trauma-informed lens to multiple sectors across the region.

Additionally, CPAA encourages partners to share their successes and lessons learned with the broad stakeholder group at CPAA Council and Board meetings and in the Partner Highlights section of the monthly CPAA newsletter.

**7. *Independent Assessor Question:* Please list identified best practices on transformation approaches for the reporting period.**

During this reporting period, CPAA identified the following best practices:

- Soliciting and then incorporating partner feedback on reporting, meetings, and shared learnings
- Broadly sharing partner success stories and highlighting lessons learned
- Combine project-specific workgroups into Regional Learning Collaborative with broader topics (e.g., toxic stress, harm reduction, motivational interviewing)
- Cohort calls to address specific interventions (e.g., pediatric call, behavioral health agency call)
- Partner site visits
- Compliance report/email following partner reporting

**8. *Independent Assessor Question:* What will be the trigger(s) that will warrant the development of a partner performance improvement action plan?**

During this reporting period, CPAA identified the following triggers that warrant the development of a partner performance improvement action plan:

- Partner self-identifies challenge(s)
- Program manager Identifies need(s) during site visit



- Quarterly reporting reflects challenge(s)
- TA provider (i.e., Comagine Health, XPIO) identifies challenge(s)

**Question 19 – Regional integrated managed care implementation update:** For 2020 adopters, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.

9. **Independent Assessor Question:** Who will be leading the Communications work group in Great Rivers BHO region? Your report notes that Great Rivers Interlocal Leadership Structure (ILS) will absorb the communications responsibilities for the region. What exactly will this responsibility entail?

The Communications Workgroup in the Great Rivers BHO region will be absorbed by the Great Rivers ILS. These responsibilities include providing recommendations to MCOs and HCA about needed system changes, reviewing existing HCA communications materials, distributing useful informational materials to providers and clients, and engaging with consumers about IMC. The main purpose is to ensure a smooth transition to IMC through the development of clear communication materials, client notifications, and transparent transition processes.

10. **Independent Assessor Question:** You noted that "The Thurston-Mason BHO is taking the lead on developing an ILS for their region. As the ILS is developed, it’s unclear which entities will be responsible for leading the early warning system, communication, or provider readiness workgroups." What are the time frames for starting these workgroups in the Thurston-Mason BHO region? How you are working to determine which entities are leading the three workgroups?

The first Thurston-Mason ILS meeting took place in July 2019, which will be reported on in more detail in the SAR4. At that meeting, the group decided to start developing the sub-workgroups immediately. The Thurston-Mason Provider Readiness Committee was combined with the Great Rivers region, making one Provider Readiness Workgroup for both regions, which is being led by CPAA. The first meeting was scheduled for August 2019. Early warning system and communications workgroups will be developed later, in Quarter 3 2019. The Thurston-Mason ILS will determine which entities are leading each workgroup.

## Cascade Pacific Action Alliance

### ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority<sup>1</sup>

Funds Earned by ACH During Reporting Period <sup>2</sup>		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	4,195,729.00
2B: Community-Based Care Coordination	\$	2,884,565.00
2C: Transitional Care	\$	1,704,516.00
2D: Diversion Interventions	\$	-
3A: Addressing the Opioid Use Public Health Crisis	\$	524,467.00
3B: Reproductive and Maternal/Child Health	\$	655,583.00
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	1,048,932.00
Integration Incentives	\$	-
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus pool/High Performance Pool	\$	-
<b>Total Funds Earned</b>	<b>\$</b>	<b>11,313,792.00</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
Administration	\$	159,507.00
Community Health Fund	\$	1,417,842.00
Health Systems and Community Capacity Building	\$	550,505.50
Integration Incentives	\$	-
Project Management	\$	903,875.00
Provider Engagement, Participation and Implementation	\$	3,350,429.00
Provider Performance and Quality Incentives	\$	1,188,840.00
Reserve / Contingency Fund	\$	886,151.00
Shared Domain 1 Incentives	\$	1,826,655.00
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>10,283,804.50</b>

Funds Distributed by ACH During Reporting Period, by Provider Type <sup>3</sup>		
ACH	\$	3,443,172.00
Non-Traditional Provider	\$	1,627,666.50
Traditional Medicaid Provider	\$	3,285,520.00
Tribal Provider (Tribe)	\$	100,791.00
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	1,826,655.00
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>10,283,804.50</b>

<b>Total Funds Earned During Reporting Period</b>	<b>\$</b>	<b>11,313,792.00</b>
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>10,283,804.50</b>

<sup>1</sup> 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 July 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019.

<sup>2</sup> 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.

<sup>3</sup> Definitions for [Use Categories and Provider Types](#)