



Medicaid Transformation Project

Semi-Annual Report 4

July 1, 2019 – December 31, 2019



January 30, 2020

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

RE: CPAA Semi-Annual Report 4

Dear Semi-Annual Report Review Team:

Please find attached a copy of Cascade Pacific Action Alliance's (CPAA) fourth semi-annual report for the Medicaid Transformation Project (MTP). This report summarizes CPAA's work from July 1, 2019, through December 31, 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, participating in the mid-point assessment and HCA Learning Symposium, hosting regional trainings, preparing the region to transition to IMC January 1, 2020, and developing Quality Improvement activities (i.e., the Change Plan Modification process and Performance Improvement Plans) for our MTP Implementation Partners.

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

Thank you for your time and consideration.

Sincerely,

Jean Clark, CEO
Cascade Pacific Action Alliance

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**CPAA P4R Metric Reporting, Partner 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, also include their information.

ACH name:	Cascade Pacific Action Alliance (CPAA)
Primary contact name	Jean Clark
Phone number	360-539-7576 ext. 116
E-mail address	clarkj@crhn.org
Secondary contact name	Christina Mitchell
Phone number	360-539-7576 ext. 131
E-mail address	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"> • Primary care providers • Behavioral health providers • Health plans, hospitals or health systems • Local public health jurisdictions • Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region • Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region. 	x	
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 template or a similar format) that addresses internal controls, including financial audits. ¹	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	

¹ <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:

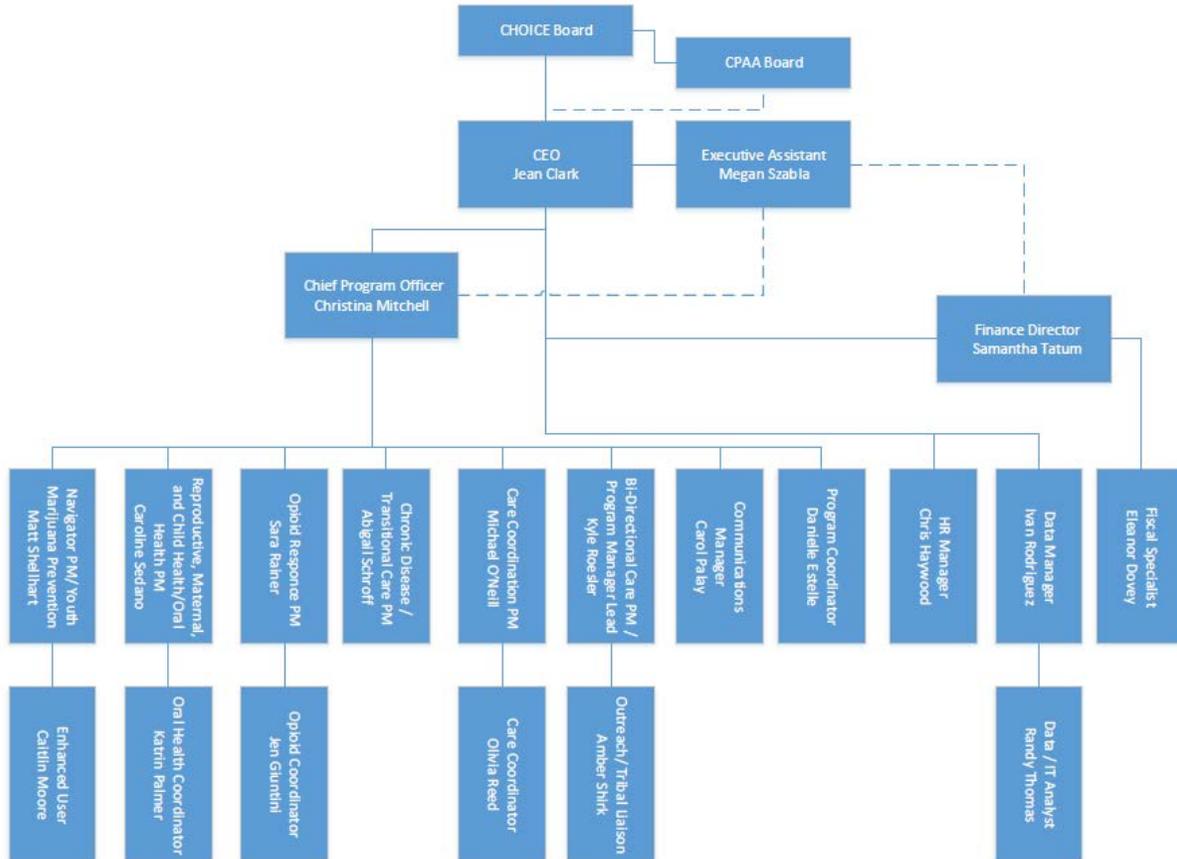
- 9. Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

If applicable, attach or insert current organizational chart.

Table 1: CPAA Organizations Updates

Name	Position	Role
Jean Clark	CEO	Provides strategic direction and oversight of the organization.
<i>*Samantha Tatum</i>	Finance Director	Provides oversight of finances.
<i>*Christina Mitchell</i>	Chief Program Officer	Provides oversight of all program areas. <i>*Absorbs duties of Program Director</i>
<i>*Position will not be rehired at this time</i>	Program Director	Provides oversight of Pathways, Reproductive and Maternal/Child Health and the Youth Marijuana Prevention and Education program.
Matthew Shellhart	YMPEP Manager	Manages the Youth Marijuana Prevention and Education program.
Christine Haywood	HR Manager	Manages HR.
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.
<i>*Kyle Roesler</i>	Lead Program Manager and Care Integration Manager	<i>Lead manager for all MTP programs</i> and 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.
<i>*Abigail Schroff</i>	Chronic Disease and Transitional Care Manager	Manages the Chronic Disease and Transitional Care programs.
Caroline Sedano	Reproductive, Maternal, and Child Health Manager	Manages Reproductive and Maternal/Child Health programs.
Megan Szabla	Executive Assistant	Provides administrative support for the CEO.
<i>*Danielle Estelle</i>	Coordinator II	Provides administrative support for programs and Chief Programs Officer.
Eleanor Dovey	Fiscal and Contracts Specialist	Provides fiscal and administrative support.
Randolph Thomas	Data and IT Specialist	Provides data analytics and IT support.
Olivia Reed	Pathways Referral Coordinator	Provides technical support for care coordination agencies in the Pathways HUB.
<i>*Amber Shirk</i>	Community and Tribal Outreach Liaison	Collaborates and coordinates with Tribes, outreach efforts, local forums, and the Consumer Advisory Committee. <i>*Absorbs duties of Tribal Liaison</i>
Carol Palay	Communications Manager	Provides communications expertise and supports stakeholder, implementation partner, and community engagement.
<i>*Position will not be rehired at this time</i>	Tribal Liaison	Collaborates with the tribes to inform, make recommendations, and gather input.

Table 2: CPAA Organizational Chart



10. Budget/funds flow.

- a) 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. 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).

Portal activities for this reporting period are categorized appropriately, with the exception of \$100,995 paid directly to Cascade Pacific Action Alliance (CPAA) to fund capacity investments and local forums. Local forum investments to date are \$62,995; capacity improvement investments total \$38,000. These funds were drawn by CPAA and paid to local forum and capacity improvement partners not registered in the Financial Executor Portal.

As of November 30, 2019, CPAA led the state in ACH distribution of Medicaid Transformation Project (MTP) funds to partnering providers (Appendix A), with 69.68% of funds distributed.

A funds flow methodology for DY3-5 was developed by the CPAA Finance Committee and was approved by the CPAA Board in December 2019 (Appendix B). The new funds flow takes into account P4P; CPAA will pay out P4P as the ACH earns it and not hold any Design Funds for partner performance.

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.

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.

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 Community and Tribal Outreach 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.

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 healthcare 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 **Community and Tribal Outreach Liaison** meets one-on-one with each tribe in addition to supporting a bi-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 Liaison.

After a year of project implementation, some tribes are choosing to communicate directly with program managers. With more staff members directly engaged with tribes, CPAA requested additional training on cultural competency, tribal sovereignty, and Indian Health Services. Jessie Dean, Health Care Authority's (HCA) Tribal Liaison, presented to CPAA staff, and Lena Nachand, HCA's Tribal Liaison for Medicaid Transformation, presented to a broad stakeholder group at the December CPAA Council Meeting (Appendix C).

The bi-monthly **Tribal Health Director call** and bi-annual in-person **Tribal Health Director Meeting** serves as one of several ways CPAA communicates and collaborates with tribes. 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 calls and in-person meetings serve 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.

Additionally, while all regional partners are invited to CPAA training opportunities and made aware of partnership and funding opportunities, the **Community and Tribal Outreach Liaison individually identifies, communicates, and discusses these opportunities with each of the seven federally recognized tribes**, which allows for any questions or concerns to be immediately addressed (Appendix D). This communications policy has resulted in the Skokomish Tribe and the Nisqually Indian Tribe forming a grant writing and resource distribution partnership with the Moore Wright Group, exploration of partnership with the CHOICE Youth Marijuana Prevention and Education Program, and a CPAA Tribal Infrastructure Fund Award (Appendix E). Most notably, CPAA 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 (CHOICE), 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.

- a) 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.

Please see CPAA.SAR4.Design Funds.1.31.20.

- b) 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.

Phase I and Phase II Design Funds continue to sustain the operations and management of CPAA. As of December 31, 2019, CPAA has expended 72% of Design Funds. Remaining Design Funds are supplemented with DY1 and DY2 DSRIP funds to support CPAA throughout the course of the MTP.

Table 3: Design Funds

Design Funds		
Use Categories	Expenditures (\$)	
	Actual	Expenditure Details
Administration		Includes indirect expenses incurred in the management of Transformation activities such as accounting, audit, human resources, data analysis, information technology, and facility expenses.
Health Systems and Community Capacity Building	\$522,969.63	Pathways CCS platform, TA, and capacity investments.
Project Management	\$3,095,369.85	Funds for direct management of each project area, including salaries, benefits, travel, meeting expenses, and training.
Other:	\$262,751.94	Other category includes B&O taxes and capacity investments to expand CPAA in preparation for the Medicaid Transformation Project.

13. 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.

- a) Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- b) ACHs may use the table below or an alternative format as long as the required information is captured.
- c) Description of use should be specific but concise.
- d) List of use and expenditures should reflect a cumulative accounting of all incentives distributed or projected to support behavioral health providers transitioning to integrated managed care. It is not limited to the reporting period.

Table 4: Incentives to Support Integrated Managed Care

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected
Managed Care Contracting from a Position of Strength: an IMC training event with Adam Falcone, held on April 18, 2019.	\$12,000	\$15,000
Host MCO-BHA Forum on May 8, 2019.	\$1,950	\$1,500
EHR enhancement funding to support partners transitioning to IMC.	\$270,000	\$330,000
Contract with XPIO Health to provide technical assistance for up to 12 behavioral health agencies.	\$102,296	\$150,000
Interpreter Services for the IMC Provider Readiness Workgroup.	\$1532	\$2000

Section 2. Project implementation status update

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

Attachments

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

14. 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*.²

- a) 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:
 - i. Work steps and their status.
 1. 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.
 2. 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.
 - b) If the ACH has made minor changes for any work step from their originally submitted

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.
CPAA SAR4 Report 1.31.20
Reporting period: July 1, 2019 – December 31, 2019

work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.

- c) If the ACH has made substantial changes to the work plan format since the last 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.SAR4.Work Plan.1.31.20.

Table 5: 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	

15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.³ To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

- a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.

³ Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).

- b) By **October 15**, HCA will provide ACHs a clean version of the ACH's partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.
 - i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.
- c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
 - i. 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).
 - ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.
- d) Update partnering provider site information as needed over each reporting period.

Submit updated partnering provider roster.

Please see CPAA.SAR4.Partner Site List.1.31.20.

Documentation

The ACH should provide documentation that addresses the following:

16. 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

As reported in previous SARs, CPAA required all MTP Implementation Partners, including tribes and community-based organizations, to complete a Change Plan at the end of 2018, detailing their Transformation work (Appendix F). 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, 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 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 will 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 G). 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 H). CPAA worked with Providence CORE (CORE) to determine what measures to be reported for each evidence-based intervention.

Table 6: 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, CPAA SAR4 Report 1.31.20

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 uses 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 I). Additionally, a regional performance report is shared with the broad stakeholder group semi-annually (Appendix J). The regional performance report includes an overview of finances, training opportunities, community engagement, and Community CarePort (Pathways) data.

CPAA is 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 contracted with Comagine (formerly Qualis Health) to provide technical support for organizations that requested 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. While the contract with Comagine Health ends in Q1 2020, partners currently working with consultants have the opportunity to continue to do so.

As reported in previous SARs, CPAA is 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 original Change Plan and quarterly reporting, 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 the 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.

During this reporting period, and after a year of project implementation, as part of CPAA's Quality Improvement Strategy, CPAA is requiring all MTP Implementation Partners to review and modify their Change Plans (Appendix K). While this process will not be complete until Quarter 1 2020, Change Plan Modification encourages and supports partners as they modify their Change Plan to accurately and realistically reflect their scope of work, add milestones in Year 4 and Year 5 to plan for achieving sustainability in approved projects, and potentially drop interventions and project areas. CPAA is supporting partners as they modify their Change Plans with in-person meetings, phone calls, and a webinar scheduled for January 9, 2020.

As a region, CPAA is keenly aware we need to put our limited resources where the funding can make the biggest impact. To this end, based on a year of reporting, some MTP Implementation Partners have been placed on a Performance Improvement Plan (PIP) (Appendix L). CPAA Program Managers are working closely with those partners as they modify their Change Plans and work towards meeting MTP milestones and fulfilling their PIPs.

During this reporting period, CPAA provided the following Quality Improvement support:

- Change Plan Modification
- Performance Improvement Plan (PIP)
- Infrastructure Fund Awards to help offset project start-up costs
- VBP survey incentives (Appendix M)
- Collaborative partner meetings and calls focused on peer-to-peer learning and peer-to-peer training (Appendix N)
- One Key Question training and follow-up, MAT waiver training, Language of Stigma, Transforming Trauma Regional Learning Collaborative, OUD and Methamphetamine training, 6 Building Blocks training, Tribal Sovereignty and Indian Health Services training, and AIMS Center Whole-Person Care webinars and in-person trainings: Quality Improvement, Chronic Disease Management for BHAs, Addressing the Mortality Gap for Patients with Serious Mental Illness, Tools for Supporting BH Outcomes (Appendix O)
- Provider Readiness Workgroup and MCO/BHA Symposium to support transition to IMC (Appendix P)

During this reporting period, CPAA complied with identified best practices and lessons-learned:

- CPAA continues to solicit and then incorporate partner feedback on reporting, meetings, and shared learnings. One example: due to partner interest, a Motivational Interviewing training series begins in Q1 2020 (Appendix Q). All three sessions (identical content offered in different locations around the region) are at capacity with a waiting list for openings.
- CPAA continues to broadly share partner success stories and highlight lessons learned. Transformation Talks (T²), an MTP Implementation Partner Showcase, is being planned for Q1 2020 (Appendix R). This opportunity will allow partners to learn from each other and share their Transformation stories.

- CPAA continues to host and facilitate Regional Learning Collaborative with broader topics (e.g., toxic stress).
- CPAA continues to host and facilitate cohort calls to address specific interventions (e.g., pediatric call, behavioral health agency call).
- CPAA continues to provide MTP Implementation Partners a compliance report/email following partner quarterly reporting.

During this reporting period, CPAA partners, through quarterly reporting, identified the following challenges to Transformation:

- Workforce shortage/not enough providers, particularly in rural areas, and staff turnover
- High demand for services/not enough capacity, particularly around medication-assisted treatment (MAT)
- Transportation barriers for recipients of services, particularly in rural areas
- Lack of affordable housing

Regional Framework for Supporting Partnering Providers’ Quality Improvement Processes	
QI Area for Improvement	QI Activities
Structured Quality Improvement Activities and Partnering Provider Support Provided by CPAA	<ul style="list-style-type: none"> • Develop, test, and distribute Change Plan Modification template for partners to modify, revise, and further develop their MTP planning and implementation activities and quality improvement targets; support implementation partners in completing a quality Change Plan modification • Develop menu of project metrics that align with HCA metrics to monitor evidence-based practices and monitor outcomes • Review new quality improvement methods with the regional Learning Collaborative • Test new quality improvement methods with partnering providers • 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 • Host regular webinars, CPAA Council meetings, and Learning Collaborative • Conduct MTP Implementation Partner site visits
Methods and Frequency of Tracking Partner QI Progress	<ul style="list-style-type: none"> • MTP Implementation Partners report on Change Plan milestones quarterly – Excel milestone report and Word narrative report submitted to CPAA

	<ul style="list-style-type: none"> • MTP Implementation Partners report on metrics semi-annually - Excel milestone report and Word narrative report submitted to CPAA • Conduct annual MTP Implementation Partner site visits • Monitor qualitative and quantitative data for intervention/s to evaluate success of organizations' implementation of selected evidence-based interventions • Regular check-ins with Comagine Health regarding partners they're assisting • CPAA issues quarterly performance emails to individual MTP partners and a regional report to the broad stakeholder group • TA partners (Comagine Health, Xpio Health, AIMS Center) provide quarterly reports to target efforts and advise progress
<p>Process of Communicating and Implementing Adjustments to Optimize MTP Approaches</p>	<ul style="list-style-type: none"> • 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 • Identify partnering providers who need additional technical assistance to expand/improve their program • Solicit advice from clinical experts, including the Clinical Advisory Committee and partner champions • Develop partner performance improvement action plans as needed
<p>Technical Assistance Provided or Facilitated by CPAA</p>	<ul style="list-style-type: none"> • Use performance improvement action plans, as needed, to monitor project progress • Identify regional champions who implemented a successful program and who are interested in training other organizations • Develop a peer-to-peer training model that works for regional champions and partnering providers • Contract with Comagine Health for partners requiring additional support • Contract with AIMS Center for partners participating in Bi-Directional Care Integration • Contract with Xpio for partners transitioning to Integrated Managed Care • CCS contract for partners participating in Community-Based Care Coordination (Pathways)
<p>Methods and Frequency of Sharing Approaches and Lessons Learned</p>	<ul style="list-style-type: none"> • Host regional networking events, facilitate opportunities, encourage dialogue, increase clinical-community linkages, and share lessons-learned and best-practices • 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

Narrative responses

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

17. General implementation update

- a) *Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities.
 - i. Across the project portfolio, provide three examples of *each* of the following:
 1. Trainings and technical assistance resources provided to or secured by partnering providers or members of care teams necessary to follow required guidelines and to perform their roles in an approach in a culturally competent manner. Be specific when describing the project(s), partnering provider(s), the guidelines or evidence-based approaches, specific needs that the training and/or technical assistance addresses and describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner. Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future.

- **Community CarePort, CPAA’s Pathways HUB**, trains care coordinators and supervisors to perform their roles in a culturally competent manner. Cultural competency is fully integrated into the two-week, all-day, on-boarding training, as well as during the required monthly Community CarePort Advisory meetings.

Care coordinators work with clients who often have different lived experiences and/or come from different backgrounds. CPAA has approached training care coordinators in cultural competency by first maintaining a safe space for open, honest discussion, to share on-going challenges, to ask culturally appropriate questions, and to learn. Care coordinators are encouraged to discuss how their own lives, families, and cultures have impacted them and their interactions with others, including with various service providers. They are then encouraged to be purposefully aware that other people’s experiences and perspectives may be very different from their own and openly discuss how to approach topics with the understanding that their clients may think, feel, and believe differently than they do.

Community CarePort’s cultural competency training includes translation services for non-native English speakers. CPAA’s Care Coordinating Agencies (CCAs) have Spanish-speaking care coordinators. CCAs work with other partners when additional language barriers are identified.

Additionally, care coordinators have specific resources for LGBTQ clients, particularly legal resources for healthcare services. CCAs have also worked to adapt existing Pathways, like the “Family Planning” Pathway, to take into account healthcare needs of LGBTQ clients, moving beyond just contraception to include safe sex practices for all clients, regardless of gender or orientation. CCAs have also adapted the “Pregnancy” Pathway to include support for parents with an unplanned pregnancy (rather than assuming all pregnancies are planned), parents who might not have or retain

custody of newborns (due to incarceration, in-patient treatment, etc.), and other cultural factors (e.g., Catholic clients might have religious beliefs that prevent them from using contraceptives).

- Given the long history in Washington State of invasion, treaty-signing under duress, treaty-breaking, boarding schools, persistent and severe underfunding of healthcare programs, and discrimination against tribes, Jessie Dean, HCA's Tribal Liaison, presented to CPAA staff, and Lena Nachand, HCA's Tribal Liaison for Medicaid Transformation, presented to a broad stakeholder group at the December CPAA Council Meeting. These trainings were both on **Tribal Sovereignty and Indian Health Care Delivery**. Increasing general understanding about tribal governments and tribal sovereignty, health disparities, historical trauma, resiliency, and Indian Health Care Delivery fosters more effective collaboration between tribes and non-tribal organizations, increases strategies for care coordination across health care providers, and spreads awareness of the need for trauma-informed care.

CPAA will continue to partner with the seven federally recognized tribes in the region and facilitate training opportunities for non-tribal partners to promote cultural competency, awareness, and understanding.

- CPAA hosted a **Language of Stigma** training because words matter. Trauma-informed care/healing-centered engagement is a cornerstone of CPAA's portfolio of MTP program areas, particularly Opioid Response and Reproductive/Maternal & Child Health, but acknowledging stigma and trauma can be broadly applied to Transformative efforts across all project areas throughout the region. CPAA is committed to providing training for not only paid MTP Implementation Partners, but also for any provider of services in the region who is interested in learning more about applying trauma-informed care practices. This includes training for direct service providers as well as training for organizations around policy, including educators, community health workers, dentists, hygienists, law enforcement, and community-based and social service organizations that provide outreach.

A key aspect of an informed approach, particularly with Opioid Response, is addressing the role of stigma as one of the greatest barriers when addressing SUD or the health and social issues associated with opioid use in order to achieve recovery. CPAA seeks to transform how intervention, treatment, and support is provided to patients and clients by introducing training opportunities among the general population, professionals (medical, chemical dependency, and law enforcement), and families and individuals living with OUD on the following topics: profound stigma about OUD, medication-assisted treatment (MAT) as the established evidence-based treatment for OUD, social contributors to OUD including socioeconomic disadvantage, physical, psychological and sexual trauma, adverse childhood experiences (ACE), trauma-informed care, and principles of harm reduction.

- During the **One Key Question** training, trainers from Power to Decide taught the importance of cultural competency in implementing family planning programs. Stark racial disparities helped healthcare workers in clinical and non-clinical settings see the importance of ensuring everyone they work with has access to timely and high-quality care. The training empowered physicians, social workers, community health workers, nurses, and home visitors to feel more comfortable helping families identify goals around if or when they want to become pregnant. Whether a client wants one

child or five, or to be pregnant in three years or next month, providers were encouraged to help clients achieve their reproductive goals in the most safe and healthy way possible.

In order to effectively implement One Key Question screening, providers must recognize that pregnancy is deeply personal and private for many people and that culture and family background affects pregnancy intentions. The training included an activity on unconscious bias, which Power to Decide defined as “social stereotypes about certain groups of people that individuals from outside their own conscious awareness,” and that patients often report provider bias because they are poor, unmarried, on Medicaid, or are people of color. Furthermore, a history of contraceptive coercion and injustice impacts clients’ ability to trust medical providers.

A challenge providers often face is when clients answer as “unsure” or “fine either way” regarding their reproductive future. Providers often feel the need to provide suggestions or guidance to clients. One Key Question training discourages providers from seeing themselves as needing to solve ambivalence or make the right choice for a client. Instead, One Key Questions encourages providers to start a conversation in which they are respectful of a client’s goals for their own health and avoid using yes/no questions to allow clients to express ambivalence or neutrality.

- During this reporting period, CPAA identified the following gaps in cultural competency trainings that remain for partnering providers to follow required evidence-based guidelines, which are currently being explored for future training opportunities:
 - Continue to address OUD and MAT stigma with the on-going Medications for Opioid Use Disorder (MOUD) Provider Group and the Regional Learning Collaborative.
 - Continue to address tribal inequity and tribal health disparities with Regional Tribal Trainings. CPAA is also exploring a partnership with Wisdom Warriors, a tribal chronic disease self-management program.
 - Continue to encourage partners to include the consumer voice in decision-making to address the disconnect between providers and the people they serve (e.g., Medicaid beneficiaries, homeless, people experiencing OUD). CPAA Local Forum contracts, which go out Q1 2020, require Local Forums to recruit at least one consumer.
 - Continue to explore future implicit bias training for healthcare providers. CPAA is searching for “the right fit” with this training, with emphasis on implicit bias in healthcare settings.
 - Continue to explore health disparities when treating women, particularly pregnant women and women of color. CPAA is partnering with the University of Washington to expand Reproductive and Maternal/Child Health provider trainings, including Perinatal Behavioral Health in Q1 2020 (Appendix S).
 - While people with disabilities have not been at the forefront of CPAA’s MTP strategy to date, one in three patients on Medicaid have a disability. Internal discussion led to a Program Manager applying for a position on the Governor’s Commission on Disability and Employment Issues (Appendix T).

2. **Implementation of bi-directional communication strategies/interoperable HIE tools to support project priorities. Be specific when describing the project(s), partnering provider(s), strategies and/or tools, and how these activities support project priorities.**

- For project 2B (care coordination), CPAA Community CarePort HUB provides all 12 Care Coordinating Agencies (CCAs) with the **Care Coordination Systems (CCS) software platform** for documenting client needs and care plans. With a client's consent, records from this system can be sent via direct message or secure fax to other organizations and individuals that are on the client's care team. Communication with care team members can even be scheduled in advance to increase the exchange of information between agencies serving the same client and to ensure that all providers have up-to-date information about progress the client has made.
- During this reporting period, CPAA continued the strategy of helping partners implement the **Collective Platform**, which is a HIE tool that allows for bi-directional sharing of basic care plans and monitoring of emergency department visits. Initially, CPAA gathered interest from partners by conducting a survey. Next, CPAA worked with each partner to complete Collective Medical's Discover Form and facilitated MCO sponsorship to implement the tool. In the last quarter, CPAA supported one pediatric clinic, one FQHC, and five behavioral health agencies to implement the Collective Platform. In the coming months, CPAA will monitor each partner's implementation and determine an ongoing strategy of support for these partners. These activities help support all the MTP project areas by allowing CPAA's partners to receive real-time notifications when clients/patients use the emergency department. By receiving real-time updates, partners have the ability to rapidly respond with appropriate care coordination, active follow-up, and care transition services. The ultimate goal with this strategy is to decrease emergency department utilization and increase access to primary care and other forms of care.
- For project 2A (bi-directional care integration), CPAA continued to provide the **AIMS Center Caseload Tracker** to partners implementing the Collaborative Care Model. There are currently five primary care practices implementing the caseload tracker. The caseload tracker allows practices to take a population health approach to a specific subset of patients with common mental illness who seek care in primary care settings. This tool is critical for doing measurement-based treatment-to-target, tracking patients over time, performing regular follow-up, and ensuring quality improvement metrics are being met in the program. Additionally, this tool is essential to implementing the Collaborative Care Model, as it provides the consulting psychiatrist with the database of patient information necessary to offer medication changes and treatment recommendations.
- All ACH Executive Directors are collaborating to develop an **ACH Health IT Strategy**

comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities.

The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

Better engage people, organizations, and community partners in the circumstances, health events, and care-system encounters to enable whole-person care in traditionally-disconnected care settings and services through the use of health IT.

To achieve this vision, the ACHs are working to identify a set of initial goals and recommended activities that support each goal.

The ACHs will discuss the goals and recommendations with stakeholders and determine how each fits with the ACHs' priorities, projects, and roadmaps, and adding relevant activities to their plans for 2020 and beyond. The ACHs are also identifying best practices to be shared and potentially scaled among ACHs and developing individual action plans for accomplishing priority recommendations. Later in 2020, the ACHs plan to begin implementing their action plans.

The ACHs plan to share the Health IT Strategy with HCA in Q1 2020 and look forward to discussing partnership opportunities in pursuit of the collective ACH vision.

3. Mechanisms that have been established for coordinating care management and/or transitional care plans with related community-based services and supports such as those provided through supported housing programs. Be specific when describing the project(s), partnering provider(s), care management and/ or transitional care approaches/supports, and how these activities support project activities.

- The **CPAA Community CarePort HUB** is a mechanism for coordinating care management when a client receives services and supports from multiple organizations and/or multiple programs from a single organization. As an example of this mechanism, please see the memo from Washington State Health Care Authority to CPAA, entitled "Integrated Use of Medicaid Transformation Project and Department of Commerce Funding" (Appendix U). Community CarePort provides a service platform for delivering care coordination that enhances services and incentivizes client outcomes. As a result of having this mechanism in place, clients are less likely to have multiple agencies duplicating coordination services and are less likely to encounter programmatic limitations on the types of needs they can receive care coordination services for.
- For project 3A (Opioid Response), the **Lewis County Sheriff's Department** implemented an opioid treatment medication program at their county jail, which includes a focus on coordinating care management and transitional care plans as individuals are released from incarceration. The jail's Health Services Administrator

partnered with Medtriq Treatment Services and the jail's medical contractor, NaphCare, to offer this program. Since March of 2019, when an individual enters Lewis County Jail, they are screened for opioid use disorder and offered access to the program.

When individuals transition out of jail, the 24-48-hour Medicaid reactivation timeframe poses major risk to participants of the Lewis County Sheriff's Office's MAT program. Individuals are at a significantly increased risk of overdose death post-release, and access to MAT substantially reduces this risk. This is a high-need population with high rates of health care utilization and a gap in care that requires system-level changes.

CPAA has provided technical assistance to our partners at the Lewis County Sheriff's Department to minimize the impact of the Medicaid enrollment and suspension process for individuals as they transition from the jail. CPAA provided training to the jail's Community Resource Specialist to become an on-site Health Care Navigator, allowing for in-house, hands on case management and the initiation of health care benefits immediately following their release from the jail.

- Through Project 2C (Transitional Care), **PeaceHealth and Lower Columbia CAP** have partnered to create a "Food Farmacy" program and prescription food boxes for shared clients who identify as food insecure or screen positively for malnourishment as a mechanism for coordinating care management and transitional care plans. High risk patients initially identified in the target population were defined as patients with a diagnosis of Malnutrition, Diabetic Ketoacidosis, Diabetes, or congestive heart failure during an in-patient stay who also screened positive for food insecurity and accepted participation in the Food Farmacy program at discharge from the hospital.

After implementation of the project, hospital staff found that self-identification of food insecurity is a better indicator of participation, and thus modifications have been made to no longer offer the service based on disease state alone.

Released patients leave with increased education about food and nutrition as part of the healing process, a couple days' worth of food for their entire family, and a direct referral to Lower Columbia CAP, which provides additional food boxes on site and community resources to support social determinants of health. The Food Farmacy program aims to reduce hospital readmission rates and tracks how many participants in the program report on-going nutritional needs that are met through community resources or other means 60 days, 90 days, and six months after discharge.

Based on the success of the Food Farmacy, CPAA applied for additional funding through grants for produce vouchers and nutritional education and support for Community CarePort care coordinators and Oral Health clients.

4. **Systems or rapid-cycle quality improvement processes that have been developed to monitor performance, provide performance feedback, implement changes and track outcomes.**

CPAA has developed the following systems of rapid-cycle quality improvement to monitor performance, provide performance feedback, implement changes, and track outcomes:

- **Quarterly Reporting/semi-annual metric reporting:** As previously noted, 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. All implementation partners must submit a report by the end of the first month following every quarter. As outlined in the contracts, all implementation partners 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. CPAA worked with Providence CORE (CORE) to determine what measures to be reported for each evidence-based intervention.
- **Bi-Annual Regional Performance Report:** As previously noted, CPAA issues compliance emails to partners no later than the last day of the second month following every quarter. Additionally, a regional performance report is shared with the broad stakeholder group semi-annually. The regional performance report includes an overview of finances, training opportunities, community engagement, and Community CarePort (Pathways) data.
- **Change Plan Modification and Performance Improvement Plan:** As previously noted, after a year of project implementation, as part of CPAA's Quality Improvement Strategy, CPAA is requiring all MTP Implementation Partners to review and modify their Change Plans. While this process will not be complete until Quarter 1 2020, Change Plan Modification encourages and supports partners as they modify their Change Plan to accurately and realistically reflect their scope of work, add milestones in Year 4 and Year 5 to plan for achieving sustainability in approved projects, and potentially drop interventions and project areas. CPAA is supporting partners as they modify their Change Plans with in-person meetings, phone calls, and a webinar scheduled for January 9, 2020.

Additionally, based on a year of reporting, some MTP Implementation Partners have been placed on a Performance Improvement Plan (PIP). CPAA Program Managers are working closely with those partners as they modify their Change Plans and work towards meeting MTP milestones.

- ii. **For each project in the ACH Project Plan, provide clear, specific, and concise responses to the below as applicable. For projects the ACH is not implementing, indicate "Not Applicable."**
 1. **Project 2A: Provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.**

CPAA released an **application for Infrastructure Funds** (Domain 1) to MTP Implementation Partners during the SAR3 reporting period (Appendix V). This one-time funding opportunity, open only to MTP partners, was intended to make targeted investments to support MTP projects and help offset MTP project start-up costs. The funding could 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. For example, many partnering providers were awarded funding to convert interview rooms or other office spaces into an examination rooms to support integrated care activities.

The Infrastructure Fund awards were announced in August 2019. Additional Tribal Infrastructure Awards were announced October 1. Due to the number of strong applications submitted, CPAA made the decision to equally award partners who applied \$11,500, rather than fully fund far fewer applications, with the belief that some investment dollars for everyone would be more impactful than many partners not receiving any.

Additionally, CPAA continued to make available **psychiatric consultation, AIMS Whole Person Care Training Program, and the AIMS Center Caseload Tracker** to partners for implementing integrated care activities. CPAA also contracted with Xpio Health to provide technical assistance to behavioral health partners preparing for the transition to IMC.

2. Project 2B: Provide information related the following:

a. Schedule of initial implementation for each Pathway.

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Adult education	11/5/18	All Pathways have been available since program launch November 2018
Employment	11/5/18	
Health insurance	11/5/18	
Housing	11/5/18	
Medical home	11/5/18	
Medical referral	11/5/18	
Medication assessment	11/5/18	
Medication management	11/5/18	
Smoking cessation	11/5/18	
Social service referral	11/5/18	
Behavioral referral	11/5/18	
Developmental screening	11/5/18	
Developmental referral	11/5/18	
Education	11/5/18	
Family planning	11/5/18	
Immunization referral	11/5/18	
Immunization screening	11/5/18	

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Lead screening	11/5/18	
Pregnancy	11/5/18	
Postpartum	11/5/18	

b. Partnering provider roles and responsibilities to support Pathways implementation.

- HUB - CHOICE/CPAA
 - Provide access to training & technology platform
 - Quality Monitoring & Continuous Improvement
 - System Administration & Outcome-Based Incentive Payments
 - Sustainability planning
- CCAs - 12 Selected MTP Partners
 - Recruit & supervise workforce
 - Deliver care coordination services according to quality standards
 - Outreach & engagement of clients
 - Participate in HUB QI activities
- Referral Partners – (e.g. Providence, Arbor Health)
 - Identify & refer clients
 - Information exchange
- Potential Payers
 - Review & understand early impact of project implementation
 - Negotiate & test payment models
 - Data sharing

c. Inventory of Care Coordination Agencies (CCAs) and the number of referrals initiated to date.

CCA Name	Total # of Referrals to CCA for any Pathway
Coastal Community Action Program	673
Community Action Council	140
Gather Church	41
Lifeline Connections	0 – just hired first care coordinator
Love Overwhelming	39
Lower Columbia CAP	51
Mason General	0 – still hiring care coordinator
Peninsula Community Health Svcs.	3 – agency elected to end participation in project area
Physicians of Southwest Washington	14
Sea Mar	131
Summit Pacific Medical Center	19
Youth and Family LINK	176

d. Systems the HUB lead entity is using to track and evaluate performance. Provide a list of the related measures.

The CPAA Community CarePort HUB utilizes the software platform developed by Care Coordination Systems (CCS). The Community CarePort HUB has developed eight quality assurance standards that are used to monitor compliance of participating CCAs:

- 1) Referrals are contacted within two business days of receipt from CarePort.
- 2) All clients must have a valid Release of Information uploaded into the software platform at all times.
- 3) Client Profile and Initial Checklist completed within the first two visits.
- 4) Patient Activation Measure (PAM) screening within 30 days of enrollment.
- 5) Each client receives no less than one face to face visit per month.
- 6) Active clients have valid “next visit date.”
- 7) Care coordinators fill their caseload within 6 months of completing training.
- 8) Care coordinators and supervisors attend all scheduled quality assurance meetings (monthly Community of Practice meetings and occasional site visits scheduled by Community CarePort).

The CCS platform allows a HUB to track and analyze data for any field in client records. Community CarePort has used this capability to provide quarterly reports to CCAs on additional performance data:

- 1) Average caseload number
- 2) Number of assessment checklists in the last month
- 3) Number of initial assessments in the last month
- 4) Average visits/average caseload
- 5) Number of Pathways started and completed in the last month
- 6) Total number of Pathways started and completed ever

7) Additional data about individual Pathways and screening tools

- e. **Success in hiring staff, a listing of open positions and efforts to fill those. Describe barriers or gaps that exist in retaining staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.**

CPAA has been successful in hiring and retaining the two staff positions it maintains for operating the Community CarePort HUB. Both staff members are the original hires reported in previous SARs.

Care Coordinators working within the Community CarePort HUB are employed independently by the Care Coordinating Agencies and are not funded directly by CPAA. Most CCAs have increased the number of staff serving Community CarePort clients since the initial launch in November 2018. By offering three full training sessions during the initial year of implementation, CCAs had multiple options throughout the year to onboard new staff. Additionally, the monthly quality assurance meeting provides ongoing support to CCA staff that helps them feel supported and ensures CPAA staff are engaged in their work. When CCAs have experienced staff turnover, CPAA provides individual onboarding training as needed.

While workforce shortages, staff hiring, and retention are on-going challenges in CPAA's predominantly rural region, Community CarePort staffing has not been an issue for the majority of CCAs. As noted above in this report, only one CCA has an open position and one recently filled an open position.

- f. **Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.**

During initial implementation of the project, CPAA contracted with CCS to provide in-depth training for over 40 care coordinators and supervisors. The course consisted of two full weeks of in-person classroom instruction with a multi-week supervised practicum period in-between the first and second week of instruction. Participants in the CCS curriculum were monitored and evaluated by course instructors throughout the training, and received certificates upon satisfactory completion of all course requirements and practicum hours. The CCS curriculum has been offered three times since 2018.

Community CarePort HUB continually monitors quality assurance and performance data via the CCS software platform. This is used to evaluate trends in performance of care coordinators and their agencies and to identify topics for re-training or new training. The HUB holds monthly in-person meetings to address training topics and quality assurance issues. The HUB also provides ongoing coaching to care coordinators and supervisors as individual and agency requests are received. Supervisors are encouraged to develop reflective supervision practices and are regularly coached on the importance of their role in supporting the ongoing growth and development of their team.

- g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.**

The **CCS software** was designed specifically for the Pathways Community HUB model and is accessible on most laptops or tablet devices with an internet connection. Care coordinators with multiple years of experience in this field report that the CCS platform is the best software they have ever used. Supervisors report that the software helps their staff reduce time spent documenting their work, keeps their notes and casework organized, and helps them be more productive in working with clients.

The CCS software ensures all care coordinators in our network collect information in a standardized format. Comprehensive initial assessment, regular check-ins, treatment of risk with standardized Pathways, and screening using evidence-based tools (e.g. Patient Health Questionnaire (PHQ -9), PAM 13, etc.), along with ongoing case notes, are documented in a client record. This data can be easily accessed and sent securely and electronically to other members of the client’s care team that are listed on their Release of Information form.

While the CCS platform has the capability through APIs to exchange data with other health information systems, such as the statewide health information exchange, this has not been prioritized by partners participating in this project. CPAA is open to pursuing statewide health information exchange at partners’ request.

- h. Include two examples of checklists or related documents developed for care coordinators.**

For examples of checklists or related documents developed for care coordinators, please refer to:

1. 2B Initial Assessment Form (Appendix W)
2. 2B Education Pathways How-To Guide (Appendix X)
3. 2B Pathway How-To All (Appendix Y)

The Initial Assessment Form is part of CCS. The Education Pathways How-To Guide and the Pathways How-To All were developed by the HUB team to help care coordinators more effectively work with clients.

- i) Project 2C: Provide a summary of activities that increase the availability of POLST forms across communities/agencies, where appropriate and when applicable based on the strategies the ACH has promoted. Describe activities that have been most successful as well as any continued challenges in increasing the availability of POLST forms, as applicable.**

Clinical partners participating in project 2C (Transitional Care) were **surveyed on their implementation of POLST forms in their clinic setting** (Appendix Z). All responses reported complete integration of the POLST form. CPAA was interested in who initiates POLST forms and how they are administered to clients. To understand the challenges and barriers to using the POLST form, CPAA asked, “What, if any, is

your greatest concern about the use of POLST forms in clinical practice?” Common responses included forms get lost, no concerns, or other, including education between POLST forms and Advance Directives and out dated copies.

As patient navigators are becoming more common in non-clinical settings, CPAA intends to gauge use and understanding of POLST forms in community-based organizations and increase the understanding and use of the form. CPAA will continue to provide TA services to organizations looking to increase the availability and utility of POLST forms.

ii) **Project 3A: Provide two examples of the following:**

(1) Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recovery supports.

Prevention

- **Grays Harbor Community Hospital and Mason General Hospital**, in collaboration with the University of Washington and Comagine Health, have entered into a partnership to implement a team-based approach to improving opioid management in primary care. Utilizing the Six Building Blocks (SBB) model, both sites are working with a quality improvement expert to implement an evidence-based, quality improvement roadmap to help primary care teams implement effective, guideline-driven care for their patients using long-term opioid therapy for chronic non-cancer pain. Through this 12-15-month coaching process, each clinic will identify an Opioid Improvement Team to lead this initiative, host a clinic-wide kickoff event, receive ongoing guidance and support regarding implementation of the SBB model, and learn from other teams and clinics participating in this work.
- **YWCA of Olympia** has worked closely with community partners and stakeholders to build out their Youth Circle curriculum. Youth Circle is an evidence-based program that uses the Girls Circle Model to improve the health and well-being of adolescents. By integrating harm reduction and prevention education into their curriculum, YWCA is able to meet youth where they are at and refer out, as appropriately, to community treatment and support providers who have been identified as culturally responsive.

Treatment

- The **Lewis County Sheriff's Department** implemented an opioid treatment medication program at their county jail through their Transformation project. The jail's Health Services Administrator partnered with Medtriq Treatment Services and the jail's medical contractor, NaphCare, to offer this program. Since March of 2019, when an individual enters Lewis County Jail, they are screened for opioid use disorder and offered access to the program. On average, the jail has between 15 and 20 individuals in the program, with approximately 130 graduates to date.
- **Summit Pacific Medical Center** opened a Medication Assisted Treatment (MAT) clinic for safe

and effective walk-in opioid and heroin treatment. Providers rotate from the wellness center to urgent care, where the clinic currently resides. This service is filling a significant gap in access to medications for opioid use disorder in Grays Harbor, the county with the highest opioid overdose rate in CPAA's region.

Overdose Prevention

- **Mason County Public Health** continues to spearhead county and community opioid and substance use response. Through their Transformation work, the Public Health Department secured and opened a mobile outreach site to expand individual outreach, distribute naloxone, exchange syringes, and provide community education and direct access to overdose prevention. From treatment opportunities to soft tissue infection and communicable disease prevention, the mobile outreach site has served as a valuable community resource to those accessing their services. At each visit, individuals are screened for overdose risk and provided with appropriate harm reduction interventions, including naloxone. On average, individuals utilizing mobile outreach services are exchanging for 4 people. To date, 101,356 syringes have been exchanged.
- Since June 2018, **Gather Church** in Centralia has served as a naloxone distribution point for the community. As explained by Cole Meckle, Gather's lead Pastor, "[Harm reduction] seeks to intervene in situations where people aren't necessarily wanting to make a change and reduce the impact on the individual and the community at large." Harm reduction can be a controversial concept, and it certainly has been in rural Lewis County. Meckle described a common attitude in a recent publication in the Lewis Chronicle, "They don't recognize that the bigger impact is not having somebody end up in the ER from frostbite. This cost of picking up a discarded blanket is extremely tiny in comparison, to the taxpayer, of having somebody show up in the ER."

Excitingly, **Gather Church** has expanded its harm reduction services to include a mobile outreach site. This mobile site became operable in November 2019 and offers harm reduction and overdose prevention supplies, including NARCAN®.

Recovery Supports

- Peer support is embedded in the team-based model of the **Olympia Bupe (buprenorphine) Clinic**. Peers are the first to greet patients utilizing the Olympia Bupe Clinic services. They serve as clinic anchors alongside the nurse care manager. Peers provide formal and informal counseling; however, the pay scale and reimbursement rate for peer counselors/recovery coaches is not reflective of the immense value they provide to team-based care.

The lead Peer at the **Olympia Bupe Clinic**, Tamara, said, "As a Peer, I am able to bridge the gap between a person coming into the clinic and seeing a provider." Before seeing a nurse or prescriber, patients are able to speak with a Peer, like Tamara, who truly knows where they are coming from and what they are going through.

- **Consejo Counseling and Referral Services** offers substance use prevention, drug and alcohol outpatient treatment, intensive outpatient treatment, recovery services, case management,

children and family services, and behavioral health treatment. Peer support is made available to patients at any point while accessing services. “We do our best to help clients feel welcome and feel like family,” Christine Boyer, Consejo’s Behavioral Health Administrative Manager explains. “We understand that wellness is only achieved when agencies act at teams to treat all the complex needs of each individual.” Peers help to bridge the gap between patients and providers.

(2) Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.

By **assigning a program manager to oversee all opioid-related programming** for the ACH, CPAA is able to participate in and monitor a number of local and state-level meetings, including those pertaining to the strategies outlined in the WA State Interagency Opioid Working Plan. This allows CPAA to stay abreast of any modifications to the plan or related clinical guidelines and incorporate those changes. For example, concerning strategy 1.2.3 (formerly noted under goal 1 strategy 1) of the Interagency Opioid Working Plan, the Centers for Disease Control and Prevention (CDC) released a statement in April 2019 advising against the misapplication of the CDC Guideline for Prescribing Opioids for Chronic Pain (CDC, 2016). Discussions at the Department of Health’s State Opioid Response Workgroup highlighted these new findings and implications for education efforts of providers.

Another practice used to monitor state-level modifications is through **continued collaboration with the agencies involved in the development and implementation of the Interagency Opioid Working Plan**. Through collaboration with such agencies, CPAA is able to engage with and support implementation of the strategies outlined in the Working Plan. Examples of CPAA’s collaborative efforts include:

- Hosting a series of Waiver trainings with the Department of Health (DOH), with CPAA offering logistical support and the physical training space and DOH providing reimbursement to the instructors for their time.
- Offering a series of training and technical assistance opportunities in collaboration with the University of Washington’s Alcohol and Drug Abuse Institute and AIMS center, including The Language of Stigma and Opioid Use Disorder and Methamphetamine: Polysubstance Use in Treatment.
- Partnering with tribal agencies in the region, such as Chehalis Tribal Behavioral Health Center, to integrate peer recovery counselors into their existing services.

In addition to these partnerships, CPAA seeks to reach and collaborate with other agencies to align with new policies, legislation, and partnerships in response to the opioid epidemic. For example, after HCA finalized their contract with AbbVie to eliminate hepatitis c virus (HCV) in WA, the Opioid Response Program Manager initiated a connection with AbbVie to offer learning opportunities about the prevalence of HCV in WA and the need for additional evaluation and treatment options (Appendix AA).

CPAA continues to work with AbbVie to raise awareness of the importance of screening and linkage to care.

- (3) A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.

CPAA leverages existing local opioid networks and meetings across the region, often serving as a standing agenda item and regional expert. County-based meetings include a variety of stakeholders, including law enforcement, fire departments, behavioral health treatment providers, community service organizations, tribes, criminal justice, primary care providers, syringe services, elected officials, the recovery community, and others.

County groups that regularly convene in the CPAA region include:

- The **Grays Harbor Opioid Consortium**, which meets monthly and has more frequently convening workgroups;
- The **Lewis County Opioid Task Force**, which meets on a quarterly basis;
- The **Mason County Opioid Stakeholder’s Meeting**, which meets bi-monthly;
 - **Moving Mason Forward**
- The **Thurston County Opioid Response Task Force**, which just shifted from bi-monthly to quarterly meetings with smaller workgroups frequently convening; and
- The **Pacific County Opioid Response Team**, which meets monthly and occasionally overlaps with the county’s Behavioral Health Subcommittee.

Stigma around both OUD and MAT, as well as availability/access to MAT, continue to be a challenge in the region. CPAA has successfully identified opportunities to mitigate these challenges with the support of regional partners and champions:

- CPAA convened the first regional **Medications for Opioid Use Disorder (MOUD) Provider Group** in November. The primary goal of this group is to increase access to medications for opioid use disorder and reduce stigma around MAT as the evidence-based best-practice for OUD. The group is headed by CPAA and supported by the WA Recovery Help Line and the Olympia Bupe Clinic, providing peer-to-peer learning opportunities and a peer-driven agenda. Active prescribers of medications for opioid use disorder wishing to offer or receive mentorship, and those who are interested in learning more about it, are invited to participate in this peer-led discussion group. Approximately 20 medical providers came to the table for the first meeting. The group will meet every other month to discuss a variety of topics related to treatment for opioid use disorder.

The lead peer at the Olympia Bupe Clinic, in advocating for this group, explained, “There are many barriers people face when trying to access treatment in our community. By learning about medications for opioid use disorder, community providers can directly help their patients into recovery.”

The next provider meeting will be in Q1 2020 at Thurston County Public Health and Social Services in Olympia. It will focus on workflows for prescribing medications for opioid use disorder in a variety of settings, including primary care, behavioral health care, hospitals, jails, and traditional and low-barrier substance use treatment centers.

- In an effort to expand access to medication treatment for opioid use disorder, CPAA is partnering with community providers to host **buprenorphine waiver trainings** across the region. Through this effort, CPAA provides physical training space, logistical support, oversight of course registration and organization, and recruiting participation of various provider types (e.g., MD, DO, ARNP, PA). The Department of Health has been a valuable partner offering trainer reimbursement when they are able to. Additionally, Lucinda Grande, MD, and Kari Lima, MD, have stepped in as local champions to lead these trainings.
- CPAA’s local **opioid and substance use disorder-focused workgroups** are led by community champions and leaders. With active and robust participation from local partners around the region, CPAA is able to leverage the work that is already happening in communities and respond to/address needs, challenges, and gaps in care that are identified in these local efforts.

(4) Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH’s planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

An important component of our regional opioid response program is supporting individuals to engage in treatment services and programs that support long-term recovery management.

Gap in Access/Availability: Identifying community-based providers of treatment and recovery services and those who are actively accepting clients.

CPAA’s Approach: CPAA secured additional funding through the Department of Labor to further the reach of the Washington Recovery Help Line. The WA Recovery Help Line is a 24-hour help line for substance use, problem gambling, and mental health, offering free and anonymous support and referrals to local treatment providers and community services. Through this partnership, the WA Recovery Help Line is building out their reach in the region to increase the availability of resources that can help families and individuals experiencing opioid and substance use disorders. A dedicated, full-time staff person at the WA Recovery Help Line liaises with regional providers and agencies to gather up-to-date service information and increase local utilization of the near real time directory. This approach increases awareness and connectivity with current provider locations.

The WA Recovery Helpline recently added four new search categories to the Medications for Opioid Use Disorder (MOUD) Locator. A client can now search for providers that offer hepatitis c treatment, syringe

exchange services, residential treatment programs that either allow patients to bring their medication with them or are able to prescribe medications for their patients, and Peer Support programs specific to individuals struggling with opioid use disorder. Often times people have multiple intersecting healthcare needs, and this integration will help ensure they find the clinic or program that best supports their individual recovery journey.

Gap in Access/Availability: Navigating the care system can be a challenge for individuals working to maintain long-term recovery from substance use disorders. Peer recovery counselors and peer support services offer person-centered, strength-based supports⁴ shown to help build the internal and external resources⁵ needed to begin and maintain recovery.

CPAA's Approach: Additional funds were secured to build the peer recovery counselor workforce in the region. As a result, CPAA/CHOICE piloted the first ever Certified Peer Counselor (CPC) trainings with a specific focus on peers who have been impacted by opioid use disorder. Through this effort, the number of certified peer counselors in the region increases at a fortuitous time, as the Medicaid (Title XIX) State Plan has been amended to include "Substance Use Peers" as a billable Medicaid Service. One training was hosted in Lewis County, one in Grays Harbor County, and a third will be hosted in Pacific County. To date, more than 60 newly certified peers have graduated from the program. This approach will increase the number of and location of CPCs working in the region.

To support this effort, CPAA is exploring strategies and partnerships to effectively operationalize peer support in the region by providing support and training to agencies on the best practices to integrate peers into clinical and non-clinical teams. Promising tools have been identified (e.g., Setting the Organizational Culture for Peers) and potential technical assistance providers identified (e.g., Washington State University's Peer Workforce Alliance). This approach will promote best practices for peer workforce development.

Gap in Access/Availability: A significant gap in recovery support has come to CPAA's attention through the Medicaid enrollment and suspension process for incarcerated individuals post-release. The 24-48-hour Medicaid reactivation timeframe poses major risk to participants of the Lewis County Sheriff's Office's new Medication Assisted Treatment (MAT) program. Individuals are at a significantly increased risk of overdose death post-release, and access to MAT substantially reduces this risk.

This is a high-need population with high rates of health care utilization and a gap in care that requires system-level changes. An estimated 80 percent of individuals released from prison in the United States each year experience a substance use disorder or chronic medical or psychiatric condition, and incarcerated individuals have 9 to 10 times the rate of HIV infection than the general population.

CPAA's Approach: CPAA has provided technical assistance to partners at the Lewis County Sheriff's Department to minimize the impact of the Medicaid enrollment and suspension process for individuals' post-release. CPAA provided training to the jail's Community Resource Specialist to become an on-site

⁴ <https://www.thersa.org/globalassets/pdfs/blogs/a4-recovery-capital-230710-v5.pdf>

⁵ <https://www.ncbi.nlm.nih.gov/pubmed/19016174>

Health Care Navigator, allowing for in-house, hands-on case management and the initiation of health care benefits immediately following program participants' release from the jail.

Additional activities to address this gap in care have included advocating for shorter Medicaid reactivation timeframes to the State Criminal Justice Workgroup, seeking training for pharmacists on retroactive billing processes, connecting the jail staff with similar programs, and linking the jail staff up with experts and peers such as the State Health and Values Strategies Program⁶ at Princeton University (i.e., Emerging Strategies for Connecting Justice-Involved Populations to Medicaid Coverage and Care⁷). As more jails begin screening for opioid use disorder and offering buprenorphine induction, it will be critical for the state to establish a process that allows individuals to reactivate Medicaid coverage immediately prior to and following their release from prison or jail.

This approach supports new and current jail-based providers to offer quality care, improve health outcomes, and reduce recidivism. This approach will influence other jail-based programs as they continue to expand across the state. The Lewis County Sheriff's Office has gained local and national attention⁸ for their MTP work, and have been eager and willing to share their experiences with other sites (e.g., Thurston County Jail) as they look toward offering MAT screening and induction.

iii) Project 3C: Provide the following:

Not applicable.

iv) Project 3D: Provide the following:

- (1) Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

For Project 3D (Chronic Disease Prevention and Control), CPAA is **ensuring integration of clinical and community-based strategies in project implementation by monitoring partner quarterly reporting** of milestones and standardized narrative questions. To help assess partners' challenges, lessons learned, gaps in care, and best practices, as well as find commonality among CPAA's project portfolio, CPAA Program Managers review partner quarterly reports together to identify common themes and cross-project connections/partnerships/linkages that could be facilitated to increase both individual project and broader MTP success.

As social determinates of health are becoming more incorporated into clinical health care settings, integration of clinical and community-based strategies is becoming increasingly essential as the focus shifts to whole person care. CPAA is in a strategic position to **recognize gaps in communications and facilitate cross-sector connections and clinical/community linkages**. Regional trainings and networking

⁶ <https://www.shvs.org/about/state-health-and-value-strategies/>

⁷ <https://vimeo.com/343437802>

⁸ <https://www.usnews.com/news/best-states/articles/2019-10-25/washington-jails-treat-inmates-opioid-addiction>

events are provided to introduce partners, facilitate working partnerships, and improve relationships. Additionally, CPAA coordinates and facilitates meetings between partners who share common target populations to reduce limited healthcare resources and ensure efforts aren't being duplicated.

Community and clinical partners are working together to share data sources of shared partner populations. Through the MTP, organizations have become creative in the way they partner and offer incentives to participants. For example, Chronic Disease Self-Management Classes and Diabetes Prevention Programs have had a difficult time getting full course participation. Through unique partners and referrals, community-based organizations are able to host the classes, provide additional health incentives (e.g., exercise classes), and refer participants back to clinical care through the tracking of clinical measures (i.e., blood sugar, weight). Measures are securely shared with providers, noted in their chart, and are available at follow-up appointments.

Additionally, clinical and community partners have worked together on communication by **co-branding 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 BB). Total team engagement increases program success and health of the participants.

Another way CPAA is supporting Chronic Disease Prevention partners overcome challenges is by **coordinating activities and TA with Comagine Health and the UW AIMS Center**. During this reporting period, Comagine and CPAA co-hosted Promoting Chronic Disease Management in Behavioral Health Settings webinar. Through the use of shared data platforms and tracking, data collection can expand to encompass whole person health.

(2) **Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).**

The Pathways Community HUB model is an approach to identifying and addressing health, social, and behavioral risk factors. In the CPAA region, community-based care coordination agencies (CCAs) are using care coordinators to assess these risk factors. Together, community-based organizations and clinical agencies are working with shared client populations to address whole-person care and assure the basic needs of clients are being met. "Pathways" are assigned to clients to complete with their care coordinator, beginning with action steps to resolve health needs defined by the client. Chronic Disease Management is one example of how the MTP project-areas overlap with the goal of helping people get and stay healthy.

Skill-building and education are some of the main focuses of the Pathways model. Education is an element of every meeting that a client and care coordinator have. Due to the nature of many Pathways referrals, Chronic Disease management, identification, and treatment are major components. Co-occurring chronic conditions is one of the three eligibility criteria to participate in Pathways. Education

can focus on medication management and adherence, making and keeping appointments, Chronic Disease Self-Management, and health testing including PHQ9 and PAM.

Care coordinators and agencies offering Chronic Disease Self-Management are looking to increase partnerships in the coming years. Five MTP Implementation Partners have selected **Chronic Disease Self-Management Education (CDSME)** as one of their interventions. CPAA is currently working to create a website to serve as a master regional resources. The website will empower self-enrollment and also act as an additional resource for care coordinators to share with their clients. **Warm hand-offs** have increased completion rates of CDSME programming around the country, and with the support of a care coordinator, CPAA anticipates this program will increase its success.

A second way the Chronic Disease project area and Pathways are working together is through direct referrals. One of the most notable partner successes includes the relationship between **Providence Clinic Nurse Care Manager and CPAA's CarePort Referral Coordinator**. At the end of each week, Nurse case managers make referrals to CPAA's CarePort. The most common requests include social needs interventions. Patients are unable to focus on their health care needs when basic needs such as housing, food, and safety are not being met. CPAA assists with this transition of care by connecting them to a Community CarePort care coordinator who can help connect them to community resources.

- b) 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.

One trending risk category across all project areas in the CPAA region 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, particularly in rural areas. 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). Intervention-specific trainings included 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. A motivational interviewing training series is scheduled to begin Quarter 1 2020, and there is already overwhelming interest from regional partners.

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-agency referrals are slow due to competing priorities. To mitigate this risk, as previously noted, CPAA is routinely providing regional trainings and networking events to introduce partners, facilitate working partnerships, and improve relationships. Based on partner feedback, CPAA is deliberately including opportunities for partners to share lessons-learned and best practices. A partner showcase Transformation Talks event, or T², is scheduled for Quarter 1 2020, giving MTP partners the opportunity to share their successes to discuss challenges with other partners from around the region. 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 both 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 CC). 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 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, implicit 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 developed 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. Additionally, CCAs far exceeded CPAA's 2019 client 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 additional CCAs in Cohort 2 came online during this reporting period, bringing the total number up to twelve. Furthermore, long-term sustainability for Community CarePort continues to be a challenge, and CPAA is exploring various options moving forward, post-MTP, to ensure the investments made in regional infrastructure to support regional care coordination continue for years to come.
- 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 Opioid Use Reduction and Recovery (OURL) Alliance to host additional regional Certified Peer Counselor training with an emphasis on substance use disorder (SUD). CPAA is also planning additional waiver trainings for providers (two trainings are scheduled for Q1 2020), as well as addressing stigma and provider discomfort with MAT through regional educational opportunities, which will build capacity around the region to meet demand (Appendix DD). 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. Already lessons-learned, like using the word “protect,” rather than “vaccinate” have shown to increase patient buy-in. Additionally, CPAA set 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., CDSME, 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. CPAA is encouraging these successful partners to become “provider champions” so other providers will use their successes as a model.

18. Pre- and post-project implementation example

- a) **Highlight a success story during the reporting period that was made possible due to DSRIP investments, including how DSRIP removed the barrier to implementation and lessons learned that the ACH has used to make modifications moving forward.**

While all CPAA MTP Implementation Partners are working hard and doing innovative, life-changing Transformation work that’s impacting lives around the region, the **Lewis County Sheriff’s Department (LCSD)** is a stand-out success. Using DSRIP investments, LCSD implemented an opioid treatment medication program at their county jail through their Transformation project. The jail’s Health Services Administrator partnered with Medtriq Treatment Services and the jail’s medical contractor, NaphCare, to offer this program. Since March 2019, when an individual enters Lewis County Jail, they are screened for opioid use disorder and offered access to the program. On average, the jail has between 15 and 20 individuals in the program, with approximately 130 graduates to date.

A significant barrier to recovery support is the 24-48-hour Medicaid reactivation timeframe that poses major risk to all Medicaid beneficiaries transitioning from incarceration. Individuals are at a significantly increased risk of overdose death post-release, and access to MAT substantially reduces this risk.

CPAA provided both DSRIP funding and technical assistance to partners at the Lewis County Sheriff’s Department to minimize the impact of the Medicaid enrollment and suspension process for individuals’ post-release. CPAA provided training to the jail’s Community Resource Specialist to become an on-site Health Care Navigator, allowing for in-house, hands-on case management and the initiation of health care benefits immediately following program participants’ release from the jail.

Additional activities to address this gap in care have included advocating for shorter Medicaid reactivation timeframes to the State Criminal Justice Workgroup, seeking training for pharmacists on

retroactive billing processes, connecting the jail staff with similar programs, and linking the jail staff up with experts and peers.

As previously noted, CPAA is especially proud of LCSD's work of reducing barriers to care and the national attention their program has received.

19. Regional integrated managed care implementation update

- a) For **2019 adopters**, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken, in partnership with providers and MCOs, to address these challenges?

Not applicable.

- b) 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.

During this reporting period, CPAA leadership continued to participate in the Great Rivers Integrated Care Leadership Committee and Early Warning System and Communication workgroups. All three of these groups are composed mostly of the same representatives from the five-county Great Rivers region as well as representatives from HCA and the MCOs. The Integrated Care Leadership Committee reviewed the charter and determined that deliverables are on track to being met. The Early Warning System is in place to identify and resolve any implementation issues after January 1, 2020. The Communications Workgroup ensured all the relevant stakeholders, primarily behavioral health agencies and Medicaid recipients, received Apple Health documents detailing the transition to IMC.

CPAA participated in the Thurston-Mason BHO's first Interlocal Leadership Structure (ILS) meeting in July 2019 and attended all subsequent ILS meetings during the reporting period. The ILS established a Joint Operating Committee to oversee development of the Early Warning System and other workgroups. During the reporting period, the group agreed that the Thurston-Mason region would participate in a combined Provider Readiness Workgroup with Great Rivers to minimize meeting duplication and improve efficiency. The ILS approved a charter and designated a separate Communications Workgroup, which also convened to develop an awareness campaign for Medicaid recipients.

CPAA formed and facilitated a monthly Provider Readiness Workgroup composed of both the Thurston-Mason and Great Rivers regions. The meetings focused largely on technical and operational topics such as claims testing, prior authorizations, billing configuration, provider rosters, and overall IMC readiness. The forum-style meetings provided a forum for providers to discuss

concerns and challenges as well as have ongoing questions answered by subject matter experts from MCOs and HCA. In between monthly meetings, CPAA regularly updated an IMC webpage, compiled questions in a tracker document, and coordinated communication between relevant stakeholder groups in support of the IMC Provider Readiness Workgroup.

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

CPAA worked closely with behavioral health agencies, MCOs, HCA, and BHOs on ensuring behavioral health provider readiness for IMC was prioritized in the region. Through the monthly Provider Readiness Workgroup, behavioral health providers had direct access to MCOs and HCA to address challenges, ask questions, and troubleshoot problems that arose when making infrastructure changes necessary for IMC.

One of the challenges identified by partners pertained to the financial cost of purchasing new electronic health records or modifying existing systems. In anticipation of this challenge, CPAA allocated funding to behavioral health partners to offset the technology cost of updating this crucial piece of infrastructure.

As previously reported, CPAA identified a need for technical assistance and contracted with Xpio Health to provide direct technical assistance to behavioral health partners through the end of January 2020. Xpio Health played an essential role in preparing agencies for the IMC transition by leading agencies through their own individualized and comprehensive work plans.

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
<p>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:</p> <ul style="list-style-type: none"> • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews 	X	

	Yes	No
<p>for the evaluation is voluntary.</p> <ul style="list-style-type: none"> 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. 		

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

Section 3. Value-based Payment

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 3, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2019).*

Narrative responses

21. Identification of providers struggling to implement practice transformation and move toward value-based care

- a) Describe methods the ACH uses to identify providers struggling to implement practice transformation and move toward value-based care and a general overview of activities the ACH conducted to support those providers. **Include one detailed example** of the ACH's efforts to support a provider to address the identified struggles, progress that was made, and lessons learned.

The most important method used to identify providers struggling to move toward value-based care was the process of **analyzing individual responses to HCA's annual VBP survey**. During the survey analysis, CPAA specifically targeted providers in need of outreach who showed low VBP readiness, low percentage of revenue in VBP arrangements, negative VBP experiences, and low expectations of increasing VBP contracts in the next year. As a VBP educator, the ACH's role as defined by HCA in the 2019 VBP Roadmap, CPAA used this survey analysis to send targeted VBP information to specific partners, including the updated VPB Roadmap, VBP Practice Transformation Guide, and Defining a Strategy for Value-Based Contracting. Additionally, CPAA made available Comagine Health, technical assistance partner, to offer tailored assistance for any partners interested in this service.

The second method focused on **regularly monitoring individual organization's Change Plans** developed by each CPAA partner. CPAA tracked completion of project milestones, which provided a general overview of progress in practice transformation. As organizations that were slow or failed to make progress were identified, CPAA Program Managers enhanced project support by scheduling partner meetings, sharing training resources, and offering technical assistance.

As outlined by HCA in the 2019 VBP Roadmap, CPAA's main function has been an educator as it relates to VBP. CPAA fulfilled this role by sharing educational resources, encouraging participation in the annual VBP survey, and incentivizing partners to expand adoption of value-based contracts.

One detailed example of CPAA's efforts to support a small provider to address identified struggles, progress made, and lessons learned is with a small, pediatric provider. CPAA worked with Pediatric-Transforming Clinical Practice Initiative (P-TCPI) to coordinate with the partner's VBP Champion. During monthly meetings, which included going over the VBP Practice Assessment Tool (PAT), CPAA helped the provider assess their readiness for VBP contracts. Lessons learned include EHR are

essential for VBP contracting, and providing peer-support for the VBP Champion increases confidence and success.

22. Support providers to implement strategies to move toward value-based care

- a) **Provide three examples** of how the ACH has supported providers to implement strategies to move toward value-based care, including provider type, provider needs, supportive activities, description of action plan, and key milestones that have been achieved. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

As outlined by HCA in the 2019 VBP Roadmap, CPAA's main function has been an educator as it relates to VBP; CPAA will continue to follow the state's lead if further action is required of the ACH to support partner's' move towards VBP. By adhering to the state's 2019 VBP Roadmap during this reporting period, **CPAA fulfill the defined role of the ACH as an educator by sharing educational resources, encouraging participation in the annual VBP survey, and incentivizing partners to expand adoption of value-based contracts.**

In an effort to implement VBP strategy, the following four milestones are outlined in CPAA's Work Plan (submitted as a separate document: CPAA.SAR4.Work Plan.1.31.20). These milestones apply to all CPAA partners, including providers with low VBP knowledge, small volume providers, and behavioral health providers:

1. Promote annual HCA VBP survey.
2. Develop and promote VBP preparedness educational materials for providers.
3. Facilitate communication between MCOs and regional partners on VBP strategies.
4. Promote alignment between DSRIP projects and regional VBP goals.

These are the key milestones CPAA completed to achieve the deliverables detailed in the 2019 VBP Roadmap:

- Identification of providers struggling to implement practice transformation and move toward value-based care.
- Support providers to implement strategies to move toward value-based care.

To complete the milestones and achieved the defined deliverables, CPAA sent the following to all partners, including providers with low VBP knowledge, small volume providers, and behavioral health providers:

- VBP Roadmap
- VBP for Pediatric Providers

- Defining a Strategy for Value-Based Contracting
- VBP Practice Transformation Planning Guide
- Healthier Washington / Medicaid Transformation VBP Toolkit

23. Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey

- a) **Provide three examples** of the ACH's efforts to support completion of the state's 2019 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

CPAA's efforts to support completion of the state's 2019 provider Paying for Value Survey during this reporting period included:

1. Provide \$500 to each partner organization that completes the 2019 HCA VBP Survey; this is a new tactic.
2. Post the 2019 HCA VBP Survey link to the CPAA webpage and on social media.
3. Include the 2019 HCA VBP Survey link in CPAA's monthly newsletters.
4. Individually email the 2019 HCA VBP Survey to all CPAA partners.

- b) **Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.**

CPAA analyzed individual responses from both the 2017 and 2018 HCA VBP surveys. During the survey analysis, CPAA specifically targeted providers in need of outreach who showed low VBP readiness, low percentage of revenue in VBP arrangements, negative VBP experiences, and low expectations of increasing VBP contracts in the next year. As an educator, CPAA used this survey analysis to send specific VBP information to partners including the updated VBP Roadmap, VBP Practice Transformation Guide, and Defining a Strategy for Value-Based Contracting. Additionally, CPAA made available our technical assistance partner, Comagine Health, to offer tailored assistance for any partners interested in this service.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

24.P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.⁹ Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to 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 affiliated with Project 2A and 3A. 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 sheets.](#)
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under “ACH pay for reporting metrics.”
- The value of the P4R metric information to HCA is to track progress by primary care, behavioral health and community-based organizations in implementing changes that advance clinical integration and strengthen statewide opioid response. Reporting may evolve over time to ask ACHs to generate reports or increase the participation among providers as needed to track progress on Projects 2a and 3a.

Instructions:

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

Format:

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

Submit P4R metric information.

Please see CPAA.SAR4.P4P Metric Reporting.1.31.20.

⁹ 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>

Appendixes

Financial Executor Payment Portal Dashboard Report
Data was extracted through the reporting period of November 30, 2019

PROJECT DESCRIPTION	Total	Greater Columbia									
		Better Health Together	Cascade Pacific Action Alliance	Accountable Community of Health	HealthierHere	North Central Accountable Community of Health	North Sound Accountable Community of Health	Olympic Community of Health	Pierce County Accountable Community of Health	SWACH	IHCP-Specific Projects
Funds Earned by ACH											
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$ 182,487,453.88	\$ 20,675,302.48	\$ 14,768,071.96	\$ 30,468,869.27	\$ 47,879,649.35	\$ 6,741,947.96	\$ 18,607,771.31	\$ 7,633,956.79	\$ 22,554,873.84	\$ 13,157,010.92	
2B: Community-Based Care Coordination	\$ 66,347,175.55	\$ 14,214,271.60	\$ 10,153,051.57			\$ 4,635,087.48	\$ 12,792,842.14		\$ 15,506,476.74	\$ 9,045,446.02	
2C: Transitional Care	\$ 48,126,938.26		\$ 5,999,530.25	\$ 12,377,977.13	\$ 19,451,107.35	\$ 2,738,914.88	\$ 7,559,408.65				
2D: Diversion Interventions	\$ 13,399,620.08					\$ 2,738,914.88	\$ 7,559,408.65	\$ 3,101,296.55			
3A: Addressing the Opioid Use Public Health Crisis	\$ 22,810,937.50	\$ 2,584,414.29	\$ 1,846,009.92	\$ 3,808,608.27	\$ 5,984,956.57	\$ 842,744.27	\$ 2,325,972.66	\$ 954,245.02	\$ 2,819,360.31	\$ 1,644,626.19	
3B: Reproductive and Maternal/Child Health	\$ 6,407,782.25		\$ 2,307,512.40				\$ 2,907,464.33	\$ 1,192,805.52			
3C: Access to Oral Health Services	\$ 2,460,161.51						\$ 1,744,477.00	\$ 715,684.51			
3D: Chronic Disease Prevention and Control	\$ 45,621,861.99	\$ 5,168,824.58	\$ 3,692,016.84	\$ 7,617,216.54	\$ 11,969,912.13	\$ 1,685,486.54	\$ 4,651,943.32	\$ 1,908,490.03	\$ 5,638,719.64	\$ 3,289,252.37	
Behavioral Health Integration Incentives	\$ 68,111,492.00	\$ 8,301,872.00	\$ 8,301,872.00	\$ 10,183,916.00	\$ 14,888,792.00	\$ 5,781,980.00	\$ 10,831,088.00		\$ 9,321,788.00	\$ 8,802,056.00	
Value-Based Payment (VBP) Incentives	\$ 2,700,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	
IHCP-Specific Projects	\$ 12,841,500.00										\$ 12,841,500.00
Bonus pool/High Performance Pool	\$ 6,308,649.00		\$ 1,455,842.00			\$ 1,455,842.00	\$ 1,941,123.00	\$ 1,455,842.00			
Interest accrual	\$ 509,175.81	\$ 55,269.99	\$ 22,872.04	\$ 83,285.95	\$ 154,084.68		\$ 35,032.04	\$ 48,228.11	\$ 7,261.81	\$ 50,854.99	\$ 52,286.21
TOTAL FUNDS EARNED	\$ 478,132,747.83	\$ 51,299,954.94	\$ 40,544,906.98	\$ 64,839,873.16	\$ 100,628,502.08	\$ 26,955,950.05	\$ 71,269,727.17	\$ 17,269,582.23	\$ 56,192,073.52	\$ 36,290,677.71	\$ 12,841,500.00
Funds Distributed by ACH											
Administration	\$ 16,432,565.38	\$ 1,464,657.22	\$ 335,891.00	\$ 1,556,500.00	\$ 6,117,865.95		\$ 4,707,454.42	\$ 14,081.37	\$ 1,400,000.00	\$ 836,115.42	
Community Health Fund	\$ 13,357,865.29	\$ 2,929,314.40	\$ 2,358,557.00	\$ 1,395,201.87			\$ 4,651,875.36		\$ 1,500,000.00	\$ 522,916.66	
Health Systems and Community Capacity Building	\$ 25,737,024.23	\$ 5,217,701.00	\$ 1,286,788.41	\$ 2,510,921.17	\$ 370,090.34	\$ 1,381,966.69	\$ 8,141,735.79	\$ 110,000.00	\$ 4,816,733.00	\$ 1,351,087.83	\$ 550,000.00
Integration Incentives	\$ 19,235,935.47	\$ 2,930,000.00		\$ 6,200,267.14	\$ 4,662,993.67	\$ 58,421.66	\$ 553,320.00		\$ 4,745,933.00	\$ 85,000.00	
Project Management	\$ 4,460,089.82		\$ 1,903,385.00	\$ 890,500.00		\$ 557,063.86	\$ 889,245.43	\$ 196,000.00		\$ 23,895.53	
Provider Engagement, Participation and Implementation	\$ 73,326,596.43	\$ 7,860,717.00	\$ 7,551,736.00	\$ 6,008,552.00	\$ 11,565,603.00	\$ 2,684,372.49	\$ 15,132,210.00	\$ 5,968,867.01	\$ 3,795,200.00	\$ 1,465,198.93	\$ 11,294,140.00
Provider Performance and Quality Incentives	\$ 20,379,275.21		\$ 4,641,774.00	\$ 1,356,473.00	\$ 1,663,416.67	\$ 1,373,481.74			\$ 7,405,952.80	\$ 3,938,177.00	
Reserve / Contingency Fund	\$ 2,404,473.07		\$ 1,474,098.00				\$ 930,375.07				
Shared Domain 1 Incentives	\$ 87,005,581.00	\$ 9,570,613.50	\$ 8,700,558.00	\$ 12,180,782.00	\$ 19,141,228.50	\$ 4,350,278.00	\$ 13,050,837.50	\$ 3,480,224.00	\$ 10,440,668.50	\$ 6,090,391.00	
TOTAL FUNDS DISTRIBUTED BY ACH	\$ 262,339,405.90	\$ 29,973,003.12	\$ 28,252,787.41	\$ 32,099,197.18	\$ 43,521,198.13	\$ 10,405,584.44	\$ 48,057,053.57	\$ 9,769,172.38	\$ 34,104,487.30	\$ 14,312,782.37	\$ 11,844,140.00
Funds Available											
Total Funds Distributed to Date	\$ 262,339,405.90	\$ 29,973,003.12	\$ 28,252,787.41	\$ 32,099,197.18	\$ 43,521,198.13	\$ 10,405,584.44	\$ 48,057,053.57	\$ 9,769,172.38	\$ 34,104,487.30	\$ 14,312,782.37	\$ 11,844,140.00
Total Funds Available for Distribution	\$ 215,676,437.41	\$ 21,315,717.68	\$ 12,287,196.94	\$ 32,721,359.41	\$ 57,070,600.79	\$ 16,542,445.12	\$ 23,200,749.00	\$ 7,498,728.50	\$ 22,076,171.42	\$ 21,966,108.56	\$ 997,360.00
% OF TOTAL FUNDS DISTRIBUTED	54.87%	58.43%	69.68%	49.51%	43.25%	38.60%	67.43%	56.57%	60.69%	39.44%	90.81%
% of Total Funds Distributed by ACH											
Administration	6.26 %	4.89 %	1.19 %	4.85 %	14.06 %		9.80 %	0.14 %	4.11 %	5.84 %	
Community Health Fund	5.09 %	9.77 %	8.35 %	4.35 %			9.68 %		4.40 %	3.65 %	
Health Systems and Community Capacity Building	9.81 %	17.41 %	4.55 %	7.82 %	0.85 %	13.28 %	16.94 %	1.13 %	14.12 %	9.44 %	4.64 %
Integration Incentives	7.33 %	9.78 %		19.32 %	10.71 %	0.56 %	1.15 %		13.92 %	0.59 %	
Project Management	1.70 %		6.74 %	2.77 %		5.35 %	1.85 %	2.01 %		0.17 %	
Provider Engagement, Participation and Implementation	27.95 %	26.23 %	26.73 %	18.72 %	26.57 %	25.80 %	31.49 %	61.10 %	11.13 %	10.24 %	95.36 %
Provider Performance and Quality Incentives	7.77 %		16.43 %	4.23 %	3.82 %	13.20 %			21.72 %	27.52 %	
Reserve / Contingency Fund	0.92 %		5.22 %				1.94 %				
Shared Domain 1 Incentives	33.17 %	31.93 %	30.80 %	37.95 %	43.98 %	41.81 %	27.16 %	35.62 %	30.61 %	42.55 %	
TOTAL	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %

PROPOSED MTP Year 3-5 Funds Allocation REVISED 12/2/2019

Use Category	Action	Incentives Paid after Transformation													
		Yr 1 %	Yr 1	Yr 2 %	Yr 2	Yr 3 %	Yr 3	Yr 4 %	Year 4	Yr 5 %	Year 5	Yr 6 %	Year 6	Yr 7 %	Year 7
Project Management/Administration	Hold	10%	\$ 1,175,894	6%	\$ 1,063,382	0%		0%		0%	\$ -	0%	\$ -	0%	\$ -
Reserve/Contingency	Hold	5%	\$ 587,947	5%	\$ 886,151	5%	\$ 416,813	5%	\$ 247,150	5%	\$ 114,866	0%	\$ -	0%	\$ -
Regional Wellness Fund	Hold	8%	\$ 940,715	8%	\$ 1,417,842	8%	\$ 666,900	8%	\$ 395,440	8%	\$ 183,785	8%	\$ 138,404	8%	\$ 111,279
Capacity Development Fund ₁	Disburse	3%	\$ 335,179	3%	\$ 531,691	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -
Health Systems & Community Capacity (D1)	Invest	28%	\$ 3,285,272	4%	\$ 708,921	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -
Health Systems & Community Capacity (Tribes)	Disburse	3%	\$ 352,768	3%	\$ 531,691	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -
Provider Engagement	Disburse	32%	\$ 3,787,683	25%	\$ 4,430,756	30%	\$ 2,500,875	30%	\$ 1,482,900	30%	\$ 689,194	30%	\$ 519,015	30%	\$ 417,296
Provider Engagement (Tribes)	Disburse	3%	\$ 352,768	3%	\$ 531,691	6%	\$ 500,175	6%	\$ 296,580	6%	\$ 137,839	6%	\$ 103,803	6%	\$ 83,459
Provider Performance	Disburse	8%	\$ 940,715	25%	\$ 4,430,756	51%	\$ 4,251,488	51%	\$ 2,520,930	51%	\$ 1,171,629	56%	\$ 968,828	56%	\$ 778,953
Provider Performance - Pathways Outcome Payments	Disburse	0%	\$ -	5%	\$ 840,352	\$ -		\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Provider Performance - Pathways Outcome Payments	Defer	0%	\$ -	13%	\$ 2,349,792	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -	0%	\$ -
Grand Totals			\$ 11,758,942		\$ 17,723,025	100%	\$ 8,336,250	100%	\$ 4,943,000		\$ 2,297,313		\$ 1,730,050		\$ 1,390,988

CPAA Funds Yr 1	\$ 11,758,942
CPAA Funds Yr 2	\$ 17,723,025
CPAA Funds Yr 3	\$ 8,336,250
CPAA Funds Yr 4	\$ 4,943,000
CPAA Funds Yr 5	\$ 2,297,313
CPAA Funds Yr 6	\$ 1,730,050
CPAA Funds Yr 7	\$ 1,390,988
	<u>\$ 48,179,567</u>

	2019	2020	2021	2022	2023
DY 3 Projected					
DY 4 Projected					
DY 5 Projected					
Projected Funding Available	\$ 11,115,000	\$ 9,886,000	\$ 5,299,000		
% Withheld for P4P	\$ (2,778,750)	\$ (4,943,000)	\$ (3,974,250)		
	\$ 8,336,250	\$ 4,943,000	\$ 1,324,750		
		DY3 P4P	DY4 P4P	DY5 P4P	
P4P @ 70%		\$ 1,945,125	\$ 3,460,100	\$ 2,781,975	
At-Risk@50%		\$ (972,563)	\$ (1,730,050)	\$ (1,390,988)	
		\$ 972,563	\$ 1,730,050	\$ 1,390,988	
Total by Year	\$ 8,336,250	\$ 4,943,000	\$ 2,297,313	\$ 1,730,050	\$ 1,390,988

Non-Tribal Provider Engagement

A. Basic Engagement	93%	\$ 3,518,530	92%	\$ 4,091,821	100%	\$ 2,500,875	100%	\$ 1,482,900	100%	\$ 689,194	100%	\$ 519,015	100%	\$ 417,296
Base Payments	45%	\$ 1,587,457	45%	\$ 1,846,109	65%	\$ 1,625,569	65%	\$ 963,885	65%	\$ 447,976	65%	\$ 337,360	65%	\$ 271,243
Bonus Pools:														
Attribution	18%	\$ 634,983	18%	\$ 738,444										
Equity	10%	\$ 352,768	10%	\$ 410,246										
Rural	7%	\$ 246,938	7%	\$ 287,173										
Multi-Project	15%	\$ 520,000	15%	\$ 604,726	30%	\$ 750,263	30%	\$ 444,870	30%	\$ 206,758	30%	\$ 155,705	30%	\$ 125,189
B. Community Forums₁	5%	\$ 176,384	5%	\$ 205,123	5%	\$ 125,044	5%	\$ 74,145	5%	\$ 34,460	5%	\$ 25,951	5%	\$ 20,865
C. Networks of Transformation (Formerly Centers)	8%	\$ 269,152	8%	\$ 338,933										
Total Engagement		\$ 3,787,682		\$ 4,430,756		\$ 2,500,875		\$ 1,482,900		\$ 689,194		\$ 519,015		\$ 417,296

Provider Performance

Outcome Based Payments (Pathways)				\$ 1,083,713	\$ 642,950	\$ 298,651
Quarterly Reporting - Total				\$ 3,167,775	\$ 1,877,980	\$ 872,978
*P4P Equity Bonus Pool (If Approved)						
Subsequent Performance Payments (2022-2023)					\$ 968,828	\$ 778,953



CPAA Funds Yr 1	\$ 11,758,942
CPAA Funds Yr 2	\$ 17,723,025
CPAA Funds Yr 3	\$ 8,336,250
CPAA Funds Yr 4	\$ 4,943,000
CPAA Funds Yr 5	\$ 2,297,313
CPAA Funds Yr 6	\$ 1,730,050
CPAA Funds Yr 7	\$ 1,390,988
	<u>\$ 48,179,567</u>

	2019	2020	2021	2022	2023
	DY 3 Projected	DY 4 Projected	DY 5 Projected		
Projected Funding Available	\$ 11,115,000	\$ 9,886,000	\$ 5,299,000		
% Withheld for P4P	\$ (2,778,750)	\$ (4,943,000)	\$ (3,974,250)		
	\$ 8,336,250	\$ 4,943,000	\$ 1,324,750		
			DY3 P4P	DY4 P4P	DY5 P4P
P4P @ 70%			\$ 1,945,125	\$ 3,460,100	\$ 2,781,975
At-Risk@50%			\$ (972,563)	\$ (1,730,050)	\$ (1,390,988)
			\$ 972,563	\$ 1,730,050	\$ 1,390,988
Total by Year	\$ 8,336,250	\$ 4,943,000	\$ 2,297,313	\$ 1,730,050	\$ 1,390,988

Breakout Session: Tribal Sovereignty and Indian Health Care Delivery

Cascade Pacific Action Alliance

December 12, 2019



Who am I?

- ▶ My name is Lena Nachand.
- ▶ I am non-Native.
- ▶ I have been working in the space of Medicaid Transformation since 2014.
- ▶ My current title is Tribal Liaison – Medicaid Transformation.
 - ▶ This is my third position in this realm.
 - ▶ I often say, “If only I knew then what I know now...”

Jessie Dean, me and Vicki Lowe on the land of the Makah Tribe



Part I

Objectives

Objectives

Increase General Understanding of:	Foster Foundation for:
Tribal governments and Tribal sovereignty	More effective collaboration between tribes and non-tribal organizations
Health disparities, historical and intergenerational trauma and resiliency	Spread awareness and increased utilization of trauma-informed care
Indian health care delivery	Strategies for care coordination across health care providers

Part II

Tribal Sovereignty, Treaties and Inter-Governmental Relations, and Special Trust Responsibility

Tribal Sovereignty

Recognized by U.S. Supreme Court in 1832

“The Indian nations had always been considered as distinct, independent, political communities, retaining their original natural rights, as the undisputed possessors of the soil, from time immemorial...”

Worcester v. Georgia, 31 U.S. 515, 559 (1832)

Treaties Included as Supreme Law of the Land

“This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.”

- Article VI of the U.S. Constitution

Treaties Signed with Tribes in Washington State

Treaty of Medicine Creek (1854)

Nisqually, Puyallup, Squaxin Island, Steilacoom, S'Homamish, Stehchass, others
 Reservation, fishing, hunting, pasturing (stallions for breeding only), **health care**

Treaty of Point No Point (1855)

Jamestown S'Klallam, Port Gamble S'Klallam, Lower Elwha Klallam, Skokomish, others
 Reservation, fishing, hunting, **health care**

Treaty with the Yakama (1855)

Yakama, Palouse, Piquouse, Wenatshapam, Klikatat, Klinquit, Kow-was-say-ee, others
 Reservation with schools and fishery, fishing, hunting, pasturing, **health care**

Treaty with the Nez Perce (1856)

Nez Perce
 Reservation with schools, fishing, hunting, pasturing, **health care**

Treaty of Point Elliott (1855)

Lummi, Suquamish, Tulalip (Snohomish, Skykomish, others), Swinomish, Snoqualmie, Skagit, Duwamish, others
 Reservations, fishing, hunting, **health care**

Treaty of Neah Bay (1855)

Makah
 Reservation, fishing, whaling, sealing, hunting, **health care**

Treaty of Walla Walla (1855)

Umatilla, Walla Walla, Cayuses
 Reservation, fishing, hunting, pasturing, **health care**

Quinault Treaty (1856)

Quinault, Quileute
 Reservation, fishing, hunting, pasturing horses (stallions for breeding), **health care**

All treaties were signed under duress and most involved relocation.

Inter-Governmental Relations



Governments



Stakeholders



Special Trust Responsibility and Health Care

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

1. to ensure the **highest possible health status** for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. to **raise the health status** of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. to **ensure maximum Indian participation in the direction of health care services** so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. to **increase the proportion of all degrees** in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. to require that all actions under this chapter shall be carried out with **active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations**, to implement this chapter and the national policy of Indian self-determination;
6. to ensure that the United States and Indian tribes work in a **government-to-government relationship** to ensure quality health care for all tribal members; and
7. to provide **funding for programs and facilities operated by Indian tribes and tribal organizations** in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

- 25 U.S. Code §1602

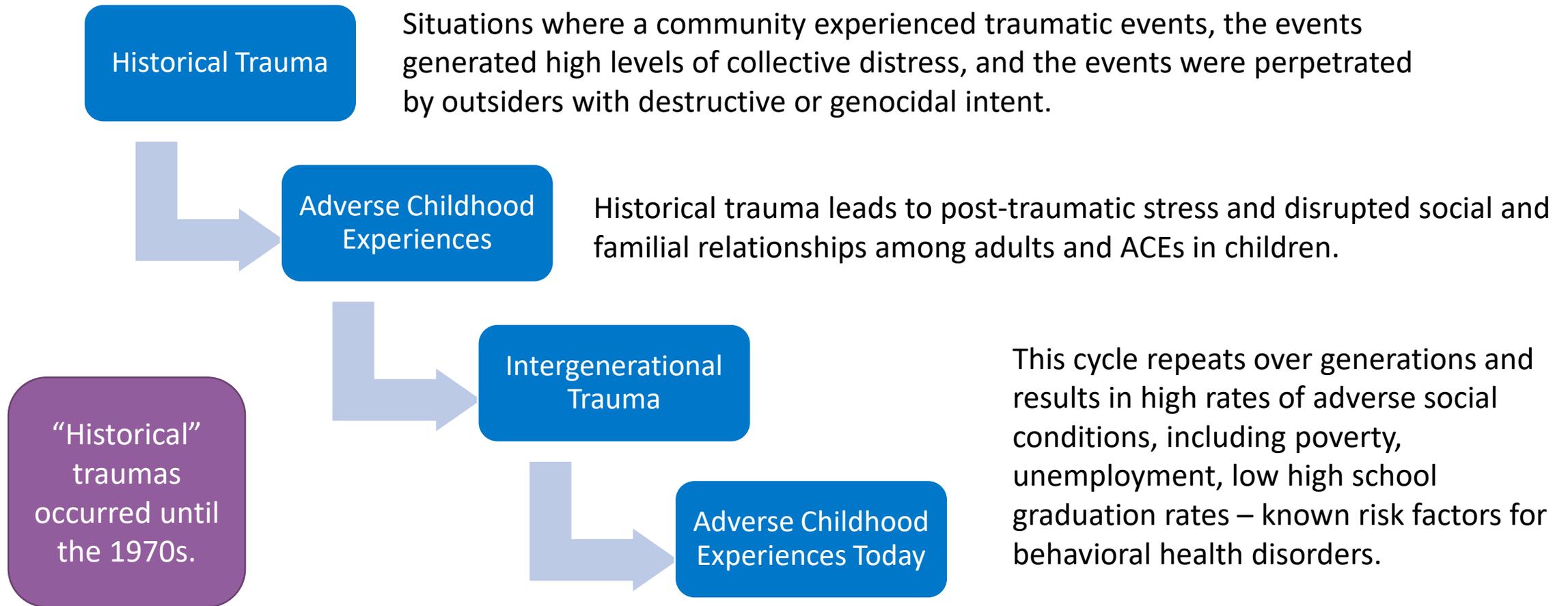
Part III

Health Disparities, Related History and Resiliency

AI/AN Have Highest Prevalence for

- ▶ Smoking
- ▶ Obesity
- ▶ Disabilities
- ▶ Drug induced deaths
- ▶ Infant mortality
- ▶ Coronary heart disease
- ▶ Adult tooth loss
- ▶ Asthma
- ▶ Colorectal cancer
- ▶ Diabetes
- ▶ Stroke
- ▶ Suicide
- ▶ Alcohol and abuse disorders
- ▶ Poor mental health

Historical Trauma and Adverse Childhood Experiences



Tribal Reservations and “Checkerboarding”

Dawes Act (1887) abolished group title and allotted Tribal reservations into 80 or 160 acre parcels per Tribal household. Excess lands were sold to non-Indians.

- ▶ 65% of traditional land base lost – not enough to support Tribal hunting and gathering

INDIAN LAND FOR SALE

GET A HOME
OF
YOUR OWN
*
EASY PAYMENTS



PERFECT TITLE
*
POSSESSION
WITHIN
THIRTY DAYS

FINE LANDS IN THE WEST

IRRIGATED GRAZING AGRICULTURAL
IRRIGABLE DRY FARMING

IN 1910 THE DEPARTMENT OF THE INTERIOR SOLD UNDER SEALED BIDS ALLOTTED INDIAN LAND AS FOLLOWS:

Location.	Acres.	Average Price per Acre.	Location.	Acres.	Average Price per Acre.
Colorado	5,211.21	\$7.27	Oklahoma	34,664.00	\$19.14
Idaho	17,013.00	24.85	Oregon	1,020.00	15.43
Kansas	1,684.50	33.45	South Dakota	120,445.00	16.53
Montana	11,034.00	9.86	Washington	4,879.00	41.37
Nebraska	5,641.00	36.65	Wisconsin	1,069.00	17.00
North Dakota	22,610.70	9.93	Wyoming	865.00	20.64

FOR THE YEAR 1911 IT IS ESTIMATED THAT 350,000 ACRES WILL BE OFFERED FOR SALE

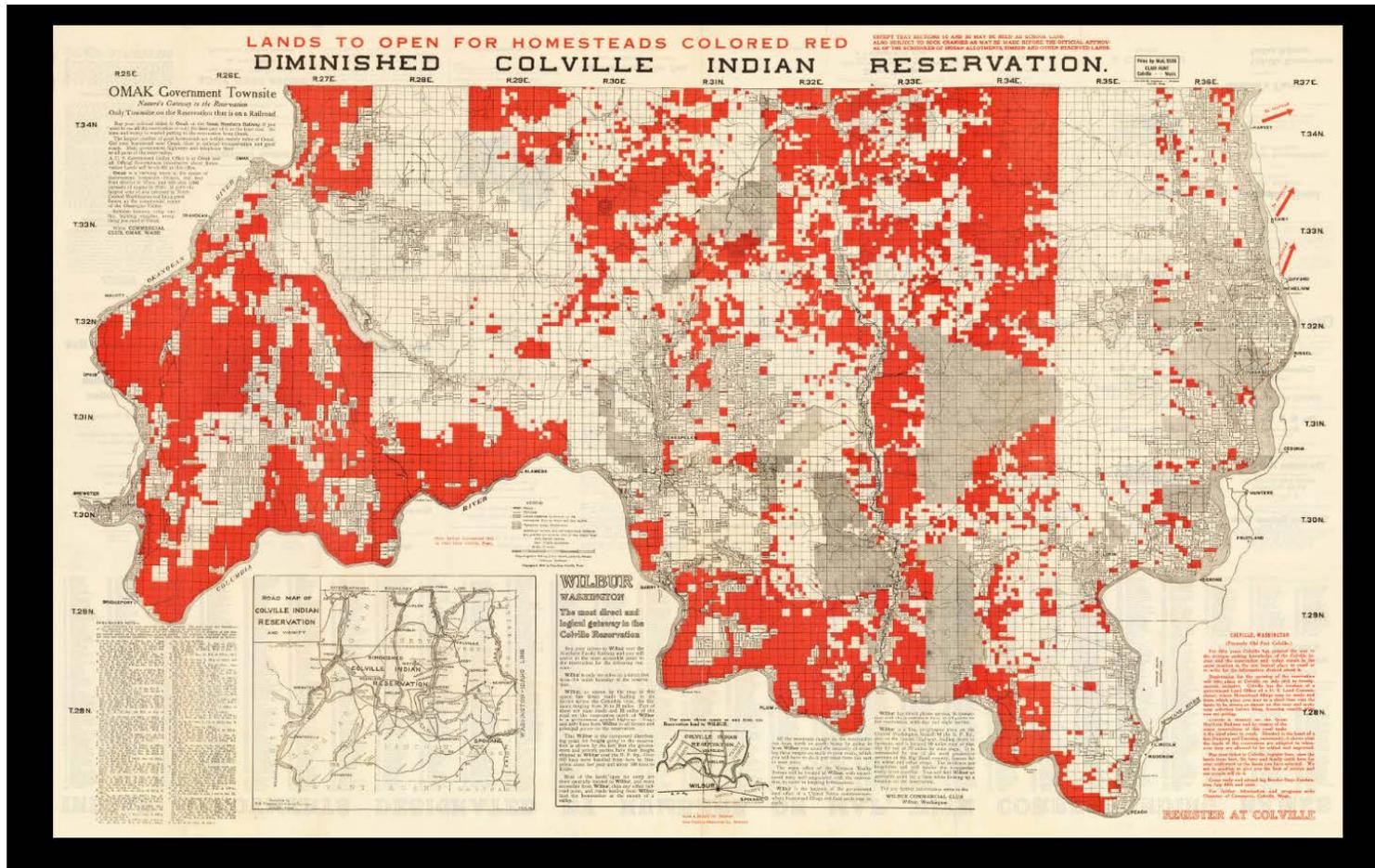
For information as to the character of the land write for booklet, "INDIAN LANDS FOR SALE," to the Superintendent U. S. Indian School at any one of the following places:

CALIFORNIA: Boopa. COLORADO: Ignacio. IDAHO: Lapwai. KANSAS: Macy. Borton. Nadeau.	MINNESOTA: Ojigum. MONTANA: Crow Agency. NEBRASKA: Macy. Santee. Winnebago.	NORTH DAKOTA: Fort Totten. Fort Yates. OKLAHOMA: Anadarko. Cantonment. Colony. Darlington. Muskogee. Pawnee.	OKLAHOMA—Con. Saw and Fox Agency. Shawnee. Wyanadette. OREGON: Klamath Agency. Pendleton. Roseburg. Siletz.	SOUTH DAKOTA: Claymont Agency. Crow Creek. Greenwood. Lower Brule. Fine Ridge. Rosebud. Sisseton.	WASHINGTON: Fort Simcoe. Fort Spokane. Tekon. Tulalip. WISCONSIN: Rosebud. Onaida.
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WALTER L. FISHER,
Secretary of the Interior.

ROBERT G. VALENTINE,
Commissioner of Indian Affairs.

“Checkerboarding” and the Colville Reservation



Clair Hunt's Map of the South Half or Diminished Colville Indian Reservation. [Map side.] (1916)

Accessed at:

<https://content.libraries.wsu.edu/digital/collection/maps/id/1112/>

100 Years of Boarding Schools (1870s – 1970s)

Children of all ages were taken from families by force and placed in boarding schools where they were stripped of their native clothing, punished for speaking their native languages, and often subject to abuse of all kinds.

- ▶ Multi-generational harm
- ▶ Prevented passing on cultural protective factors
- ▶ Legacy of distrust of outsiders
- ▶ Need for care informed by intergenerational trauma



Resiliency and Protective Factors

- ▶ Attachment and Belonging: relationships with caring, competent people
- ▶ Community, Culture and Spirituality: Foster thriving communities
- ▶ Community Capacity Development: Leadership Expansion, Coming Together, Shared Learning, Results-Oriented Decisions
- ▶ Sanctuary Model: Dr. Sandra Bloom-4 interrelated dimensions for safety
 - ▶ Physical – Psychological – Social - Moral safety
- ▶ The Scientist in the Crib: Patricia Kuhl, Ph.D.

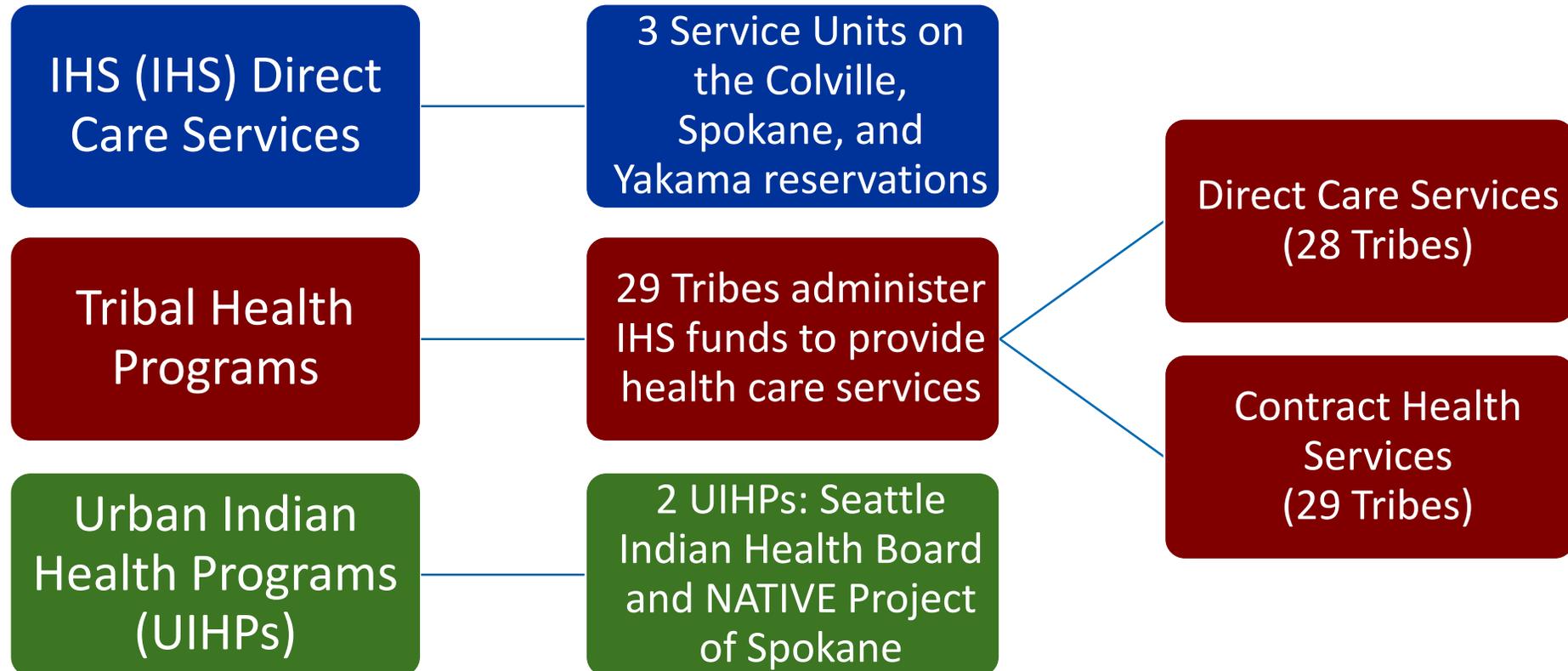
Protective Factors in Native Ways of Thinking

- ▶ Generosity as a symbol of wealth, assuring that contributing members of the community are honoring and caring for each other, or Wealth is determined by what you give, not receive or acquire.
- ▶ The importance of striving to live in balance so all our needs get the attention they deserve.
- ▶ Our relationships and recognition we are connected to each other and all things.

Part IV

Indian Health Care

Three Types of Indian Health Care Providers



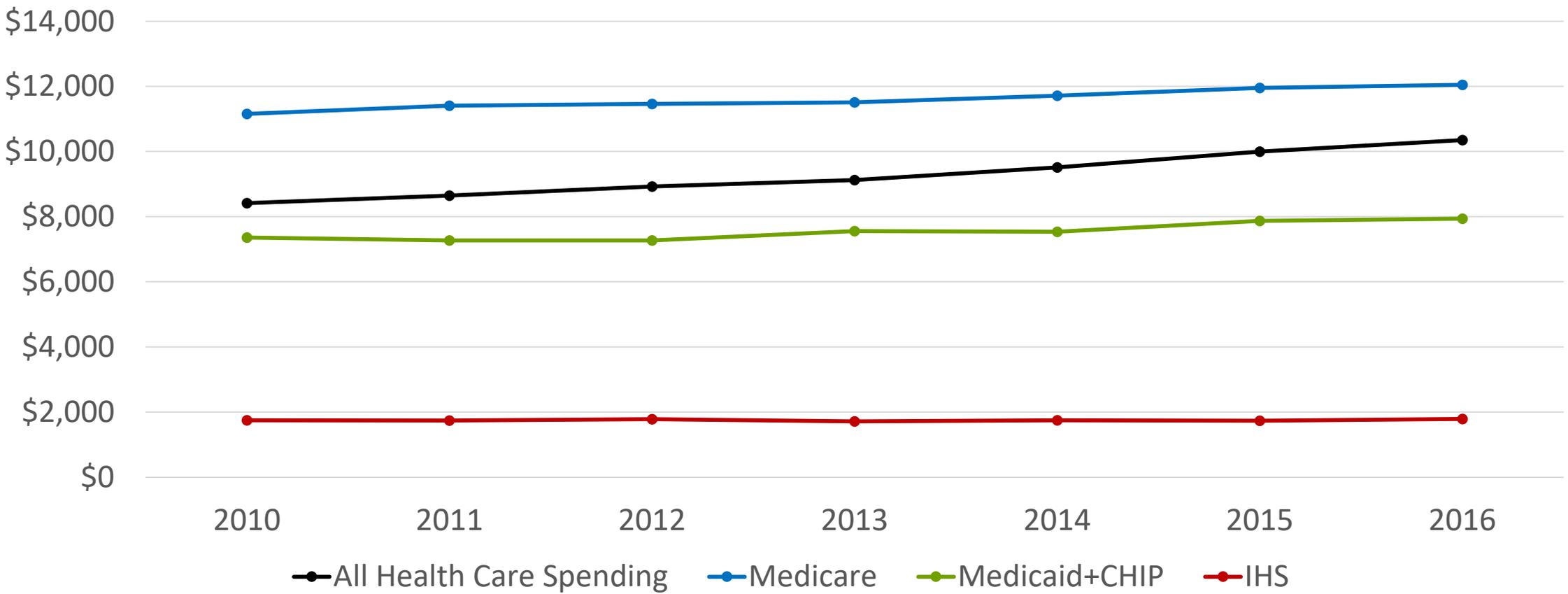
Indian Health Service (IHS)

- ▶ Federal agency in the Department of Health and Human Services.
- ▶ Coordinates and oversees funding of health care for AI/AN through IHS Service Units, tribally administered programs, and urban Indian health programs.
- ▶ IHS eligibility is based on AI/AN descendency or marriage to AI/AN.
- ▶ Three Service Units in Washington State
 - ▶ Colville Service Unit (1 facility in Nespelem, 1 facility in Omak)
 - ▶ Wellpinit Service Unit (on Spokane reservation)
 - ▶ Yakama Service Unit

Tribal Health Programs

- ▶ Tribe enters into a contract or compact with the IHS agency.
- ▶ Tribe takes responsibility to comply with various federal requirements that are attached to IHS funding.
- ▶ Tribe is audited by U.S. Office of the Inspector General.
- ▶ Tribe determines eligibility requirements; some tribal health programs serve everyone in the community, others serve only tribal members.
- ▶ Direct Care: 27 tribes
- ▶ Purchased and Referred Care: 29 tribes

National Health Care Spending Per Capita



Source: Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Accounts (NHEA) and the Department of Health and Human Services (DHHS) Budgets in Brief.

Indian Health Care = Patient Centered Care

- ▶ Goal is to preserve, support, enhance Indian health care and improve coordination with non-Indian health care
- ▶ Why?
 - ▶ Science/evidence-based practice tells us patient-centered care → high quality, effective care that produces better health outcomes
 - ▶ The patient centered medical home for an AI/AN is the Indian health clinic

Indian Health Care = Patient Centered Care

- ▶ Indian Health Care Providers serve their people from birth to death, even if the patient is non-compliant with care plans.
- ▶ Indian Health Care Providers have an investment and a lifetime commitment to that individual and to the health of AI/AN people.
- ▶ Effective coordination requires having good procedures in place between the Indian and non-Indian systems of care.

Part V

Indian Health and Medicaid

Federal failure to meet special trust responsibility to AI/AN



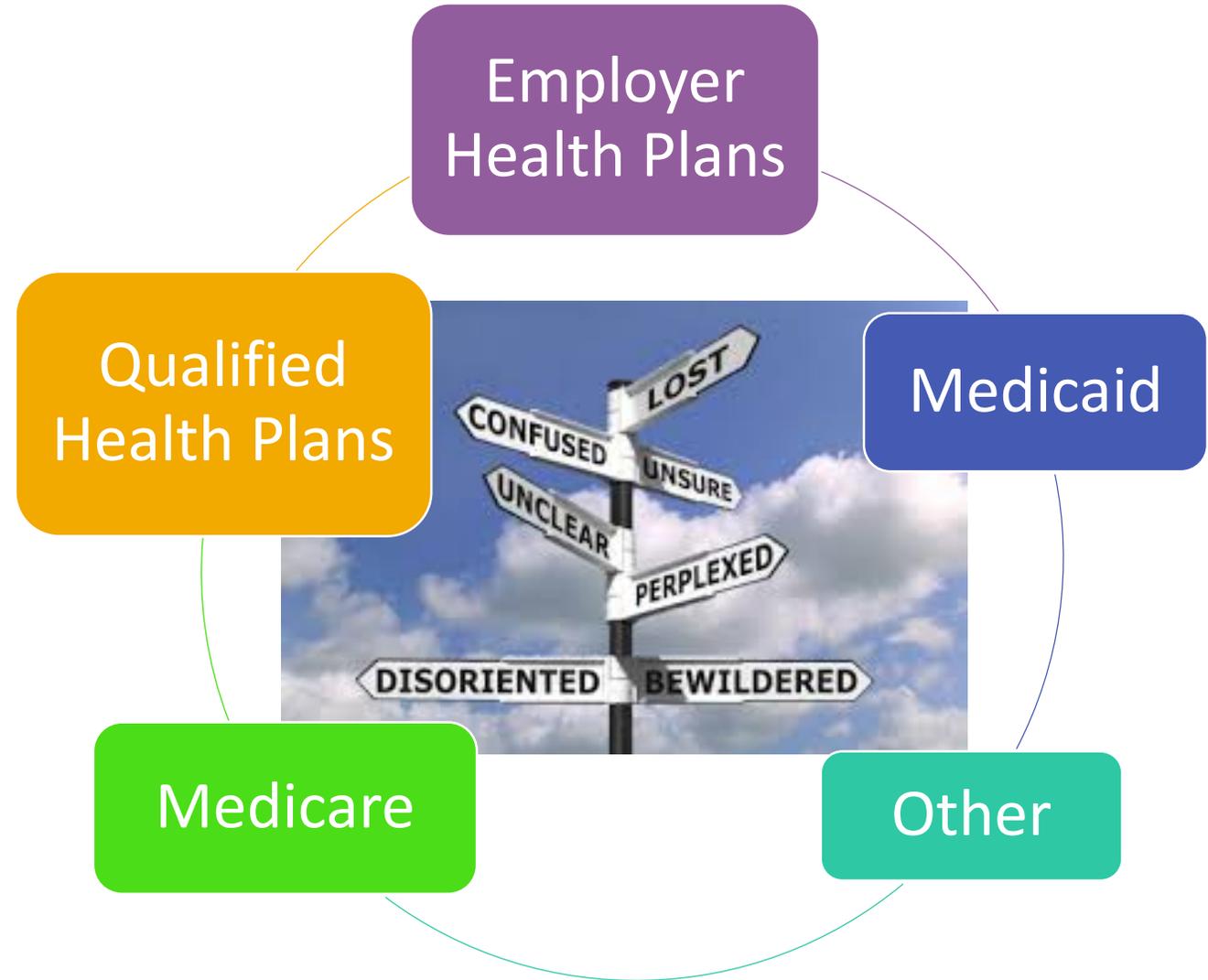
Need for AI/AN to use other resources*



Tribes and urban Indian health programs forced to fill in the gaps

**42 CFR 136.61 – IHS is payor of last resort*

Alternate Resources



Requirement to Apply for Medicaid

- Federal Regulation* requires AI/AN to sign up for and use alternate resources, including Medicaid, Medicare and Private Insurance before PRC funds can be used;
- Under Federal Regulation, I.H.S./PRC is payor of last resort when an AI/AN has any other coverage- Medicaid, Medicare, Private Insurance.

**42 CFR 136.61- I.H.S. Payor of last resort*

Many federal laws and rules in health care

- ▶ AI/AN patients may choose Indian health care provider (IHCP) as their primary care provider, and Medicaid managed care entities must respect that choice.
- ▶ Medicaid managed care entities must reimburse IHCPs – even if IHCPs are not in-network.
- ▶ States may not force AI/ANs into Medicaid managed care.
- ▶ States must consult with tribes and solicit advice from non-tribal health care providers on Medicaid programs.
- ▶ States must accept other state licenses of health care professionals who are employed by IHS and tribal health programs.

Part VI

Next Steps Discussion

Discussion on Next Steps

Given the history of invasion, treaty making under duress, treaty breaking, boarding schools, persistent and severe underfunding of health programs, and discrimination against AI/ANs and tribes:

- ▶ How can you partner with tribes more effectively?
- ▶ How can you support more appropriate care provided both by the Indian health care providers and by non-Indian health care providers?
- ▶ How can you support better coordination of care between Indian health care providers and non-Indian health care providers?

Questions?

Thank you!

Jessie Dean

Tribal Affairs Administrator

Phone: 360.725.1649

Email: jessie.dean@hca.wa.gov

Lena Nachand

Tribal Liaison – Medicaid Transformation

Phone: 360.725.1386

Email: [lena.nachand@hca.wa.gov](mailto:lana.nachand@hca.wa.gov)

From: [Carol Palay](#)
To: [Christina Mitchell](#); [Kyle Roesler](#); [Amber Shirk](#); [Sara Rainer](#)
Subject: Pls Forward: Commerce's 19-21 Behavioral Health Facilities Fall Funding Round Application is Live
Date: Friday, September 6, 2019 10:43:00 AM

Hi everyone.

This funding opportunity is live and covers capital construction projects. I'm forwarding you the language I posted on our website, nutshelling the opportunity. Please forward it to your partners. Amber, tribes are specially called out in the "who can apply" portion. Sara, one of the options is specifically for SUD.

Thanks,
Carol

The Behavioral Health Facilities (BHF) Grant program is open to nonprofits, public entities, tribes, and for-profit businesses.

All applications are due no later than 5:00pm Wednesday, November 6, 2019.

This is a reimbursement-style grant for capital construction projects only. Grant funds may be used for design, engineering, construction, and equipment costs associated with establishing these facilities. New flexibility for the 2019-21 biennium grants included the ability to fund the acquisition of a facility or land if the project results in increased capacity.

Please use the links below to access the Zoom Grants website. All applications must be submitted electronically through Zoom Grants.

- [Enhanced Service Facility](#)
- [Specialized Dementia Care Facility](#)
- [Secure Withdrawal Management and Stabilization Facility](#)
- [Community Providers to Increase Behavioral Health Services Capacity for Children and Minor Youth](#)

[Click this link for the BHF Commerce webpage](#)

[Click this link for the BHF Guidelines](#)

From: Christina Mitchell
Sent: Friday, September 6, 2019 10:31 AM
To: Carol Palay <PalayC@crhn.org>; Kyle Roesler <RoeslerK@crhn.org>
Subject: RE: Commerce's 19-21 Behavioral Health Facilities Fall Funding Round Application is Live

Yes, I recommend Amber send to the tribes.

Christina Mitchell | Chief Program Officer
CHOICE Regional Health Network
Cascade Pacific Action Alliance
1217 4th Ave E, Suite 200 • Olympia, WA 98506

From: [Carol Palay](#)
To: [Amber Shirk](#)
Cc: [Christina Mitchell](#); [Kyle Roesler](#)
Subject: Action Requested: Share Funding Opportunities with Tribes
Date: Tuesday, September 24, 2019 10:38:07 AM

Amber, there are a couple of upcoming funding opportunities we want to ensure the tribes are aware of. Please use the language below (including the hyperlinks) and forward to your tribal contacts.

Thanks,
Carol

Dear [insert Tribal contact name],

CPAA would like to share two funding opportunities with our partners:

1. Group Health Foundation is offering [Community Learning Grants](#) that prioritize culturally-specific groups. Applications are due Friday, October 25.
2. The Department of Commerce is offering a [Behavioral Health Facilities Grant](#) for capital construction projects. Applications are due Wednesday, November 6.

These are both exciting opportunities, and we wish you luck if you choose to pursue them. Please let us know if we can be of assistance.

Respectfully,

Appendix E

I am forwarding the message below as a reminder. CPAA has up to \$11,500 available to all partners for infrastructure costs (detailed below). The application is due in just a few days on September 16 – [click this link for more information and to go to the Application for Infrastructure Funds](#).

Please feel free to reach out to me with your questions.

Thanks,

Sara Rainer, MPH (she/her) | Opioid Response Program Manager

CHOICE Regional Health Network

Cascade Pacific Action Alliance

1217 4th Ave E, Suite 200 · Olympia, WA 98506

p. 360.539.7576 ext. 130 · f. 360.943.1164

www.crhn.org | www.cpaawa.org

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From: Amber Shirk <ShirkA@crhn.org>

Sent: Monday, August 19, 2019 1:25 PM

To: Alison.spencer@nisquallyhealth.org

Cc: Sara Rainer <RainerS@crhn.org>; amber.arndt@nisquallyhealth.org; Josette Ross <josette.ross@nisquallyhealth.org>

Subject: Infrastructure Funds Application Opportunity

Dear Alison, Amber and Josette

It was brought to our attention that CPAA's Tribal partners were not notified of the recent Infrastructure Funds opportunity at the same time as other Medicaid Transformation partners. Because of this, CPAA is opening this funding opportunity to Tribes only for four additional weeks, with the application due September 16. This allows Tribes time to apply for this one-time opportunity to offset project start-up costs.

Tribes are eligible to receive up to \$11,500 each. Although the original application stated partners may request up to \$20,000, due to the number of qualified applications and limited funds available, Transformation partners who applied for \$20,000 received \$11,500.

Application for Infrastructure Funds is a one-time funding opportunity open only to CPAA Medicaid Transformation Implementation Partners with a current signed contract. If your Year 2 Amendment has not been signed, please still apply; without a signed Year 2

Amendment, payment will be deferred until fully executed. 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 Tribal Infrastructure Funds application will open August 19, 2019, and close September 16, 2019. Awards will be announced October 1, 2019. [Click this link for more information and to go to the Application for Infrastructure Funds.](#)

If you have questions or concerns, please contact Amber Shirk (shirka@crhn.org), your designated Program Manager Sara Rainer (RainerS@crhn.org), or reporting@cpaawa.org. Write Infrastructure Funds Application Question in the subject line. Questions will be responded to within 3 business days.

Thank you,

Amber Shirk | Community and Tribal Outreach Liaison
CHOICE Regional Health Network
Cascade Pacific Action Alliance
1217 4th Ave E, Suite 200 · Olympia, WA 98506
p. 360.539.7576 ext. 124 · f. 360.943.1164
ShirkA@crhn.org | www.crhn.org | www.cpaawa.org



Medicaid Transformation Change Plan

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

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

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

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

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

Medicaid Transformation Change Plan

Organization Information

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

Summary of Interventions

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

Program Manager Contacts

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

Reporting

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

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

*Intervention specific

Instructions

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

Cascade Pacific Action Alliance

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

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

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

Cascade Pacific Action Alliance

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

MTP Transformation Activities

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

Date Updated/Reviewed: __/__/__

Attestations:

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

Yes	No

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

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

Yes	No

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

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

Yes	No

Partner Organization Authorizing Authority

Printed Name: _____

Title: _____

Cascade Pacific Action Alliance

Signature _____

Date: _____

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 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:

- 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).
- 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.
- 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 by 7/24/2019.**

Instructions for Milestone Report

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

- 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.

- 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

- 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.

All 2019 Quarter 1 through 3 will be prepopulated and locked. They have already been reported on and updated in the database.

Intervention	Intervention Description	M ID	Milestone	DueDate	Progress	Notes	New Due Date
2A_PC_BH	Primary Care to Behavioral Health	2A0567	Develop and Implement workflow to assess chronic disease management practices and control status	20-Apr-19	Completed		
2C_NEMT	Provide non-emergency medical transport services	2C0611	Strengthen connections with medical care providers, using Patient Navigator(s) to schedule transport services to and from appointments	30-Apr-19	Completed		
2C_CORHH	Core Health Housing	2C0628	Evaluate need and seek out appropriate avenues to add services to address additional social determinants of health	30-Jun-19	Completed		
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0644	Begin Youth Prevention Education in groups and/or in school settings (Goal #1)	30-Apr-19	In progress	We are working to get a curriculum/group guide together to implement. When school begins again we will be able to implement groups in schools.	9/30/2019
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0645	Track clients engaged in prevention education and monitoring efforts in EHR (Goals #1 and #2)	30-Apr-19	In progress	Once 3A0644 is complete, we will be able to complete this one at the same time. In the meantime, we are tracking SBIRT results for those who are flagged but not eligible for SUD/ODU tx in order to ensure that individual prevention education is employed during mental health sessions.	9/30/2019
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0646	Enroll in PDMP and develop workflow for checking database and passing pertinent information along to appropriate staff (Goal #2)	30-Apr-19	In progress	Workflow has been established, PDMP registration is still in progress.	9/30/2019
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0647	Designate staff to manage/monitor PDMP (Goal #2)	30-Apr-19	Completed		
3A_OVERD	Naloxone Distribution/High risk MAT Access	3A0668	Implement routine use of SBIRT screenings for all clients	30-Apr-19	Completed		
3A_OVERD	Naloxone Distribution/High risk MAT Access	3A0669	Track client SBIRT results in EHR and identify clients in need of services	30-Apr-19	Completed		
3A_RECOV	Provide recovery supports	3A0695	Coordinate with Patient Navigator and transport program within CORE to ensure all clients in need of OUD recovery support are engaged in services	30-Apr-19	Completed		
3A_RECOV	Provide recovery supports	3A0696	Evaluate efficacy of services, specifically noting client outcomes and any remaining barriers for clients	30-Apr-19	Completed		

Intervention	Intervention Description	M ID	Milestone	DueDate
SMART Goal: Implement Patient Navigator role by 12/1/2019, 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 from 0% to 60% by 2021				
2C_NEMT	Provide non-emergency medical transport services	2C0611	Strengthen connections with medical care providers, using Patient Navigator(s) to schedule transport services to and from appointments	01-Jan-21

SMART Goal: Implement Patient Navigator role by 12/1/2019, 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 from 0% to 60% by 2021				
2C_CORHH	Core Health Housing	2C0628	Evaluate need and seek out appropriate avenues to add services to address additional social determinants of health	01-Jan-21
2C_CORHH	Core Health Housing	2C0629	Evaluate need and seek out appropriate avenues to add services to address additional social determinants of health	01-Jan-21

SMART Goal: Implement Patient Navigator role by 12/1/2019, 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 from 0% to 60% by 2021				
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0644	Begin Youth Prevention Education in groups and/or in school settings (Goal #1)	01-Jan-21
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0645	Track clients engaged in prevention education and monitoring efforts in EHR (Goals #1 and #2)	01-Jan-21
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0646	Enroll in PDMP and develop workflow for checking database and passing pertinent information along to appropriate staff (Goal #2)	01-Jan-21
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0647	Designate staff to manage/monitor PDMP (Goal #2)	01-Jan-22
3A_OVERD	Naloxone Distribution/High risk MAT Access	3A0668	Implement routine use of SBIRT screenings for all clients	01-Jan-22
3A_OVERD	Naloxone Distribution/High risk MAT Access	3A0669	Track client SBIRT results in EHR and identify clients in need of services	01-Jan-22
3A_RECOV	Provide recovery supports	3A0695	Coordinate with Patient Navigator and transport program within CORE to ensure all clients in need of OUD recovery support are engaged in services	01-Jan-22
3A_RECOV	Provide recovery supports	3A0696	Evaluate efficacy of services, specifically noting client outcomes and any remaining barriers for clients	01-Jan-22

ID_Metric	Description	Metric	2017 Baseline	2019 Mid point actual (Q2)	2019 Actual	2019 Target Goal
2A030	Primary Care to Behavioral Health	% Universal BMI [2A030]	0	7		70
2A040	Primary Care to Behavioral Health	% Universal blood pressure screening [2A040]	0	99		70
2C010	Utilize a patient navigator to improve health outcomes for target populations of patients	# Clients in Patient Navigator Service [2C010]	5			150
2C060	Provide non-emergency medical transport services	# of transports to healthcare [2C060]	N/A			200
2C070	Provide non-emergency medical transport services	% consumers who rebook [2C070]	N/A	30		50
2C080	Provide non-emergency medical transport services	% of transportation service within 7 days [2C080]	N/A	40		50
2C220	Core Health Housing	# unique clients receiving services at SSC [2C220]	100			200

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 NR2019Q4_ organizationname.

To fulfill CPAA reporting requirements, both the Narrative Report and the Excel Milestone Report must be completed and emailed to reporting@cpaawa.org by **Friday, January 31**.

Reporting period: October 1 – December 31, 2019

Organization	
Primary Contact Name	
Narrative Questions	
1. Has your organization fully implemented the MTP projects in your Change Plan? Be sure to address each project area you're participating in.	
2. If you have not yet implemented certain elements of the project work you selected, how will you implement these activities in Q1 2020?	
3. What aspects of your project work are you scaling up, and how are you going about scaling these activities? Be sure to address each project area you're participating in.	
4. Describe key challenges you experienced in implementing your selected MTP projects during this reporting period. Include potential impacts and mitigation strategies for specific Transformation activities.	
5. Is your organization considering dropping any project work (i.e., project-specific interventions, project areas)?	
6. Please highlight a Transformation success story from this reporting period.	
7. How can CPAA help you achieve your Transformation goals?	

Change Plan Metrics Definitions

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

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

Worksheet [MTP Metrics]

Column heading	Column Description
Column A	<p>Project ID, According to the MEDICAID TRANSFORMATION PROJECT TOOLKIT: 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: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf</p>
Column B (hidden)	MetricID , Unduplicated metric code for CPAA internal use. First two digits corresponds to the Project ID, third and fourth digits is an autonumeric by project.
Column C	Sub Category / Intervention
Column D	Short Description [Metric ID] : Measurement description as pre-populated in your Change Plan.
Column E	Measure Description : Detailed description of each measurement.
Column F	Numerator : The upper part of a fraction. The metric which has been counted. (e.g. # of people developed the disease of interest)
Column G	Denominator : The lower part of a fraction, used to calculate a rate or ratio. The population from which the numerator was derived. (e.g. total # of people in the population at risk)
Column H	Initial reporting date: Initial date that the data should be submitted to CPAA using the tool provided.
Column I	Set of data, "From - To", specific set of data to be reported.

Explanation of Metrics Definitions Supplemental Document

Instructions

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

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

CPAA Change Plan Metrics

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

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

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

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

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

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

Messaging for Q3 Reports: go out by 11/15/2019

Dear MTP Implementation Partner,

Thank you for completing your MTP Quarterly Report. CPAA has compiled milestone progress from Quarter 3 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 funding methodology.

- Your Organization obtained a compliance score of ___%
- MTP partners in the CPAA region completed 210 out of 466 of the self-reported milestones due during Quarter 3 of 2019 and obtained an average compliance score of 72%

Mid-December, CPAA will email your organization's Quarter 4 Reporting template. Additionally, CPAA will send all milestones listed in your organization's Change Plan. After a year of project implementation, **CPAA is requiring partners to review, update, and modify Change Plans to accurately capture and reflect the work being done around your approved Transformation project areas in 2020.**

CPAA will send detailed instructions for Change Plan modification along with these documents mid-December.

If you have any questions, please email reporting@cpaawa.org, and someone will get back to you within three business days.

Thank you.

2019

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

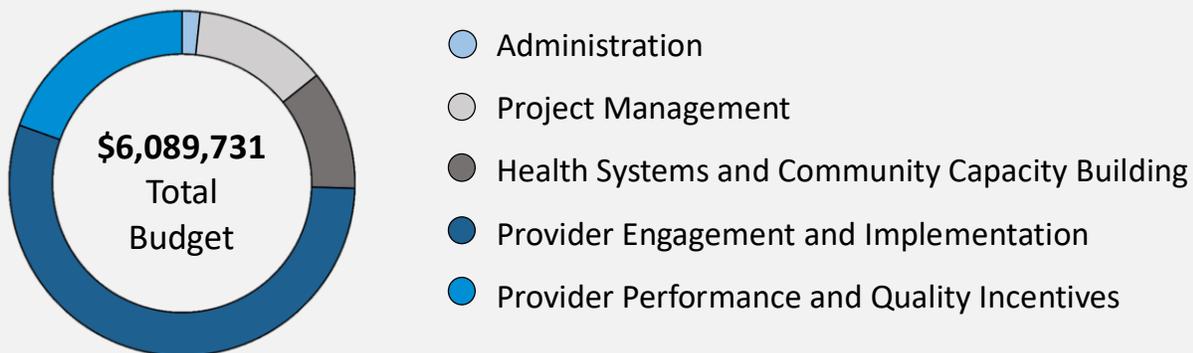
This report highlights the activities of CPAA and its 51 funded Medicaid Transformation Project (MTP) partners implementing interventions in Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum counties.

Milestone Progress

During the first two reporting periods, CPAA’s regional partners submitted progress updates on a total of 1,385 milestones as identified in their Change Plans.¹ The regional compliance score below shows regional progress toward project Implementation.



Budget Disbursement



¹ Milestones included in this report cover September 1, 2018 – June 30, 2019

² Regional Compliance Scores are a weighted average of completed and in-progress milestones divided by the total number of milestones

Trainings & Events

During the reporting period, 14 trainings and events were held with approximately 641 participants from across the region.



Harm Reduction

One Key Question

Quality Improvement

Networking **Integrated Managed Care** **Secondary Trauma**
Motivational Interviewing **Whole Person Care** **and Staff Retention**
Peer Counseling **Opioid Prescribing for Dental Providers**

Training Highlight: Through our partnership with the University of Washington AIMS Center, three cohorts of primary care and behavioral health partners participated in full day in-person training events focused on whole person care. One cohort included the first pediatric-focused cohort consisting of clinics across three different ACHs.

Community CarePort



7

Care Coordinating
Agencies



426

Clients



420

Completed
Pathways

Community CarePort, CPAA's Pathways Community HUB, has delivered care coordination services to 426 clients. More than 420 pathways have been completed, including 210 brief client education, 107 social service, 29 medical referrals, 24 housing (housed for over 30 days), 5 healthy birthweight deliveries, and more.

Cascade Pacific Action Alliance

Bi-Directional Integration of Care, Pathways, Transitional Care, Opioid Response, Maternal/Child Health, Chronic Disease Prevention



December 2018
Jean Clark joined CPAA as the Chief Executive Officer



February 2019

Regional partners attended a networking event to share experiences in Transformation work and learn from others who have shared missions and goals



April 2019

Adam Falcone JD, MPH, led an all-day training focused on Managed Care contracting from a position of strength.



June 2019

Over 50 health care workers from 15 different organizations attended a One Key Question training, empowering them to feel more comfortable helping families identify pregnancy and contraception goals.

The first of a series of buprenorphine waiver trainings was held in Lewis County. A range of providers and health workers participated, learning about the best practice for treating opioid use disorder.



August 2019

CPAA is leading a monthly Integrated Managed Care (IMC) Provider Readiness Workgroup for the region. Both Great Rivers and Thurston-Mason are combined into one workgroup.



January 2019

CPAA kicked off a series of in-person trainings with the AIMS center for primary care, behavioral health, and pediatric providers.



The Olympia Bupe Clinic led a training with regional medical and social service professionals on harm reduction approaches when serving high-risk individuals with opioid use disorder.

March 2019

Attendees of *Building Community, Advancing Outcomes* Quality Improvement Conference learned practical methods to improve the safety, timeliness, efficiency, and equity of programs and processes at their organization.



May 2019

More than 80 regional partners participated in a Learning Collaborative focused on trauma, toxic stress, and staff retention.



The first of a regional series of opioid prescribing training for dental providers was held in Grays Harbor, headed by local champion Theresa Madden, DDS, MS, PhD.

July 2019

CPAA's team of program managers completed site visits with all 51 partners to discuss training and technical assistance priorities and opportunities.

CPAA was awarded a 3-year grant to create a hub and spoke business model for providing Chronic Disease Self-Management Expansion, with CPAA as the regional hub.

September 2019

Laura van Dernoot Lipsky, a pioneer in the field of trauma exposure, led a highly demanded workshop for CPAA's regional network.



A Collective Response to Regional Priorities

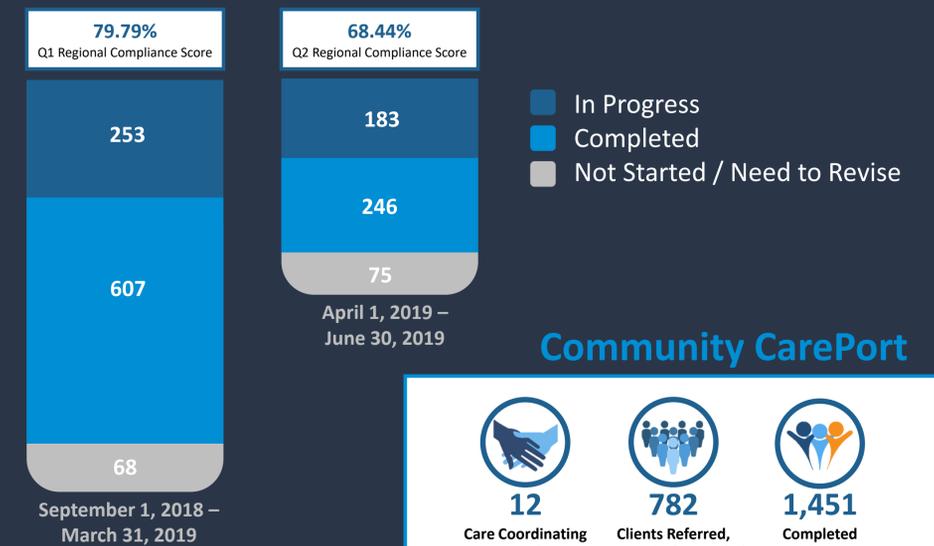
Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum



Across CPAA's seven counties, 51 partners are funded to implement projects focused on bi-directional integration of care, care coordination, transitional care, opioid response, reproductive/maternal and child health, and chronic disease prevention and control.

Regional Milestones

CPAA's implementation partners self-identified project-specific milestones and submit progress reports quarterly. The graphic below demonstrates partner progress in achieving self-directed goals to improve health outcomes and regional Pay for Performance metrics. The compliance score shows regional progress towards project implementation. Scores are a weighted average of completed and in-progress milestones divided by the total number of milestones.



Community CarePort



Community CarePort, CPAA's Pathways Community HUB, has over 40 care coordinators who have held 1,098 in-person client visits. 1,451 pathways have been completed, including 529 connections to clinical and social services, 71 people stably housed, 72 established with a medical home or behavioral health, and 15 healthy births for clients.

Appendix K

Dear MTP Implementation Partner,

CPAA is aware that the end of year is a busy time, and we ask that you please carefully read all instructions in their entirety and check to ensure you've received the correct attached documents.

Attached to this email:

- Change Plan – Excel
- Quarter 4 Milestones/Metrics Report – Excel
- Quarter 4 Narrative Report – Word

Change Plan Modification

After a year of Implementation, CPAA is requiring all MTP Partners to review their Change Plans for 2020 - 2021. Moving into Pay for Performance and Scale and Sustain years, it's time to figure out how to make successful projects sustainable and scalable, as well as make hard decisions about the future of projects and interventions that aren't progressing.

During this time, CPAA is encouraging you to modify your Change Plan to accurately and realistically reflect your scope of work, add milestones in Year 4 (2020) and Year 5 (2021) to plan for achieving sustainability in your approved projects, and potentially drop interventions and project areas.

CPAA will be reviewing all Change Plans prior to contract amendments going out. **Please keep in mind that some modified Change Plans may not be approved.** As a region, we need to put our limited resources where the funding can make the biggest impact.

The Change Plan modification process has been broken up into multiple tabs for your review and edits. Due to the way CPAA is tracking edits to milestones and updated data, we will no longer be using the Microsoft Word version of your organization's Change Plan. However, all milestones, metrics, and SMART goals have been formatted to the Excel version and verified with the final draft of the original approved Change Plan.

Your Organization's Change Plan Excel File:

Tab 1: Detailed instructions

Tab 2: 2019 Quarterly Reports 1-3 have been locked. These milestones have already been reported on and updated in CPAA's internal tracker. They are included for your reference.

Tab 3: Current 2020 - 2021 Milestones. In this tab, you will review, modify, and add milestones and SMART goals to more accurately capture project-specific work and plan for Scale and Sustain years.

- Milestones are listed by intervention. All intervention milestones are listed under their original SMART goal.
- If you choose to remove a milestone from your Change Plan, please highlight the box in yellow. Do not delete.
- To add milestones, please list them in the empty cells provided to you or right-click to add additional rows as needed.

Reviewed and modified Change Plans must be completed and returned to reporting@cpaawa.org by February 7, 2020. Submit your final document as an Excel file using the naming convention CP2020_organization name. After submission, CPAA will have two weeks to review your modified Change Plan. If there are any additional revisions requested, you will be contacted at that time.

CPAA is here to support you through this modification process. If you have any questions or concerns about modifying your Change Plan, please submit them to reporting@cpaawa.org or directly contact the relevant program manager.

2019 Quarter 4 Reporting

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.

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 MR2019Q4_organization name. Please submit your completed Narrative Report as a Word document using the naming convention NR2019Q4_organization name.

Your organization's Medicaid Transformation Project (MTP) Quarter 4 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 October 1, 2019 – December 31, 2019 (DY3 Q4).
2. **Narrative Report:** provides additional context and information about your organization's MTP activities during the DY3 Q4 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 Quarter 4 reporting must be completed and returned to reporting@cpaawa.org by 01/31/2020. 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.

If you have any questions or concerns about quarterly reporting, please submit them to reporting@cpaawa.org. Someone will respond within 3 business days.

We appreciate your dedication, your efforts, and all your Transformation work.

Thank you.

Medicaid Transformation Quarterly Report



Organizational Information	
Organization Name	
Primary Contact Name	
Phone Number	
E-mail Address	

Modified Change Plan Contents

CPAA is requiring all MTP Partners to review their Change Plans for the 2020-2021 Scale and Sustain years. During this time, modifications may be made to any existing future milestones and additional milestones should be added to more accurately reflect your organization's work around your approved project areas.

Modified Change Plans must be completed and returned to reporting@cpaawa.org by February 7, 2020. Submit your final document in the existing format (i.e., Excel).

Your organization's Modified Change Plan has been broken up into multiple tabs for your review and edits. Due to the way CPAA is tracking milestones and updating data, we will no longer be using the Microsoft Word version of your organization's Change Plan. However, all milestones and SMART goals have been formatted to the Excel version and verified with the final draft of your approved Change Plan. Your organization's Modified Change Plan is composed of two parts:

- Q1-Q3 2019 Milestones:** has been prepopulated with your organization's milestones from the beginning of implementation, through September 2019. These milestones have already been captured by CPAA and are available for reference while reviewing and modifying your Change Plan. No action is needed with this tab.
- 2020-2021 Milestones:** lists all milestone written into your organization's original approved Change Plan. In this tab, you will review, modify, and add milestones to more accurately reflect project -specific work in Scale and Sustain years 2020 and 2021.

Instructions for 2020-2021 Milestones

Your organization's existing 2020-2021 milestones can be found on the third tab of this Excel file.

- Milestones are listed by intervention. All intervention milestones are listed under their original SMART goal.
- SMART goals may be revised as needed as you add and modify milestones to accurately reflect your Transformation work.
- If you choose to remove a milestone from your Change Plan, please highlight the box in yellow. Do not delete.
- To add milestones, please list them in the cells provided to you, or right click to add additional rows as needed.

Example 2020-2021 Milestones

SMART Goal: By December 31, 2021, we will increase the number of referrals from syringe exchange programs by 50%, increase the number of waived-prescribers within CW from 4-6, and increase CW coordination of care with behavioral health providers by 75%.				
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0644	Begin Youth Prevention Education in groups and/or in school settings (Goal #1)	01-Jan-21
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0645	Track clients engaged in prevention education and monitoring efforts in EHR (Goals #1 and #2)	01-Jan-21
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0646	Enroll in PDMP and develop workflow for checking database and passing pertinent information along to appropriate staff (Goal #2)	01-Jan-22
3A_PREVE	Prevention Education/Safe Prescribing Practices	3A0647	Designate staff to manage/monitor PDMP (Goal #2)	01-Jan-22
SMART Goal: Implement Patient Navigator role by 12/1/2019, 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 from 0% to 60% by 2021				
2C_NEMT	Provide non-emergency medical transport services	2C0611	Strengthen connections with medical care providers, using Patient Navigator(s) to schedule transport services to and from appointments	01-Jan-21

Highlighted cell indicates you would like to remove this

Empty cells have been provided for you to list additional milestones. If you need more space, right click on the

For coding purposes, CPAA will populate these cells. Please leave the first three columns blank.

Email Language for Partners on PIP

Dear [insert name],

CPAA is aware that the end of year is a busy time, and we ask that you please carefully read all instructions in their entirety and check to ensure you've received the correct attached documents. Attached to this email:

- Performance Improvement Plan (PIP) - Word
- Change Plan –Excel
- Quarter 4 Milestones/Metrics Report –Excel
- Quarter 4 Narrative Report –Word

Performance Improvement Plan

Jean Clark, CPAA CEO, has been in contact with your organization's leadership regarding the attached PIP. Your approved, modified Change Plan is part of that PIP.

Program Managers will be contacting you shortly to schedule a meeting in January to discuss PIP next steps and timeline.

Change Plan Modification

After a year of Implementation, CPAA is requiring all MTP Partners to review their Change Plans for 2020 -2021. Moving into Pay for Performance and Scale and Sustain years, it's time to figure out how to make successful projects sustainable and scalable, as well as make hard decisions about the future of projects and interventions that aren't progressing.

During this time, CPAA is requiring you to modify your Change Plan to accurately and realistically reflect your scope of work, add milestones in Year 4(2020) and Year 5(2021) to plan for achieving sustainability in your approved projects, and potentially drop interventions and project areas. As a region, we need to put our limited resources where the funding can make the biggest impact.

The Change Plan modification process has been broken up into multiple tabs for your review and edits. Due to the way CPAA is tracking edits to milestones and updated data, we will no longer be using the Microsoft Word version of your organization's Change Plan. However, all milestones, metrics, and SMART goals have been formatted to the Excel version and verified with the final draft of the original approved Change Plan.

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- Milestones are listed by intervention. All intervention milestones are listed under their original SMART goal.
- If you choose to remove a milestone from your Change Plan, please highlight the box in yellow. Do not delete.
- To add milestones, please list them in the empty cells provided to you or right-click to add additional rows as needed.

Program Managers will be working with you to modify your Change Plan.

Reviewed and modified Change Plans must be completed and returned to reporting@cpaawa.org by February 7, 2020. Submit your final document as an Excel file using the naming convention CP2020_organization name. After submission, CPAA will have two weeks to review your modified Change Plan. If there are any additional revisions requested, you will be contacted at that time.

2019 Quarter 4 Reporting

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.

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2. **Narrative Report:** provides additional context and information about your organization's MTP activities during the DY3 Q4 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 Quarter 4 reporting must be completed and returned to reporting@cpaawa.org by 01/31/2020. 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.

If you have any questions or concerns about quarterly reporting, please submit them to reporting@cpaawa.org. Someone will respond within 3 business days.

We appreciate your dedication, your efforts, and all your Transformation work.

Thank you.

Performance Improvement Plan



Organization Name	
CEO/Executive Director	
Transformation Lead	
Lead Contact Information	

Purpose		
<p>The purpose of this Performance Improvement Plan (PIP) is to define areas of concern and/or gaps in an organization’s performance, iterate CPAA’s expectations going forward, and allow the organization an opportunity to demonstrate improvement. To facilitate sustained improvement, the following PIP will be used in conjunction with your organization’s modified Change Plan to monitor progress on Medicaid Transformation Project (MTP) work. The project area/s in need of improvement are checked below under the Areas of Concern section.</p>		
Performance Improvement Process		
<p>Effective immediately, your organization is being placed on a Performance Improvement Plan (PIP). Your organization has until June 30, 2020, to satisfy each of the improvement expectations listed below.</p> <ol style="list-style-type: none"> Once CPAA establishes that a partner’s performance in one or more project areas is unsatisfactory, CPAA will complete the PIP form and meet with the partner to review it. The partner will then sign the finalized PIP. CPAA will provide the partner with a finalized copy of the PIP and provide updated versions after regular progress meetings. The partner and CPAA Program Managers will meet at regular intervals during the PIP time period for performance monitoring and to document the partner’s progress. By July 15, 2020, CPAA will assess whether the partner has met the performance expectations outlined in the PIP. If the PIP was successful, CPAA will meet with the partner to formally close the PIP. If improvement has not sufficiently occurred, your organization may be dropped from a project area or as a Medicaid Transformation Partner. 		
Areas of Concern		
<input type="checkbox"/> 2A <input type="checkbox"/> 3A <input type="checkbox"/> 2B <input type="checkbox"/> 3B <input type="checkbox"/> 2C <input type="checkbox"/> 3D	<ol style="list-style-type: none"> Ex. Have not completed any milestones in project 3B Ex. Have delayed majority of milestones in 3D. 	
Improvement Expectations		
<ol style="list-style-type: none"> Develop milestones that adequately reflect the scope of work being implemented. Gain CPAA approval for modified Change Plan. Implement milestones demonstrating project implementation by the end of June 30, 2020. Attend monthly meetings with CPAA team to discuss progress. Achieve 90% compliance of completed milestones by June 30, 2020. 		
Progress To-Date		
Follow-Up Dates	Expectations Completed	Meeting Notes

Performance Improvement Plan



<input type="checkbox"/> 30-Day Follow-Up (after approved, modified Change Plan) Ex. 3/15/2020		
<input type="checkbox"/> 60-Day Follow-Up Ex: 4/15/2020		
<input type="checkbox"/> 90-Day Follow-Up Ex. 5/15/2020		

Attestations

1. I agree to continue working in the following project areas.

<input type="checkbox"/> 2A	<input type="checkbox"/> 3A
<input type="checkbox"/> 2B	<input type="checkbox"/> 3B
<input type="checkbox"/> 2C	<input type="checkbox"/> 3D

2. I agree to drop the following project areas.

<input type="checkbox"/> 2A	<input type="checkbox"/> 3A
<input type="checkbox"/> 2B	<input type="checkbox"/> 3B
<input type="checkbox"/> 2C	<input type="checkbox"/> 3D

3. I agree to the terms outlined in this Performance Improvement Plan.

Yes	No

Partner Organization Authorizing Authority

Printed Name	Title
Signature	Date

Email not displaying correctly?
[View this email with images](#)



July 2019

Take HCA's VBP Survey Today!

The Health Care Authority (HCA) is seeking provider participation in their annual value-based payment (VBP) survey, including hospitals, health systems, clinics, tribal health care, behavioral health, and others. The survey is designed to be filled out by an administrative leader, with only one response per organization.

- [Click this link to access VBP survey.](#)
- [Click this link to view offline, PDF version of survey.](#)

CPAA is helping promote the completion of this VBP survey by offering the following **financial incentives to CPAA Medicaid Transformation Project (MTP) Implementation Partners** over the next two years:

- By completing the [2019 survey](#), you organization will earn \$500.
- By completing the 2020 survey (an email with the link will be provided in the summer of 2020), you organization will earn \$500.
- Your organization can earn an additional \$1000 by demonstrating an increase in the percentage of your organization's VBP contracts (categories 2C-4D in the Alternative Payment Model Framework for Value-Based Purchasing).

Confirmation of survey completion will be conducted through the HCA post-survey results. After confirmation, CPAA will send you a notification email regarding your incentive payment.

Community CarePort

Community CarePort, CPAA's Pathways HUB, is **accepting referrals** from anywhere in the 7-county region: **800-662-2499**.

For more information, [click this link](#) or contact Michael O'Neill: oneillm@crhn.org.



Upcoming Events, Dates, and Meetings

MTP Infrastructure Funds Application Closes

July 15

MTP Infrastructure Funds Awards Announced

August 1

Little Red Schoolhouse Distribution Day

August 15

MAT Waiver Training

August 24
9:00am - 1:00pm

Please contact Kyle Roesler with any questions:
roeslerk@crhn.org.



MTP Quarter 2 Reporting

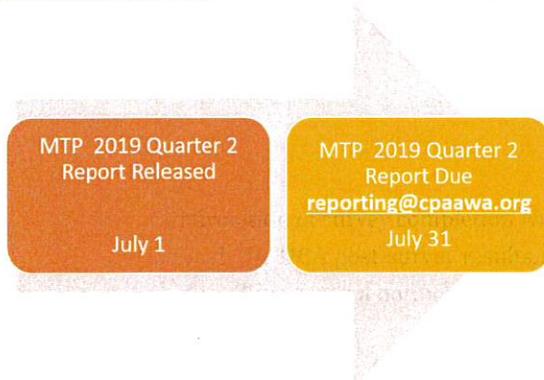
MTP Implementation Partners have received Q2 reporting templates: Q2 Milestone and Metric Report and Q2 Narrative Report. This reporting period covers April 1, 2019 - June 30, 2019.

Completed Q2 reporting is due Wednesday, July 31, 2019.

Please submit your completed reporting to reporting@cpaawa.org in the original formatting: **Excel** for the Milestone and Metric Reports and **Word** for the Narrative Report.

[Click this link to access the slides from the Q2 Reporting Webinar.](#)

If you have questions or concerns, please email reporting@cpaawa.org.



HCA VBP Survey Closes

August 30

September Council Meeting

September 12
12:00 - 3:00pm

Certified Peer Counselor Training SUD/ODU

September 16 - 20
Application due August 9

Regional Learning Collaborative

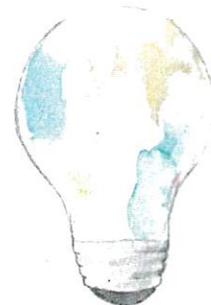
September 24
10:00am - 2:00pm

Learning Collaborative: Trauma, Toxic Stress, and Staff Retention

Thank you to everyone who attended CPAA's regional Learning Collaborative.

[Click this link to access the PowerPoint slides.](#)

The next Learning Collaborative will be September 24 and feature a workshop led by Laura Lipsky.



Stay in the Know: IA vs IEE

The Health Care Authority has contracted with Myers and Stauffer and Oregon Health Science University (OHSU) to conduct independent evaluations of both Accountable Communities of Health (ACHs) and the Medicaid Transformation Project (MTP) impact. These evaluations are required by the Centers for Medicaid and Medicare Services (CMS) as part of the MTP agreement with the state.

- [Click this link to access a comparison sheet for the two evaluators and their assessments.](#)
- You may be contacted directly by Myers and Stauffer, OHSU, or both.
- CPAA encourages you to participate if contacted by either evaluator.

Please contact Christina Mitchell if you have questions: mitchell@crhn.org.



Register Today: Buprenorphine Waiver Training

Join CPAA on Saturday, August 24, from 9:00am to 1:00pm, for a buprenorphine waiver training. Medication assisted treatment (MAT) is a best-practice, life-saving treatment for patients experiencing opioid use disorder (OUD). This 4-hour training is the "live half" of an 8-hour training requirement to obtain a waiver from the Drug Enforcement Agency to begin prescribing buprenorphine for OUD.

[Click this link to learn more or to register.](#)

If you have questions or concerns, please contact Sara Rainer: rainers@crhn.org.

Infrastructure Funds Application Closed

Thank you to all our MTP Implementation Partners who applied for Infrastructure Funds.

**Awards will be announced
by August 1.**

If you have questions or concerns, please email: reporting@cpaawa.org

Value-Based Payment Resources

CPAA is beginning an awareness campaign to share materials, resources, and VBP tools with partners. [Click here for more VBP information.](#)

Council Meeting Documents

Documents are available from the [June 13, 2019](#), Council Meeting.

The next Council Meeting will be September 12.

Share Press & Media Releases

Send CPAA your press and media releases, and we'll share your good news with our distribution list. Email Carol Palay: palayc@crhn.org.

REGISTER HERE

In the News

CPAA is proud of partners highlighted by the media:

- **Dr. Grande, Medical Director of the Olympia Bupe Clinic** received the Innovative Community Service Award in recognition for her work combating opioid addiction and homelessness. Congratulations, Dr. Grande! [Click this link to read more.](#)
- **Opioid Use Recovery & Response (OURR) Alliance** and Pacific Mountain Workforce Development Council (PacMtn) is facilitating Prepping Employment Plans and Possibilities for Youth/Young Adults (PEPPY), a pilot program that connects homeless youth and those at risk of becoming homeless with job training and work-based learning opportunities. [Click this link to read more.](#)
- **Youth Marijuana Education and Prevention Program**'s (YMPEP) campaign, done in partnership with the WA Traffic Safety Commission, warning teens about the dangers of marijuana-impaired driving was highlighted in the State Highway Safety Showcase. [Click this link to read more.](#)



Enjoy the open road, but driving high or riding with a high driver is dangerous.

CHOICE

Regional Health Network

CHOICE works to improve community health in Central Western Washington through the collective planning and action of health care leaders.

CHOICE is the backbone organization for the Cascade Pacific Action Alliance.

HealthBridge

[Click here for CPAA's HealthBridge webinar recording.](#)

For more information, contact Michael O'Neill: oneillm@crhn.org.

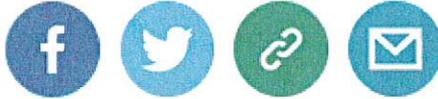


ACH Documents

[Click this link](#) for documents submitted to Health Care Authority, including CPAA's approved Project Plan, Semi-Annual Reports (SAR1 and SAR2), and Implementation Plan.

CPAA is working hard to finalize a successful SAR3, due to HCA on July 31.

Have a success story you'd like us to share or know of a partner we should highlight? Please contact Carol Palay: palayc@crhn.org.



The CPAA is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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

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Meeting Agenda

Medication Assisted Treatment (MAT) Provider Group

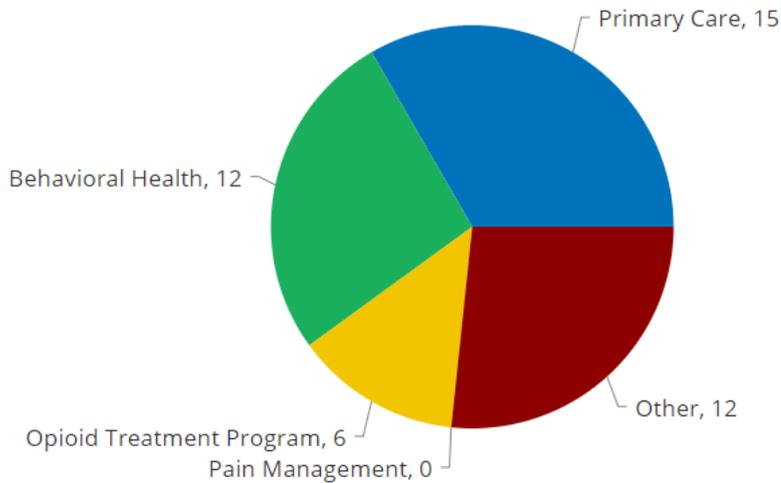
DATE: Saturday, November 2, 2019 from 9:00 – 10:00am

LOCATION: Thurston County Public Health & Social Services, Room 107, 412 Lilly Rd NE,
Olympia, WA 9850

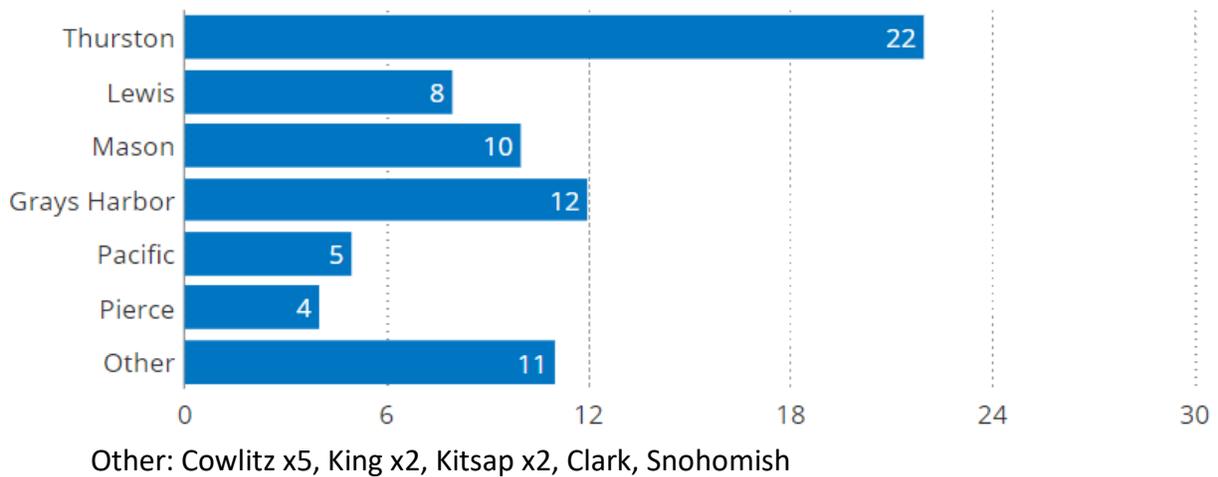
TOPIC	TIME	FACILITATOR
Introductions <ul style="list-style-type: none"> Your title, role, and interest in this group 	9:00 – 9:05	Sara Rainer
Review meeting purpose and goals <ul style="list-style-type: none"> Thurston County Opioid Response Plan 2019-2020 goals, strategies, action steps, and SMART goals 	9:05 – 9:10	Hallie Cranos
Review and interactive discussion of <i>MAT Provider Survey</i> results	9:10 – 9:40	Dr. Lucinda Grande
System of Care map	9:40 – 9:50	Jason Bean-Mortinson
Next steps and future meeting dates <ul style="list-style-type: none"> Frequency, length, and format 	9:50 – 10:00	Sara & Hallie

RESULTS: Addressing Barriers and Improving Coordination for Medication Assisted Treatment Providers and Potential Providers

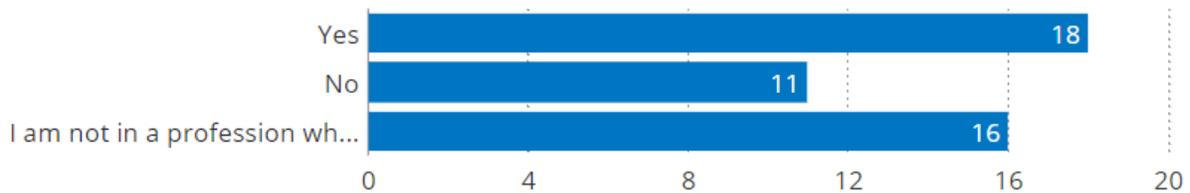
1. What type of clinic do you work at? * 45 responses in 45 results



2. In which counties do you work? * 72 responses in 45 results



3. Are you currently waived to prescribe buprenorphine? * 45 responses in 45 results



a. [If not in profession / prescriber] Do providers at the clinic you work in currently prescribe buprenorphine? * 16 responses in 16 results



4. Are you currently prescribing buprenorphine? [if YES waived] *18 responses in 18 results



a. If yes, do you have exclusions or limits on dosage? *16 responses in 16 results



- 30 for the year until applying for the 100
- 30 pt waiver limit, 24 mg daily dose limit for most patients.
- 24mg
- from my office I do not prescribe more than 3 films
- 30
- 2-32 mg per dose
- FDA guidelines
- Bup 16 mg max 24 mg

b. If yes, does your maximum patient load differ from your waiver limit? * 6 responses in 6 results



- I can only carry about 10-15 suboxone patients without negatively affecting access for the other patients on my panel.
- Time

- 40 patients limit -- more than that overwhelms my schedule and I am a general family doc, not running an addiction med clinic
- Just got waiver, only Rx for 30, but have 60 I managing with my partner
- fitting in MAT patients among other impanelled pts
- We use multiple providers to manage through the waiver limits

c. If yes, what is your policy regarding poly-substance use? * 16 responses in 16 results

- don't understand the question; my PERSONAL policy or organizational?
- I tolerate marijuana, I address other things case by case. When volunteering at OBC I am more lax given their low barrier model.
- Not a barrier to MOUD
- harm reduction primarily
- We will work with them
- use of benzodiazepines may interrupt your suboxone script
- We require patient to stop use of all illicit/non-prescribed substances, though we give them time to address these issues before considering mandatory inpatient treatment or discharge from program.
- Cannabis Ok if not interfering with function and relationships
- I don't fire people right away for relapse, but it would be an issue if chronic polysubstance abuse
- No opioid use only
- low barrier clinic, encouraging but not requiring sobriety from all intoxicants
- Must not be drinking alcohol or using benzodiazepines due to risk; strongly encourage abstinence from amphetamines and other illicit substances given risk and to support recovery/sobriety; encourage quitting nicotine and marijuana given health risks
- not a barrier
- Work on harm reduction
- Depends on each patient case.
- I require patients to undergo a Substance Use Disorder evaluation and follow the recommendations of the evaluator. I see the patients monthly.

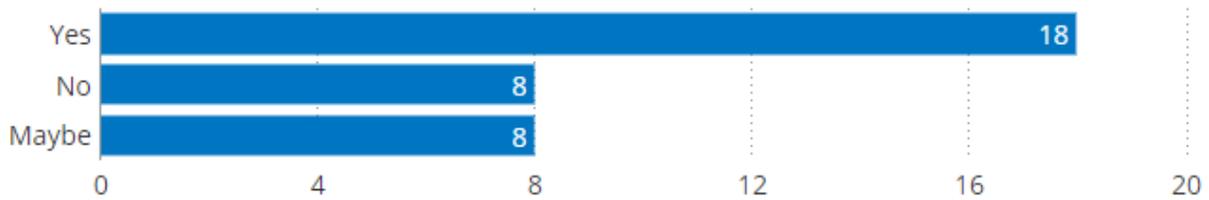
5. On a scale of 0 (not at all) to 5 (high), how significant are these barriers to becoming a waived provider and prescribing buprenorphine? N = not waived or no prescriber at clinic Y = yes waived or yes prescriber at clinic - = not asked

	0 Not at all		1 Low		2 Somewhat		3 Neutral		4 Moderate		5 High barrier		Not Sure
	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	Y
	No one in my clinic is prescribing buprenorphine	7 44%	-	1 6%	-	1 6%	-	0	-	1 6%	-	6 38%	-
Challenges with getting insurance and administrative process in place	5 11%	9 20%	0	5 11%	5 11%	2 4%	2 4%	2 4%	3 7%	5 11%	1 2%	1 2%	5 11%
Time commitment for buprenorphine training	6 13%	5 11%	1 2%	11 24%	3 7%	1 2%	4 9%	3 7%	0	1 2%	2 4%	4 9%	4 9%
Cost of buprenorphine training	7 16%	13 29%	2 4%	8 18%	2 4%	0	2 4%	1 2%	2 4%	0	1 2%	2 4%	4 9%
Lack of awareness regarding mental health resources in the community	6 13%	5 11%	1 2%	4 9%	2 4%	2 4%	4 9%	8 18%	2 4%	5 11%	1 2%	1 2%	4 9%
Lack of awareness regarding substance use disorder resources in the community	5 11%	3 7%	1 2%	6 13%	2 4%	0	5 11%	6 13%	2 4%	8 18%	1 2%	2 4%	4 9%
Insufficient mental health resources available	5 11%	4 9%	2 4%	1 2%	2 4%	1 2%	2 4%	6 13%	2 4%	7 16%	3 7%	6 13%	4 9%
Insufficient substance use programs available	4 9%	3 7%	1 2%	2 4%	4 9%	1 2%	1 2%	4 9%	3 7%	11 24%	3 7%	4 9%	4 9%
Concerns regarding behaviors of this patient population	7 16%	4 9%	1 2%	5 11%	4 9%	4 9%	2 4%	3 7%	2 4%	6 13%	0	3 7%	4 9%
Unfamiliar with procedure for buprenorphine prescribing	5 11%	9 20%	1 2%	9 20%	2 4%	1 2%	4 9%	4 9%	1 2%	0	3 7%	2 4%	4 9%
Concerns or regulations of the clinic administration	3 7%	9 20%	2 4%	9 20%	3 7%	2 4%	5 11%	2 4%	1 2%	1 2%	2 4%	2 4%	4 9%

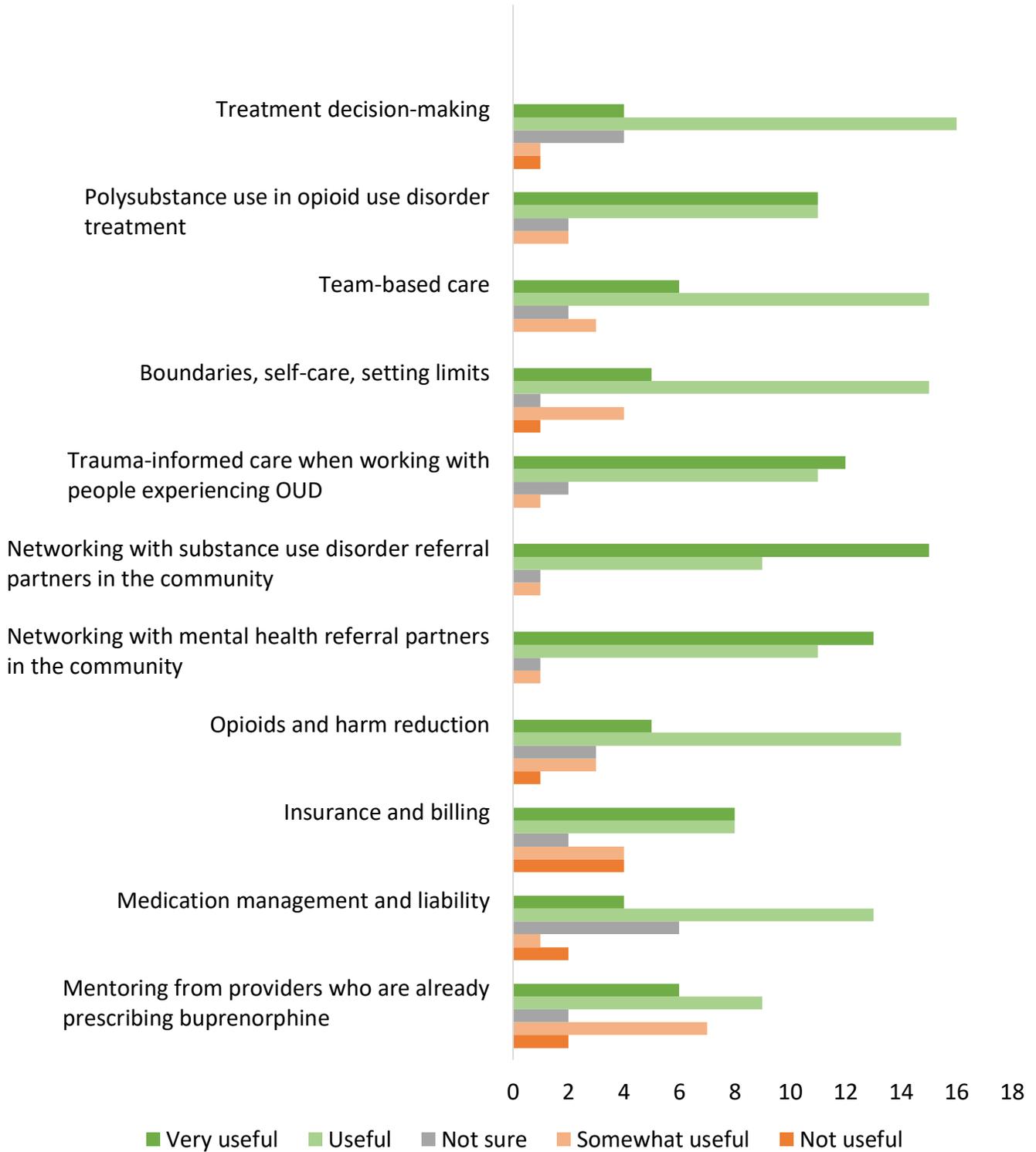
6. Are there other barriers to becoming waived or to prescribing buprenorphine not noted above? *

limited hours in all clinics/resources, ignorance of Drs/PAs/NPs and administrators, prejudice
NP maxed at 100 while MD max at 250
The requirement for ARNPs (24 hours) is excessive, I think.
It is quite time consuming with the amount of visits required.
Waiver limitations reduce interest in program. Perceived risk to license caring for these patients, usually not empanelled patients, takes time away from primary practice, limited reimbursement
The low barrier bup clinics are becoming no barrier pill mills
Public awareness of current providers.
Challenges getting other prescribers in our community to get waived
No x 9 responses; N/A x 1 response

7. Are you interested in participating in meetings with other providers to discuss and strategize solutions to barriers to accessing and prescribing MAT? Frequency will be established by the group after the initial meeting. *34 responses in 34 results



a. **If Yes/Maybe, what topics would be most useful to cover during these meetings in order to effectively address barriers to prescribing buprenorphine? *26 responses in 26 results**



Pediatric Cohort Collaborative Call

Date: Thursday, August 15th 2019, 9-10 am

Dial by your location

+1 669 900 6833 US (San Jose) Meeting ID: 560 255 771

Attendees:

NW Pediatrics: Jennifer Polly

Child and Adolescent Clinic: Julie Nye and Phyllis Cavens

Olympia Pediatric: Janelle Tiegs

Pediatric Associates: Beth Harvey

Discussion Questions for the group:

- Current phase of your behavioral health integration work
- One or two challenges you've been or anticipate experiencing
- One success you've had
- Any questions you'd like to ask the group
- Future topics of discussion

Pediatric Cohort Collaborative Call

Date: Thursday, October 10th 2019, 9-10 am

Dial by your location

+1 669 900 6833 US (San Jose) Meeting ID: 560 255 771

Attendees:

NW Pediatrics: Jennifer Polly

Child and Adolescent Clinic: Julie Nye and Phyllis Cavens

Olympia Pediatric: Janelle Tiegs

Pediatric Associates: Beth Harvey

Agenda/Discussion Questions for the group:

- What are you currently doing for care coordination? Who receives care coordination (everyone, behavioral health, medically complex etc) and what is the goal of care coordination for those clients?
- Do you have a specific person responsible for care coordination or is it built into a service that already exists?
- Are you using funding from other services to support care coordination?
- One success you've had with care coordination
- Any questions you'd like to ask the group
- Future topics of discussion

School Based Health Center Collaborative Call

Date: Thursday, August 8th 2019, 1-2 pm

Dial by your location

+1 669 900 6833 US (San Jose) Meeting ID: 560 255 771

Attendees:

Caroline Sedano, CPAA

Sandy Lennon, Washington School Based Health Alliance

Erin Wick and Amy Amegatcher, ESD 113

Chris Bischoff, Wahkiakum Health and Human Services

Jennifer Kreidler-Moss and Lynette Bird, Peninsula Community Health Services

<i>Time</i>	<i>Agenda Item</i>
1:00 pm	Introductions <ul style="list-style-type: none">- Name, organization, counties you work in- Brief overview of the school based health center project you are implementing as part of the CPAA MTP- <i>What is your goal with implementing a school based health center project?</i>
1:15 pm	Peninsula Community Health Services: update on implementation, including: <ul style="list-style-type: none">- Strategic visioning, community outreach, facilities, working with providers
1:30 pm	Sharing: <ul style="list-style-type: none">- <i>What challenges are you facing at this point in implementation?</i>- <i>What successes have you experienced so far?</i>- <i>Are there partnerships or resources that would be helpful for your next steps?</i>
1:50 pm	Closing and next steps

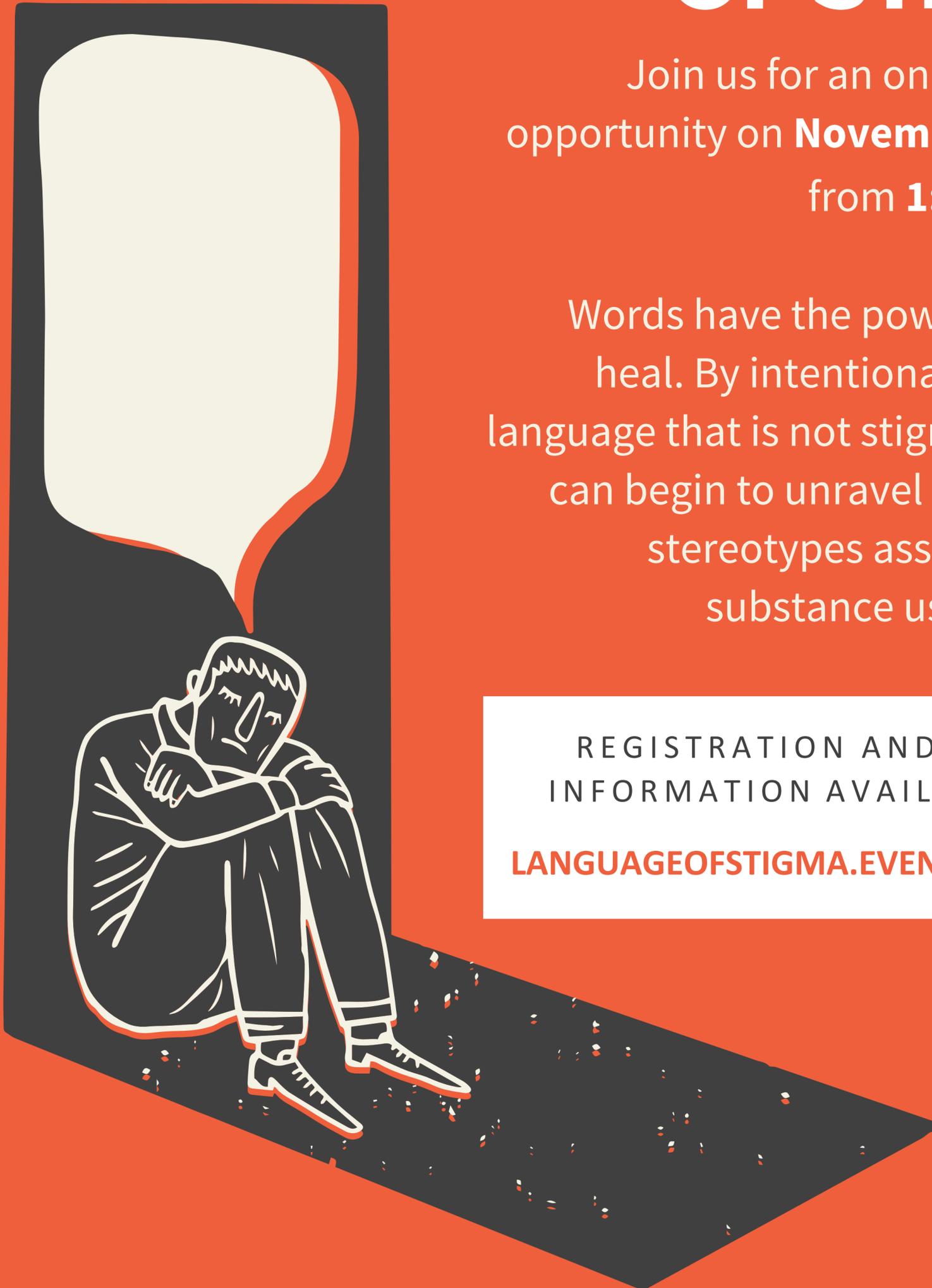
THE LANGUAGE OF STIGMA

Join us for an online learning opportunity on **November 18, 2019** from **1:00-2:00pm**

Words have the power to hurt or heal. By intentionally choosing language that is not stigmatizing, we can begin to unravel the negative stereotypes associated with substance use disorders.

REGISTRATION AND MORE INFORMATION AVAILABLE AT

LANGUAGEOFSTIGMA.EVENTBRITE.COM



August 24

9:00 am – 1:00 pm

Buprenorphine Waiver Training

Hosted by Cascade Pacific Action Alliance

Regardless of your specialty, if you see patients experiencing opioid use disorder (OUD), you may want to learn about this life-saving treatment. Medication Assisted Treatment (MAT) of OUD involves use of medication that targets the brain, and psychosocial interventions (e.g., counseling, skills development) aimed at improving treatment outcomes. Research shows that medications and therapy together may be more successful than either treatment method alone. Physicians require eight hours of training to obtain a waiver from the Drug Enforcement Agency to begin prescribing buprenorphine for OUD. This four-hour training will be the live half of a “half and half” eight-hour training sequence. The link to the online half will be provided to those who complete the live training.

Who Providers interested in prescribing buprenorphine (you are qualified if you are an MD, DO, PA or ARNP) and any others who have patient contact (e.g., nurses, medical assistants, pharmacists, psychologists, social workers, community health workers, peers). Having waived prescribers is important, but MAT is a team sport.

When Saturday, August 24, 2019 from 9:00am-1:00pm

Where Providence Centralia Classroom, 914 S Scheuber Rd, Centralia

CME This waiver training is **free of charge** and continuing medical education (CME) credits are available. Providence Southwest Washington is accredited by the Washington State Medical Association to provide continuing medical education for physicians.

Providence Southwest Washington designates this live activity for a maximum of 4.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity meets the criteria for up to 4.0 hours of Category I CME credit to satisfy the relicensure requirements of the WA State Medical Quality Assurance Commission.

To register, visit CPAAbupewaiver.eventbrite.com



The American Academy of Addiction Psychiatry (AAAP) is the data sponsor for this training. Funding for this initiative was made possible (in part) by grant no. 1H79TI081968-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government



SIX BUILDING BLOCKS

A TEAM-BASED APPROACH TO
IMPROVING OPIOID MANAGEMENT FOR
PATIENTS WITH CHRONIC PAIN

Join us to learn about an exciting opportunity to engage quality improvement personnel in a training and coaching program to support their clinics in implementing the evidence-based Six Building Blocks model.

RSVP

From 12:00-1:00 pm on
Wednesday, NOVEMBER 20 OR
Tuesday, DECEMBER 10

join us for
**AN ONLINE
LEARNING
OPPORTUNITY**

OPIOID USE DISORDER AND METHAMPHETAMINE

POLYSUBSTANCE USE
IN TREATMENT

**DECEMBER 18, 2019
9:00 - 10:00 AM**

Registration and more information available at:
<http://OUDandMeth.eventbrite.com>



ADAI

ALCOHOL &
DRUG ABUSE
INSTITUTE

AIMS CENTER
W UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

From: [Cascade Pacific Action Alliance](#)
To: [Carol Palay](#)
Subject: Sept 24 Event Reminder & Important Parking Information: Transforming Trauma
Date: Monday, September 16, 2019 12:15:31 PM



[Find events](#) [My Tickets](#)

Good afternoon,

Thank you for registering for CPAA's **Regional Learning Collaborative on Tuesday, September 24**, featuring Laura van Dernoot Lipsky, founder and director of the Trauma Institute.

- A 2-hour workshop with Laura van Dernoot Lipsky will **begin promptly at 10:00am.**
- A networking opportunity will follow the workshop, from 12:00 - 12:45pm.
- An optional Community CarePort* meeting will begin at 1:00pm. Light lunch will be provided for those who stay for the meeting.

CPAA is excited to offer this training opportunity to our partners. Due to an overwhelmingly positive response:

- Please indicate through EventBrite if you are no longer planning to attend the Learning Collaborative.
- The workshop will start promptly at 10:00am. Doors will open at 9:00am.
- Parking at the Lacey Community Center is limited. There are over 200 registrants and 150 parking spaces. **We strongly encourage you to carpool, particularly if multiple people are attending from the same organization.**
- CPAA is proud to be a Green Business. We encourage you to bring your own refillable water bottle.

Please contact Sara Rainer if you have questions or concerns:

rainers@crhn.org.

We look forward to seeing you on September 24!

**Community CarePort is CPAA's Pathways HUB, which provides care coordination for physical health, behavioral health, and social support services. Meeting attendees will learn about the rapid growth of the program, which is outpacing our initial goals, and provide input on the next phase of program development. CPAA's network of care coordinators will be participating in the meeting, and this is a great opportunity to make connections that strengthen our region's systems of care. Please contact Michael O'Neill if you have questions: oneillm@crhn.org.*

Transforming Trauma



Tuesday, September 24, 2019
from 10:00 AM to 2:00 PM (PDT)



Lacey Community Center
6729 Pacific Avenue Southeast
Olympia, WA 98503

Organized by [Cascade Pacific
Action Alliance](#)

map



[Mobile Tickets](#)

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Planned Parenthood of the Great Northwest and Hawaiian Islands Volunteer/External Learner Agreement for LARC Clinic

This agreement is intended to indicate the seriousness with which PPGNHI treats our volunteers/external learners. The intent of the agreement is to assure both our deep appreciation of your services and to indicate our commitment to do the very best we can make your volunteer/external learner experience a productive and rewarding one.

I. AGENCY

WE, PLANNED PARENTHOOD OF THE GREAT NORTHWEST AND THE HAWAIIAN ISLANDS, AGREE TO ACCEPT THE SERVICES OF Nicole Taylor (external learner) on 10/7/19 AND WE COMMIT TO THE FOLLOWING:

1. To provide an "LARC insertion clinic" staffed by an experienced clinician preceptor and appropriate support staff at our Olympia Health Center on October 7, 2019
2. To provide a brief didactic presentation followed by a practicum where the external learner will provide LARC insertions for different patients under direct supervision of clinician preceptors.
3. To provide specific feedback on LARC insertion skills from clinician preceptors.
4. To provide adequate information, training, and assistance for the external learner to be able to meet the responsibilities of your practicum.
5. To respect your skills, dignity, and individual needs, and to do our best to adjust to these requirements.
6. To be receptive to any comments from you regarding ways in which we might mutually better accomplish our respective tasks.

II. VOLUNTEER/EXTERNAL LEARNER

I, Nicole Taylor, recognizing the important responsibility I am undertaking in serving as a member of Planned Parenthood of the Great Northwest and the Hawaiian Islands, AGREE TO SERVE in a trustworthy and diligent manner AS A VOLUNTEER/EXTERNAL LEARNER AND COMMIT TO carry out the duties and obligations in my role as follows:

1. To preform my volunteer/external learner duties to the best of my ability and advocate for our clients in a positive and supportive manner.
2. To adhere to agency rules and procedures, and support agency policies and procedures.
3. To meet time and duty commitments, or to provide adequate notice so that alternate arrangements can be made.
4. To come prepared to scheduled assignments, meetings, and events.

- 5. To observe our client's confidentiality and be respectful of others.
- 6. To support, in a positive manner, all actions taken by PPGNHI.

If for any reason, I find myself unable to carry out the above duties to the best of my abilities, I agree to resign my position as volunteer/external learner.

AGREED TO:

PPGNHI Program Manager/ Date

Name (Please Print)

Nicole Taylor
Nicole Taylor 10/3/19
PPGNHI External Learner Signature/ Date

Nicole Taylor
Name (Please Print)

Save the Date!

Great Rivers and Thurston Mason Behavioral Health Provider Integrated Managed Care Symposiums

Amerigroup, Coordinated Care, Molina Healthcare, and United Healthcare are hosting a symposium for behavioral health providers that are contracted with Great Rivers and Thurston-Mason Behavioral Health Organizations.

Registration Links:

- 10/28 (Day 1): South Puget Sound Community College, Lacey
<https://www.eventbrite.com/e/gr-tm-imc-behavioral-health-provider-symposium-day-1-lacey-tickets-73374710735>
- 10/29 (Day 2): Cowlitz Event Center, Longview
<https://www.eventbrite.com/e/gr-tm-imc-behavioral-health-provider-symposium-day-2-longview-tickets-73375156067>
- 10/30 (Day 3): Cowlitz Event Center, Longview
<https://www.eventbrite.com/e/gr-tm-imc-behavioral-health-provider-symposium-day-3-longview-tickets-73375378733>

Purpose:

To provide guidance on clinical and operational requirements and processes for behavioral health agencies making the transition to Integrated Managed Care, effective January 1, 2020. We will offer three identical days of content, the Operations and Clinical session times alternate each day to accommodate as much attendance from your agencies as possible (please see details below).

Dates:

- Monday, October 28th (Lacey)-** Morning Session: **Operations**, Afternoon Session: **Clinical**
Tuesday, October 29th (Longview)- Morning Session: **Clinical**, Afternoon Session: **Operations**
Wednesday, October 30th (Longview)- Morning Session: **Operations**, Afternoon Session: **Clinical**

Who should attend?

It is very important that the individuals that perform the operational and clinical work for your organization attend the symposium. We recognize that many people hold multiple responsibilities and we are dedicated to making this a good use of time.

For the Operations Sessions:

- Billing Staff
- Front Office Staff
- Back Office Staff
- Compliance Staff
- Operations Staff
- IT/Implementation Support Staff

For the Clinical Sessions:

- Clinical Leads/Managers or Program Managers
- Office Managers/Staff (if they complete Prior Authorizations)
- Clinicians or other direct service providers interested in connecting with MCO Case Management and Utilization Management Departments

Main topics covered in the sessions:

Operations Sessions:	Clinical Sessions:
<ul style="list-style-type: none"> – Credentialing – Access to Care & Appointment Standards – Websites, Portals & Directories – Claims and Billing – Rosters – Prior Authorizations – Resources – Questions and Answers 	<ul style="list-style-type: none"> – Utilization Management Overview – Common Prior Authorization Standards – Case Management Overview – Resources – Questions and Answers

From: [Kyle Roesler](#)
Subject: Register Today! Upcoming Integrated Care Webinars
Date: Wednesday, September 25, 2019 10:22:15 AM

Greetings,

The Cascade Pacific Action Alliance (CPAA) is partnering with the UW AIMS Center to deliver two webinars about different aspects of integrated care. Register today using the links below.

Using Tools to Support Physical Health Outcomes in Behavioral Health Settings

October 23rd, 2019

12:00 – 1:00pm

Audience: case managers, navigators, medical assistants, nurses and others working with clients to improve physical health outcomes

<https://www.eventbrite.com/e/tools-for-staff-supporting-physical-health-outcomes-in-behavioral-health-tickets-71085301049>

Primary Care and Psychiatric Providers Working Together to Address the Mortality Gap for Patients with Serious Mental Illness

November 12th, 2019

12:00 – 1:00pm

Audience: Primary care providers, medical staff, psychiatric providers and, behavioral health agency staff

<https://www.eventbrite.com/e/addressing-the-mortality-gap-for-patients-with-serious-mental-illness-tickets-71085884795>

Please contact me with any questions.

Regards,
Kyle

Kyle Roesler, MPH | Program Manager

Bi-Directional Care Integration

CHOICE Regional Health Network

Cascade Pacific Action Alliance (CPAA)

1217 4th Ave E, Suite 200 • Olympia, WA 98506

p. 360.539.7576 ext. 126 • f. 360.943.1164

www.crh.org | www.cpaawa.org

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From: [Kyle Roesler](#)
To: [Carol Palay](#)
Subject: FW: Register Today! CPAA/Comagine Health Webinar About Chronic Disease Management in BH
Date: Wednesday, September 18, 2019 9:50:58 AM

Hi Carol,

Will you please add the below webinar to our communication outlets?

Thank you,
Kyle

Kyle Roesler, MPH | Program Manager
Bi-Directional Care Integration
CHOICE Regional Health Network
Cascade Pacific Action Alliance (CPAA)
1217 4th Ave E, Suite 200 • Olympia, WA 98506
p. 360.539.7576 ext. 126 • f. 360.943.1164
www.crhn.org | www.cpaawa.org

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Good morning,

Register today (link below) for a webinar presented by Comagine Health about promoting chronic disease management in behavioral health settings. Learn more about physical health ranges, population health, and tools for clinicians. Also, hear the presenters talk through three case studies of clients experiencing co-occurring physical and mental health disorders. Please forward to anyone who would benefit from this webinar.

Date: October 1st, 2019
Time: Noon – 1:00PM

Register Today! <https://www.eventbrite.com/e/chronic-disease-management-in-behavioral-health-settings-tickets-70192115507>

Contact me with any questions.

Thank you,
Kyle

Kyle Roesler, MPH | Program Manager
Bi-Directional Care Integration

CASCADE PACIFIC ACTION ALLIANCE PRESENTS:

MOTIVATIONAL INTERVIEWING

with Jonnae Tillman

What is Motivational Interviewing?

Motivational Interviewing is a client-centered communication approach used for eliciting behavior change by helping clients explore and resolve ambivalence. The goal of using motivational interviewing is to help patients move through the stages of readiness for change in dealing with risky or unhealthy behavior.

Who should attend?

This training is focused on health care workers. Behavioral health staff, social workers, primary care providers, community health workers, nurses, home visitors, or care coordinators are encouraged to attend.

Schedule:

This three-part training is being offered in three different locations. There is a free training. Space is limited, so please make sure to register. The same material will be presented at each location.

Hoquiam Timberland Library

January 15, March 18, June 10

South Puget Sound Community College, Olympia

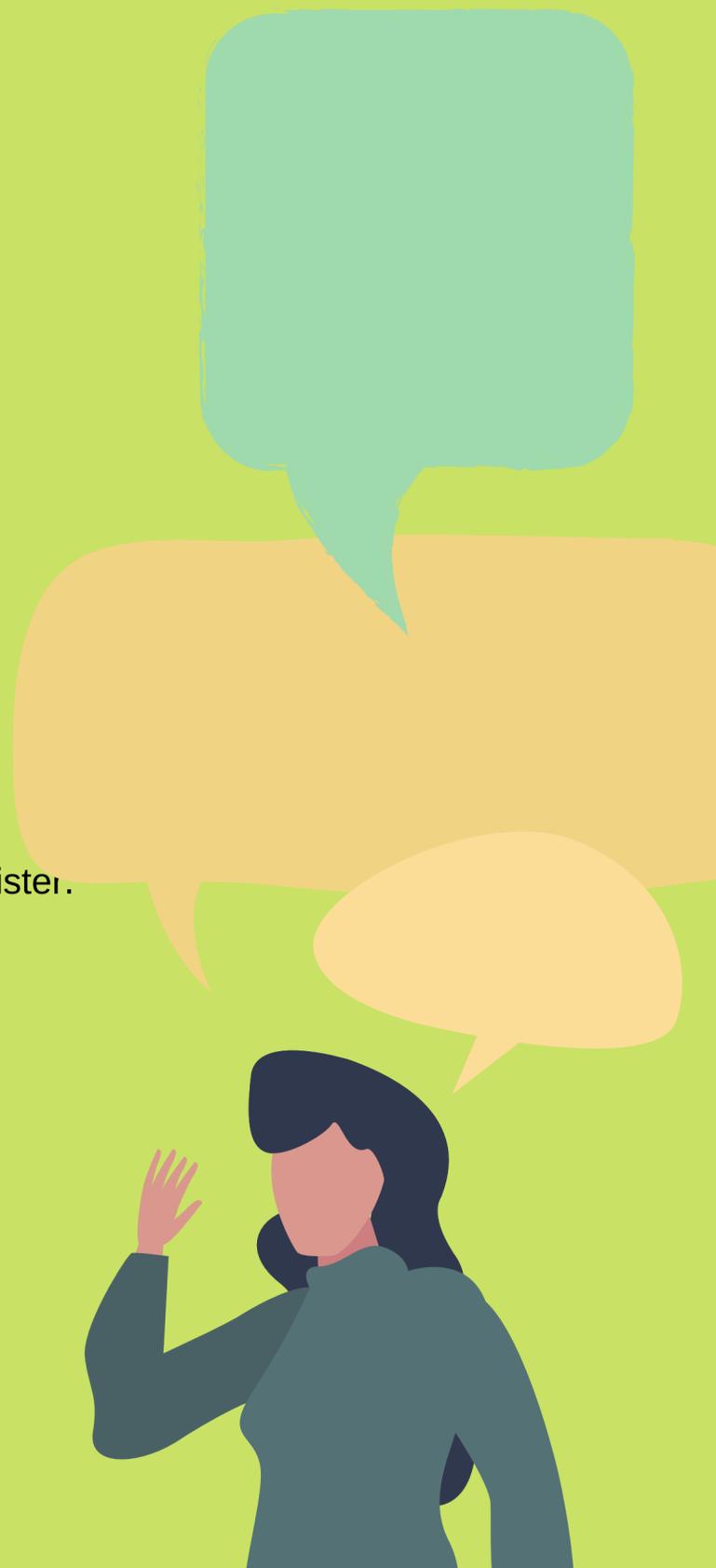
January 16, March 19, June 11

Youth and Family Link Gym, Longview

January 17, March 20, June 12

REGISTER HERE:

<https://fs27.formsite.com/crhn/wsnkkmahy6/index.html>





JOIN CPAA & PARTNERS FOR

TRANSFORMATION TALKS

FEBRUARY 20, 2020 | 10:00 AM - 3:00 PM

**SOUTH PUGET SOUND COMMUNITY COLLEGE
4220 6TH AVE SE, LACEY, WA 98503**

Reaching vulnerable populations, creating new partnerships, reducing barriers to care, and mobilizing community resources are fundamental to improving quality and access, and transforming our health care system. At CPAA's Transformation Talks, you'll hear from community partners on a wide range of topics and have the opportunity to learn, share, and network.

Learn more and register online at

<http://TransformationTalks.eventbrite.com/>

SESSION OVERVIEW

TRANSFORMATION TALKS



Join CPAA and partners for a series of presentations and panel discussions highlighting projects and programs that improve health care quality and access, and transform health care delivery in our communities.



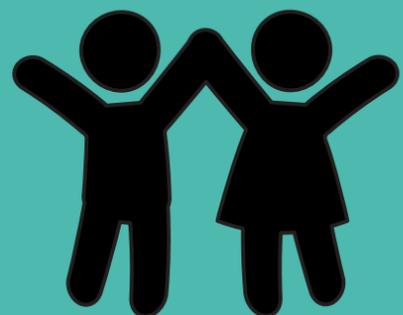
**Harm
Reduction**



Homelessness



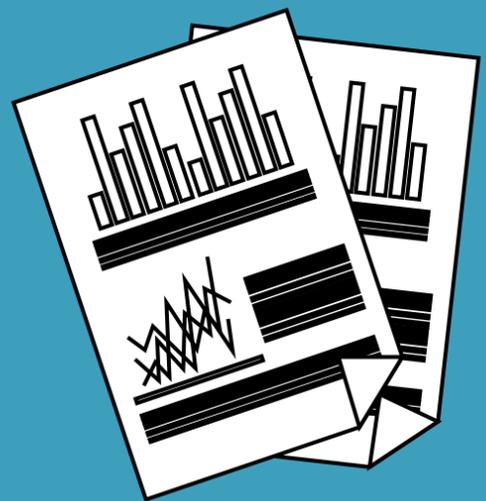
**Innovative
Partnerships**



**Adolescent
Health**



**Person-Centered
Care**



**Data to
Action**

Perinatal Mental Health Webinar: She Screened Positive for Depression, Now What?

Every year, approximately 12,000 people in Washington State experience depression or anxiety during or after pregnancy. Our goal is to give their perinatal, mental health and primary care providers the support and tools they need to effectively treat their patients' mental health disorders during pregnancy and postpartum.

Dr. Deborah Cowley, perinatal psychiatrist at the University of Washington, will lead this one-hour webinar. Attendees will learn:

- ✓ Current information about perinatal depression and anxiety in Washington
- ✓ Best practices for screening
- ✓ How to integrate screening results into care plans

Please join us! This presentation is open to anyone who cares for pregnant women or new moms including but not limited to: obstetricians, midwives, registered nurses, pharmacists, pediatricians, psychiatrists, family physicians, nurse practitioners, community health workers, peer counselors, and other primary care and mental health providers.



WHEN

Thursday, January 9th 2020
12 - 1 PM PST

WHERE

Click here to join the meeting:

<https://uw-phi.zoom.us/j/316415496>

REGISTRATION

RSVP at

<http://j.mp/2OdenAl>



UW Medicine
DEPARTMENT OF PSYCHIATRY
AND BEHAVIORAL SCIENCES

November 2, 2019

Jean Clark, Chief Executive Officer

CHOICE Regional Health Network, Cascade Pacific Action Alliance

1217 4th Ave E, Suite 200

Olympia, WA 98506

To the selection committee,

I am writing to recommend Sara Rainer to the Governor's Committee on Disability Issues & Employment (GCDE). Sara's dedication to improving the lives of all people, and ensuring the inclusion of individuals with disabilities into new and existing initiatives, would make her a valuable asset to the committee.

As the Chief Executive Officer of CHOICE Regional Health Network, Sara's current place of employment, I cannot speak highly enough of the work she is engaged in to promote the health and well-being of underserved and vulnerable populations. In her current role as the Opioid Response Program Manager of our regional Accountable Community of Health, Sara focuses on reducing the impact and harms of the opioid epidemic on our communities. Our Accountable Community of Health, Cascade Pacific Action Alliance (CPAA), focuses on regional initiatives to transform the Medicaid delivery system. While her current work focuses on individuals experiencing substance and opioid use disorders, these are not stand-alone issues. A recent [report](#) from the United States Department of Health and Human Services Office on Disability noted that over 4.7 million individuals the United States have both a disability and substance use disorder. With our programming focused on the Medicaid population, and roughly 1 in 3 Washington Medicaid enrollees having a disability, Sara's work continues to impact and improve the lives of individuals with disabilities.

Sara has brought new practices to our organization to help improve our staff's understanding of accessibility and inclusion. Just a few months after joining our team, Sara developed and shared a resource guide on planning accessible events. This included information about planning and preparing for accessibility, physical accessibility, accessible content sharing, and considerations for accommodation requests. She has been an open resource to our staff and partners on all things universal design, helping us increase our inclusivity and reach more community members. She is always willing to share her expertise in this area, and recently provided technical assistance to the Health Care Authority's Division of Behavioral Health Resources to modify some program materials with a plain language lens. Her feedback on the design, word choice, and content were impressive and all suggestions were formally incorporated.

In closing, I highly recommend Sara Rainer for the open position on this committee.

Sincerely,
Jean Clark





**STATE OF WASHINGTON
HEALTH CARE AUTHORITY**

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

December 27, 2019

TO: **Jean Clark, Chief Executive Officer**
Cascade Pacific Action Alliance | CHOICE Regional Health Network

Michael, O'Neill, Community CarePort Program Manager
Cascade Pacific Action Alliance | CHOICE Regional Health Network

FROM: Greg Claycamp, Foundational Community Supports Program Administrator

SUBJECT: Integrated Use of Medicaid Transformation Project and Dept. of Commerce Funding

Summary

This memo confirms that DSRIP funds earned by Accountable Communities of Health (ACHs) under the Special Terms and Conditions of the Medicaid Transformation Project (MTP), and used by an ACH to make outcome based payments through a Pathways program, can be braided with Foundational Community Supports (FCS) service encounter payments. We broadly confirm that funding provided through these MTP initiatives can be used in coordination.

We also confirm that MTP funds can be used in coordination with Consolidated Homeless Grant (CHG) funds administered through the WA State Dept. of Commerce to enhance supportive housing services.

Background

Cascade Pacific Action Alliance (CPAA) requested guidance regarding the coordinated use of MTP funding. CPAA is a regional ACH. CPAA pays outcome incentives to its contracted Care Coordination Agencies (CCAs) through its Community CarePort Pathways program. CPAA contracts with Coastal Community Action Program (Coastal CAP) as a CCA. CPAA and Coastal CAP are braiding CarePort Pathways with FCS supportive housing and supported employment services. This effort integrates the evidence-based practices associated with FCS and Pathways within a single service platform. Coastal CAP also regards CHG funding, used to provide rent subsidies and supportive housing services, as a component of this service platform.

Before encouraging other CCAs within its region to adopt this integrated platform, CPAA wishes to confirm that the Health Care Authority and Dept. of Commerce view Pathways and FCS as

complementary and not supplanting. We include CHG funding in this determination to fully address Coastal CAP's braided funding practice.

Elaboration

Principal staff at HCA Division of Behavioral Health and Recovery (DBHR), HCA Policy Division and Dept. of Commerce Community Services and Housing Division (CSHD) reviewed CPAA/Coastal CAP's braided funding model.

Based upon that review, we understand FCS and Pathways to be distinct and complementary components within MTP.

- FCS purchases individual *service encounters* provided to participants in Supportive Housing (SH) and Supported Employment (SE). Participants meet FCS eligibility requirements and services conform to Permanent Supportive Housing (PSH) and Individualized Placement and Support (IPS) evidence-based practices.
- CPAA CarePort provides *outcome-based payments* when participants achieve specified stability and well-being milestones. These include but are not limited to housing and employment stability outcomes. All FCS participants are eligible for CarePort within its broader eligibility criteria, and may receive care coordination beyond housing and employment. CarePort conforms to the Pathways evidence-based practice.

Engagement in FCS strengthens the likelihood that participants will achieve the outcomes that Pathways CarePort is structured to encourage. Coordinated utilization of FCS and Pathways CarePort therefore constitutes a service enhancement. FCS service encounter payments and CarePort outcome payments do not supplant each other.

CHG funding is not part of MTP. CHG provides resources to fund homeless crisis response systems to support communities in ending homelessness. These resources include rental subsidies and supportive housing services.

FCS participants whose circumstances meet HUD chronic homelessness criteria also meet CHG eligibility criteria. Because CHG funding may be used to purchase supportive housing services, we offer some guidance to ensure appropriate coordination.

- CHG and FCS may not be used to claim multiple reimbursements for the same incident of service.
- FCS may not be used to pay rental assistance. CHG can be used for this purpose.
- A provider may redirect CHG funding from SH services to rental assistance and use FCS to fund SH instead, if the rental assistance supports FCS participants. We view this coordinated use as a service enhancement, and not as supplanting.

We consider this guidance to be broadly applicable to any regional ACH utilizing the Pathways best practice, and to local jurisdiction where CHG funding is administered directly by the Dept. of Commerce.

Appendix V

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. 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. 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)



- Caseload
- Supervisor
- Admin
- Reporting

Help Center

INITIAL ADULT

Back

Demographics	
Last	First
Date of Birth	Coordinator
Active	Enroll Status
RiskQ	Gest Age
Est Due Date	PP Count Down
30 day Admit Count	Began Care
RiskQ	
Type	Gender
Program	Funder
Primary Insurance	Plan #
RiskQ	PAM Level
Initial Checklist	Client Profile
Pathways Initiated	Pathways Completed%
Open Pathways	
Address	
County	PCP Practice
PCP Name	Medical Record#
CCA	Duplicate?
Address	City
Zip Code	Client Phone
Emergency person	Emergency phone
Relationship	

Submit

Visit Date:

Start Time:

End Time:

Visit Information

Visit Type: Visit Other:

Visit Location:

Client Information

Do you live alone? Yes No [x](#)

Who do you live with?

- Spouse
- Significant Other
- Children
- Parents
- Other

Others:

Do you have concerns about your housing situation? Yes No [x](#)

Describe (Housing):

Do you have problems providing transportation for you or your family? Yes No [x](#)

Describe (Transportation):

Do you need help with child / adult dependent care? Yes No [x](#)

Do you have problems meeting your basic needs (select all that apply)? Yes No [x](#)

Select all that apply:

- Housing
- Food
- Clothing
- Transportation
- Medications
- Utilities
- Other

Other:

Select all that apply:

- Children
- Collections
- Criminal charges
- Divorce
- Immigration
- Landlord-tenant issues
- Traffic violations
- Taxes
- Other

Do you have any legal issues that need to be resolved? Yes No

Have you been in prison / jail? Yes No

Within the past 12 months? Yes No

Are you currently on probation or parole? Yes No

Have you been involved with Children /Adult Protective Services? Yes No

Do you have an active children services case? Yes No

Are you on supplemental security income (SSI)? Yes No

Do you need help in getting an identification card? Yes No

Other:

Probation / Parole Officer name:

Caseworker name:

Have you had a family crisis in the past year? Yes No

Select all that apply:

- Death
- Major physical illness
- Major behavioral health illness
- Major accident
- Jail / Prison
- Loss of home
- Financial difficulties
- Loss of relationship
- Substance use issues
- Other

Other:

General Health

How do you rate your health?

Height in Feet

Height in Inches

Weight in Pounds

BMI

Do you need health insurance for yourself? Yes No

Do you have a Family Doctor? Yes No

Family Doctor:

Practice Name:

Other care places:

If you don't have a family doctor, where do you usually get your care?

How long has it been since you last visited a doctor or a health clinic?

Do you have a Dentist? Yes No [x](#)

Dentist Name:

How long has it been since you last visited a dentist or a dental clinic? Include visits to dental specialists, such as orthodontists.

- Do you have any of the following oral health issues? (select all that apply)
- Difficulty eating/chewing
 - Pain
 - Oral bleeding
 - Skip meals due to pain
 - Problems with dentures
 - Loose teeth
 - No teeth
 - None of the above

- Do you do the following at least daily? (select all that apply)
- Brush your teeth
 - Floss your teeth
 - Use mouth wash
 - N/A - Dentures
 - None of the above

Have you missed any scheduled health care appointments in the past 12 months? Yes No [x](#)

- How many times:
- Zero
 - One
 - Two
 - Three
 - Four
 - Five
 - Six - Ten
 - More [x](#)

Have you been to the ED in the past 12 months? Yes No [x](#)

Reasons ER/ED:

- How many DAYS:
- Zero
 - One-Three
 - Four - Six
 - Seven - Nine
 - Ten - Fifteen
 - Sixteen - Thirty
 - Thirty One - Forty Five
 - More [x](#)

Have you been admitted to the hospital in the past 12 months? Yes No [x](#)

Reasons Admit:

- Select all that apply:
- ADHD
 - Anxiety
 - Bipolar
 - Depression
 - Schizophrenia
 - Other

Have you ever been diagnosed with a mental health condition? Yes No [x](#)

Other mental health issues:

Do you have allergies? Yes No [x](#)

Describe allergies:

Have you had a flu shot? Yes No Do not know [x](#)

Date of flu shot:

Have you had a pneumonia shot? Yes No Do not know [x](#)

Date of pneumonia shot:

Have you had a diptheria booster? Yes No Do not know [x](#)

Date of diptheria shot (over 60):

Are you currently being treated for any of the following conditions? Select all that apply

- None
- Infections
- Recent Surgery (within last 3 months)
- Injury
- Other

Other issues being treated:

Do you have any Chronic Conditions? Yes No [X](#)

Select all that apply:

- None
- Addictions/Substance abuse
- AIDS or HIV
- Alcohol abuse/Withdrawal
- Alzheimer's disease
- Amputation-lower limb
- Amputation-upper limb
- AMS (altered mental status)
- Amyotrophic Laterals Sclerosis (ALS)
- Anemia
- Anxiety disorder
- Aphasia
- Arthritis
- Asthma
- Attention Deficit Hyperactivity Disorder
- Autism
- Benzodiazepine withdrawal
- Bipolar - Depressed
- Bipolar - Manic
- Bipolar disorder
- Cancer (breast)
- Cancer (colorectal)
- Cancer (lung)
- Cancer (prostate)
- Cancer Other
- Cancer-skin (skin-melanoma)
- Cancer-skin (skin-non-melanoma)
- Cardiovascular disease (heart disease)
- Chronic Obstructive Pulmonary Disease
- Chronic Pain (leg, foot, back, hip, shoulder, etc.)
- Congestive heart failure
- Dementia
- Depression
- Developmental/Cognitive disorder
- Diabetes Type I
- Diabetes Type II
- Eating disorder
- Emphysema
- ETOH Intoxication
- Fibromyalgia
- GERD
- Hearing loss or impairment
- Heart attack
- Hepatitis C
- Homicidal
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Kidney disease (Chronic)
- Liver Disease
- Mood disorder
- Movement impairment (gait abnormality)
- Multiple Sclerosis
- Obesity
- OCD
- Osteoporosis

- Other Chronic Condition
- Pancreatitis
- Panic disorder
- Parkinson's disease
- Personality disorder
- Psychosis - unspecified
- PTSD
- Schizoaffective disorder
- Schizophrenia
- Seizures
- Sickle Cell
- Stroke/Transient ischemic attack
- Suicidal
- Tobacco abuse
- Vision loss or impairment

Cancer Other:

Other Chronic Conditions:

Are you taking any medicines ordered by a doctor? Yes No [X](#)

Are you currently using any assistive devices? Yes No [X](#)

Select all that apply:

- Wheelchair
- Walker
- Cane
- Hearing Aids
- Oxygen
- Other

Other assistive devices:

What method:

- Tubal Ligation
- Vasectomy-partner
- IUD
- Implant
- Shot
- Abstinence
- Natural family planning
- Pills
- Patch
- Ring
- Diaphragm
- Condom
- Cervical Cap
- Spermicide
- Other

Are you using a family planning method? Yes No [X](#)

Safety and Emotional Health

Are you using tobacco products? Yes No [X](#)

Which products?

Does anyone smoke in your home? Yes No [X](#)

How much, how often:

Are you drinking alcohol? Yes No [X](#)

How Much:

Are you using other substances? Yes No [X](#)

What substance:

Are you stressed? Yes No [X](#)

How much:

Over the past month, have you often had little interest or pleasure in doing things? Yes No [X](#)

Over the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No [X](#)

Have you experienced emotional, verbal, sexual, or physical abuse? Yes No [X](#)

Does your home have a working smoke detector? Yes No Do not know [X](#)

Are there any safety concerns in the home? Yes No [X](#)

Is there a gun in the home? Yes No [X](#)

How often does someone in your family read to your children (check only one) ?

Describe abuse:

Describe safety concerns:

Is the gun locked? Yes No [X](#)

Information Summary

List all other agencies that you are working with now:

Goals of the Pathways Coordinator

- Tobacco Cessation
- Medical Referral
- Medical Home
- Transportation to appointments
- Connect to Insurance
- Help finding permanent housing
- Utility help
- Help finding employment
- Food
- Connect to school (GED, college, etc.)
- Childcare placement for other children
- Parenting classes
- Legal assistance
- Support System
- Car seat
- Cribs for Kids
- Breast pump
- Baby items
- WIC
- Early Head Start, Help Me Grow, Heartbeat, Heart to Heart referral

Next home visit date:

Other Goals

Coordinator Central Notes

Add New Note:

Attach this note to additional forms: [Select Forms](#)

Supervisor Central Notes

Add New Note:

Attach this note to additional forms: [Select Forms](#)

Submit

How to Use the Education Pathway

When Should an Education Pathway Be Used?

An Education Pathway should be opened anytime you are teaching your client something.

The education pathway is required with some other pathways, like the social service referral

At least one education pathway should be completed every time you meet with a client

Some common examples of education topics are:

- Housing - talking to landlords, signing a lease
- Babies and Children - Breastfeeding, safe sleep for babies, nutrition for children
- Food and Nutrition - Using food benefits, reading nutrition labels
- How to prepare for a social service appointment – what to bring, information they will need to know
- How to prepare for a medical appointment – how to make an appointment, what to bring, what questions to ask, how to check in, how to use insurance
- Safety – gun safety, car seats,
- Legal assistance – how to find a lawyer, what free resources exist, the importance of showing up for court
- Basic needs – clothing, laundry, food, sleep, etc.

How to use the Education Pathway

Submit

Start Date

Date pathway was started

Start Time:

Time pathway was started

End Time:

Time pathway was completed

Referral

Who requested the education?

Referral Other

Module Date

Date education was done

Module

Subject of education

Module Other

Section

Section Other

Material Date

Date material was given

Format

What type of material was given?

Material Other

Completed Date

Date pathway was completed

Finished Incomplete

Reason Incomplete:

Reason Other:

This is what an opened education pathway looks like in Care Coordination Systems.

All boxes with red text must be filled in to complete the pathway.

What Materials Are Ok to Use?

Educational materials must come from a reliable source. If you are unsure if a resource is reliable, please contact the HUB and ask

Some examples of reliable sources are:

- Patient Activation Materials from Insignia Health (cfa.insigniahealth.com)
- Educational materials your agency has created
- Government organizations – CDC, USDA, FDA, SAMHSA, or any other website that ends in .gov
- Public health organizations – World Health Organization, National Institutes of Health, local public health departments, etc.
- Nonprofits such as AARP, Alcoholics Anonymous, American Diabetes Association, American Heart Association, Red Cross, United Way, Planned Parenthood, etc.
- Resources from accredited universities

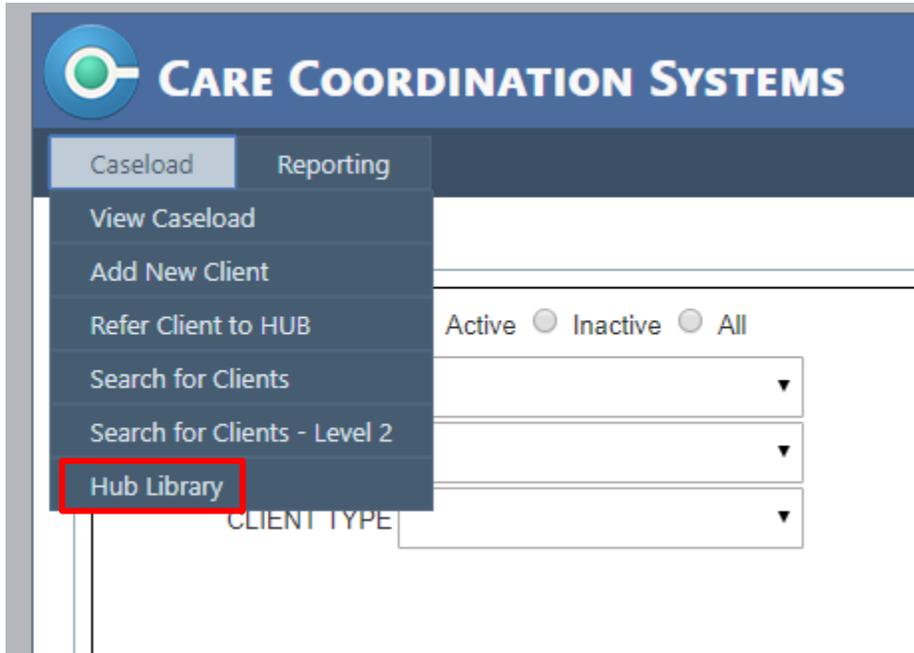
Using Videos and Websites

Videos and websites may be useful in educating clients but also must be from reliable sources

YouTube videos are fine as long as they are created by a professional organization and provide accurate information

Blogs, Facebook posts, and personal opinion articles are not allowed.

HUB Library



The HUB Library has educational materials, as well as other HUB documents.

If you have educational materials that you like to use, send them to Olivia and she will upload them into the HUB library for other care coordinators to use.

Pathways Completion Outcomes

Adult Learning	Confirm that client successfully completes stated educational goal
Behavioral Health	Client has kept 3 scheduled appointments with behavioral health specialist
Developmental Referral	Document the date and results of the completed developmental evaluation
Developmental Screening	Child successfully screened using the age appropriate ASQ or ASQ-SE
Education	Client understands the educational information presented
Employment	Client is employed for 30 days
Family Planning	Client has kept appointment – document family planning method
Health Insurance	Client has received health insurance – document insurance number in Pathway and Client Profile
Housing	Client is in stable housing for 30 days
Immunization Referral	Client has immunization record reviewed and is verified to be up to date on all vaccinations
Immunization Screening	Client is up to date on all age appropriate immunizations
Lead	Confirm that appointment was kept and document results of lead blood test
Medical Home	Client kept appointment with primary care provider
Medical Referral	Client kept appointment with medical specialist
Medication Assessment	Medication chart is sent to provider and received
Medication Management	Verify with provider that client is taking medications as prescribed
Postpartum	Confirm that client has kept 2 postpartum appointments
Pregnancy	Confirm that client has delivered a healthy baby weighing more than 5 lbs 8 oz (2500 grams)
Social Service Referral	Client kept appointment with social service provider
Tobacco Cessation	Client has stopped using tobacco products for 30 days

Adult Learning Pathway

The adult learning pathway should be used any time a client is interested in going to school, getting their GED, or attending a course or training. All boxes must be filled for the pathway to show as complete.

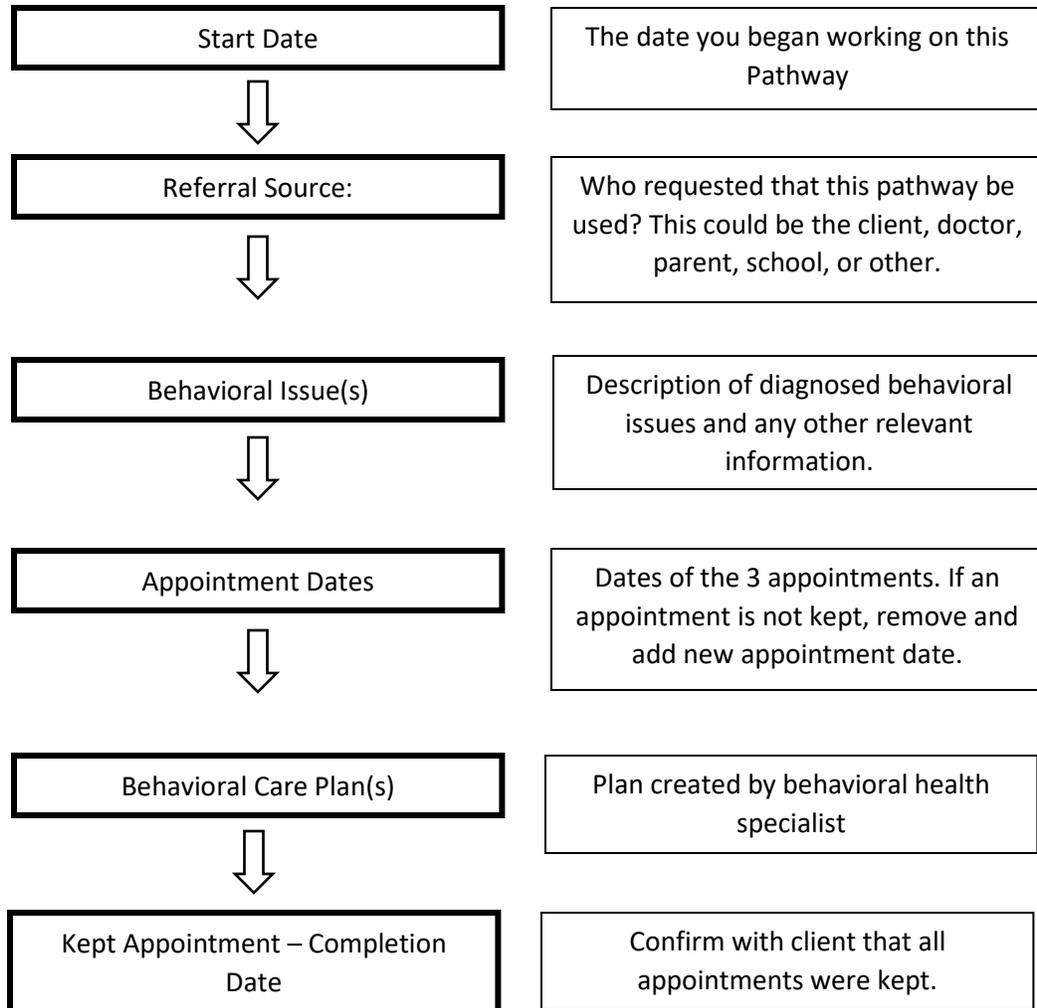
Start Date	The date you began working on this Pathway
Education Goals:	The goal for the Pathway. This goal should be short term, specific, and realistic. It could be completing a training program, getting a GED, or completing a semester of college. If the goal is long, like completing 4 years of college, break it down by semester.
Date of First Class:	Date that the client's class begins. Verify with client that they were able to attend.
Check-in Dates:	Document each time you check in with your client about their education. This should be at least every 2 weeks.
Completion Date:	Date that the client completed their education goal.
Finish incomplete if: Client was unable to complete their education goal. If they are still interested, close the Pathways as Finished Incomplete and open a new Adult Learning pathway.	

Care Coordinator's role:

- Help client plan to reach their educational goals. This may include researching programs and schools, assisting in finding financial aid or scholarships, helping with applications and registration, and breaking down any other barrier that the client faces.
- Use education, social service referrals, or other Pathways as needed.
- Check in with client at least every 2 weeks about additional barriers or support they need.
- Confirm that the client completed their goal and document in Pathway to complete.

Behavioral Health Pathway

The behavioral health pathway should be used when a client has been diagnosed with a behavioral health condition and needs to see a behavioral health specialist. If a client has not been diagnosed with a behavioral health condition, use the medical referral pathway first. The pathway is complete when 3 consecutive appointments are kept with the same behavioral health provider. This establishes the client with a provider and makes it easier for them to continue to go in the future.



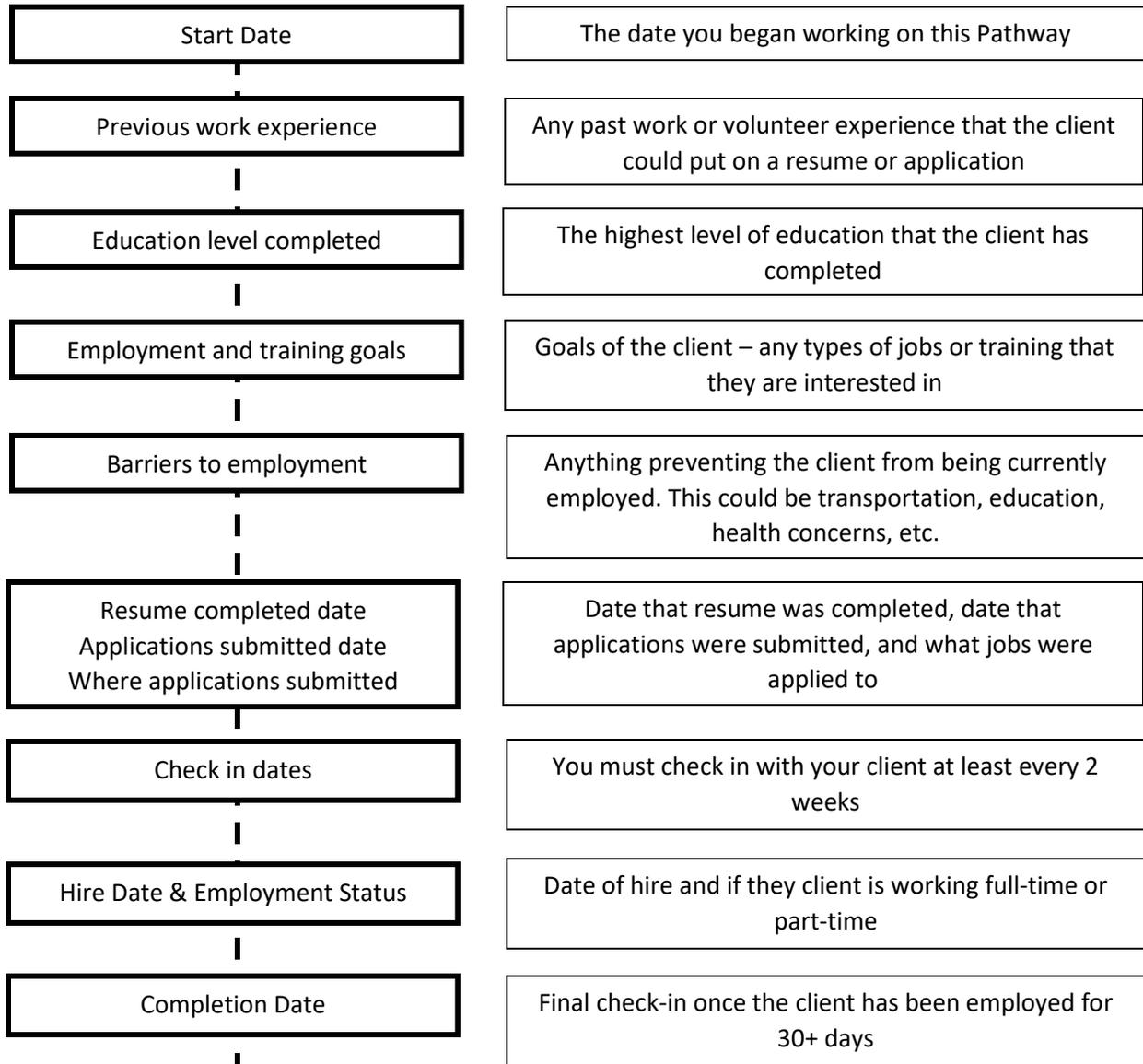
Finish incomplete if: Client did not keep 3 appointments with behavioral health provider. If client wants to switch to new behavioral health provider, finish the pathway as incomplete and open new pathway.

Care Coordinator's role:

- Help client find a behavioral health specialist that meets their needs
- Break down barriers that may stop the client from going to their appointment like health insurance, education/information on what to expect, transportation needs, etc.

Employment Pathway

The employment should be used when your client would like help finding a job. If you will be the person helping them, use this pathway. If you are referring them to another agency that provides employment support instead, use the social service referral for employment.



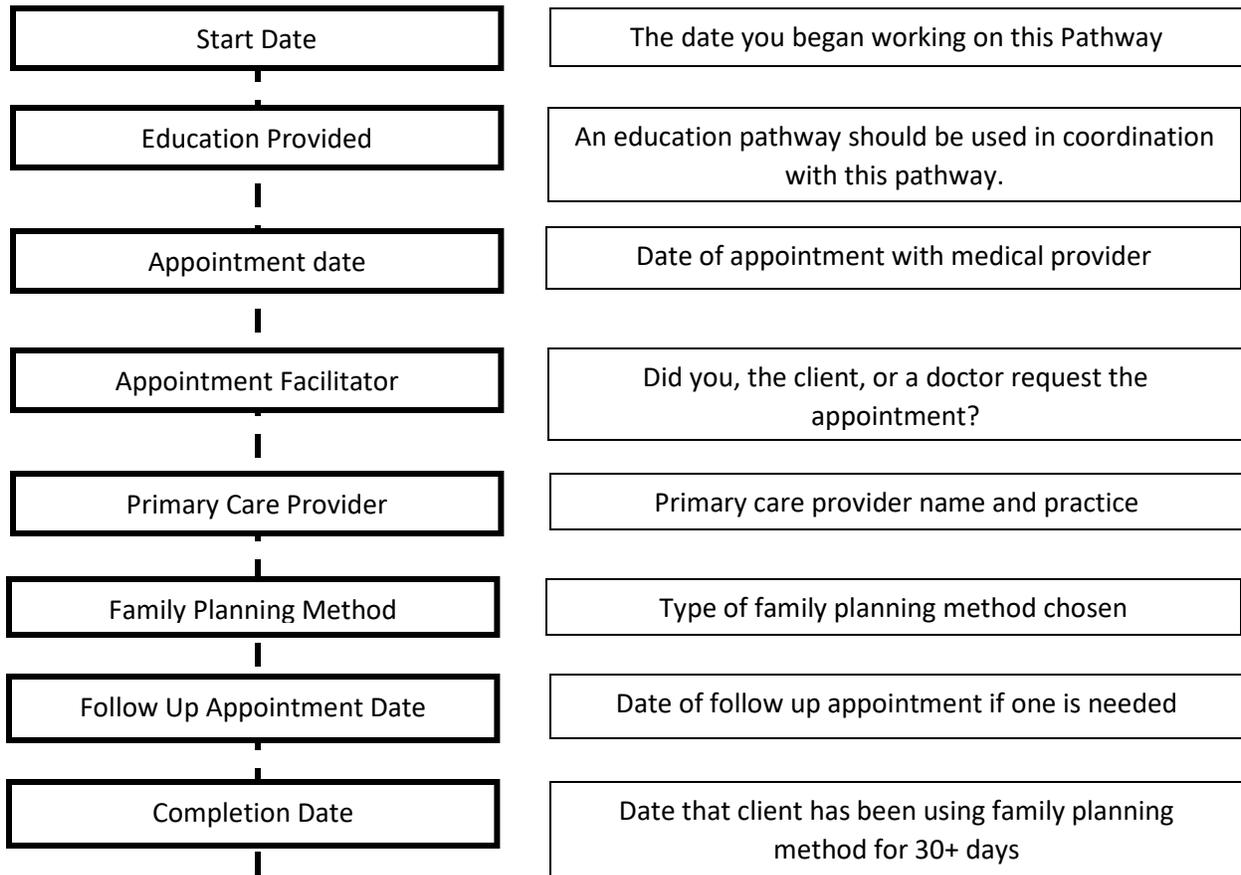
Finish incomplete if: Client was not able to find employment, did not keep employment for 30+ days, or is no longer interested in finding a job. Document the reasons why it was finished incomplete.

Care Coordinator's role:

- Find appropriate jobs for the client and help create resume or fill out applications
- Break down barriers like transportation, education, etc.
- Teach skills of finding a job instead of just doing the work for the client
- Check in with client as least every 2 weeks while trying to find a job and in the first month of employment

Family Planning Pathway

The family planning pathway should be used when your client would like help finding a family planning method. When beginning work with a client or after a birth, you should ask your client the One Key Question, “Would you like to become pregnant in the next year?” and begin a discussion about family planning.



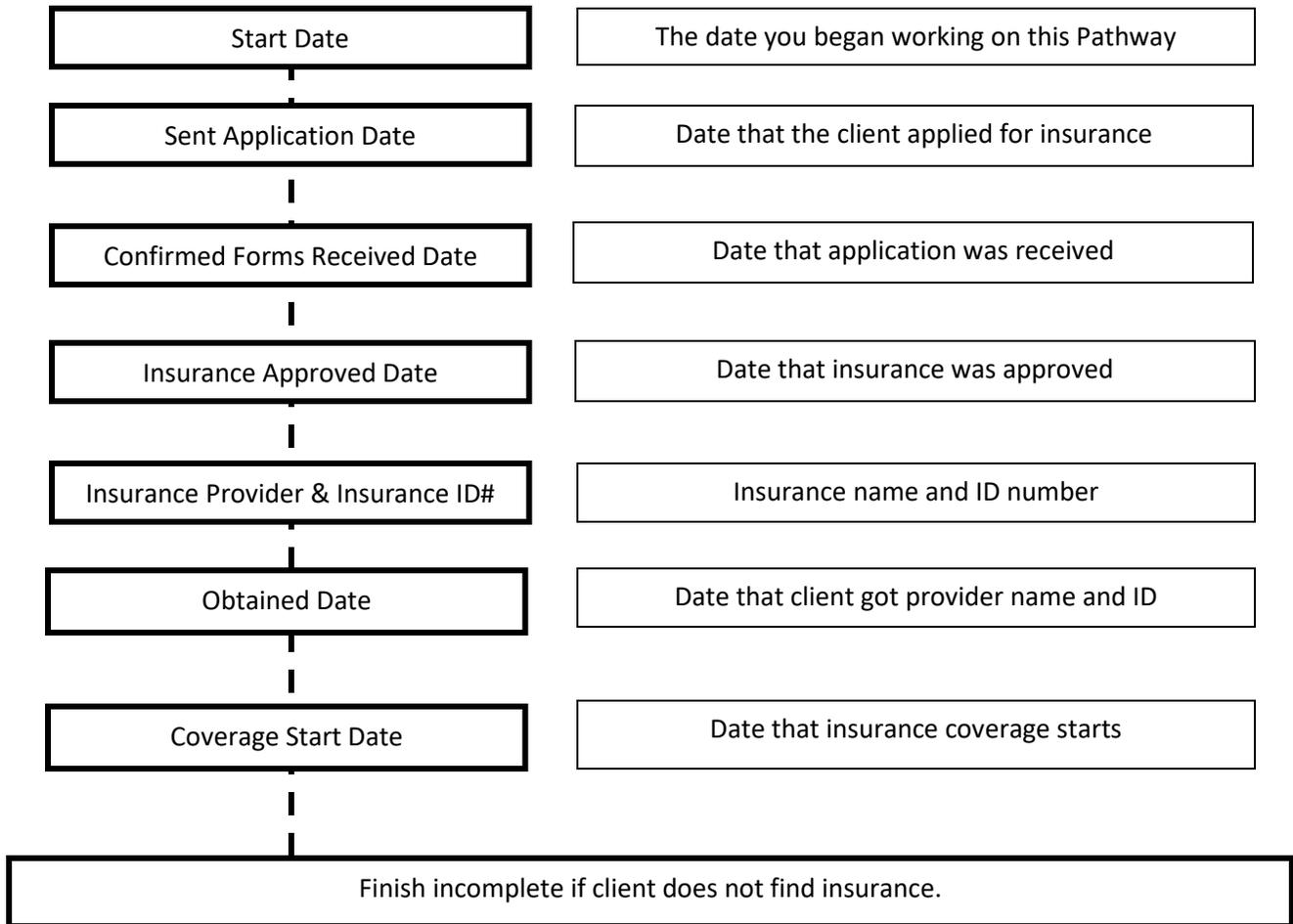
Finish incomplete if: Client did not start using a family planning method or stopped using one before 30 days.

Care Coordinator's role:

- Discuss the importance of family planning and use education pathway as needed to document education provided
- Help client schedule an appointment with their primary care provider or another medical specialist. Help them prepare anything needed for the appointment like paperwork or questions for the doctor.
- Break down any barriers like health insurance, transportation, or education needs.

Health Insurance Pathway

The medical home pathway should be used when a client needs to find health insurance coverage.

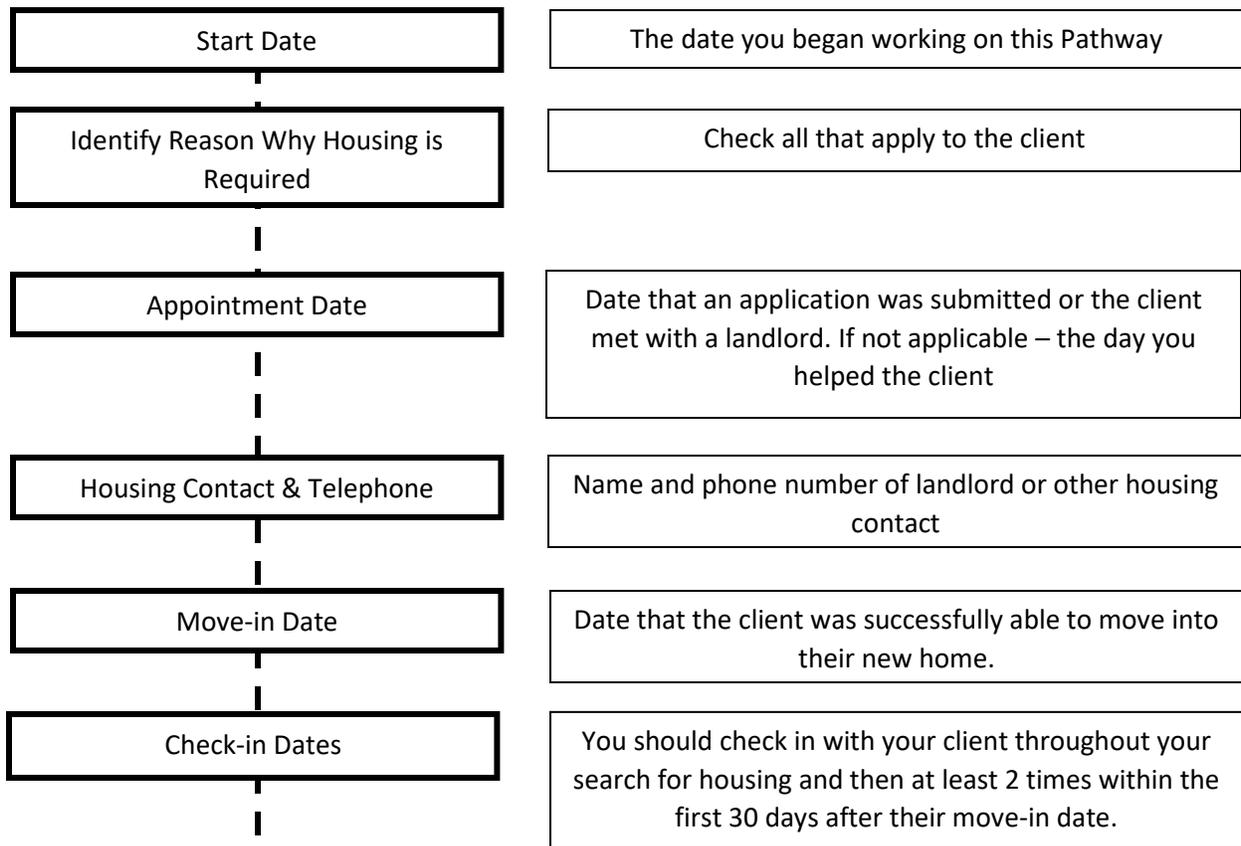


Care Coordinator's role:

- Help the client access health insurance by researching healthcare options, using Washington Health Plan Finder, or connecting the client with a Healthcare Navigator
- Help client prepare for any healthcare appointments by educating client on what they need to bring to the appointment (pay stubs, ID, etc)
- After completing the pathway, educate the client on using insurance, finding in-network doctors, etc. Use pathways and tools as needed.

Housing Pathway

The housing pathway should be used any time a client needs permanent housing due to eviction, homelessness, unsafe living conditions, or other situations that prevent them from being stably housed. The housing pathway should only be used if you are the primary person helping the client search for housing. If the client is working with a housing agency, use the Social Service Referral pathway for Housing.



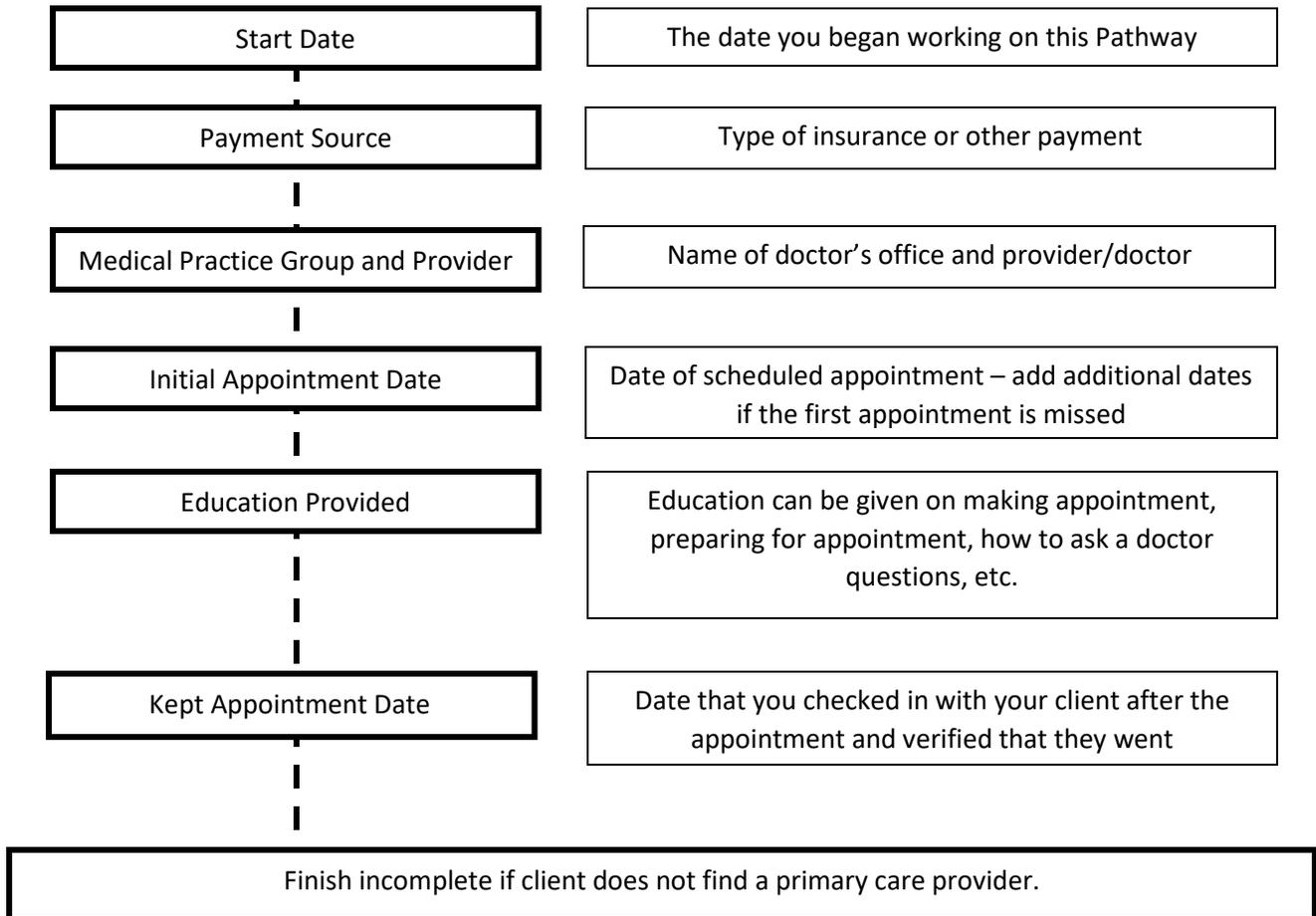
Finish incomplete if client does not find housing or no longer wants to search for housing. If client begins working with another agency to find housing, close this pathway as incomplete and open a Social Service Referral for Housing.

Care Coordinator's role:

- Help the client identify barriers to stable housing including finances, disabilities, past tenant history, lack of housing education, etc. Open pathways as needed to address these barriers
- Help the client search for available housing and teach how to find housing options.
- Help the client fill out applications, speak to landlords, and complete any other steps needed to find housing.
- Remember to educate the client on each step of the process to help them become more stable in the future.

Medical Home Pathway

The medical home pathway should be used when a client needs a primary care doctor.

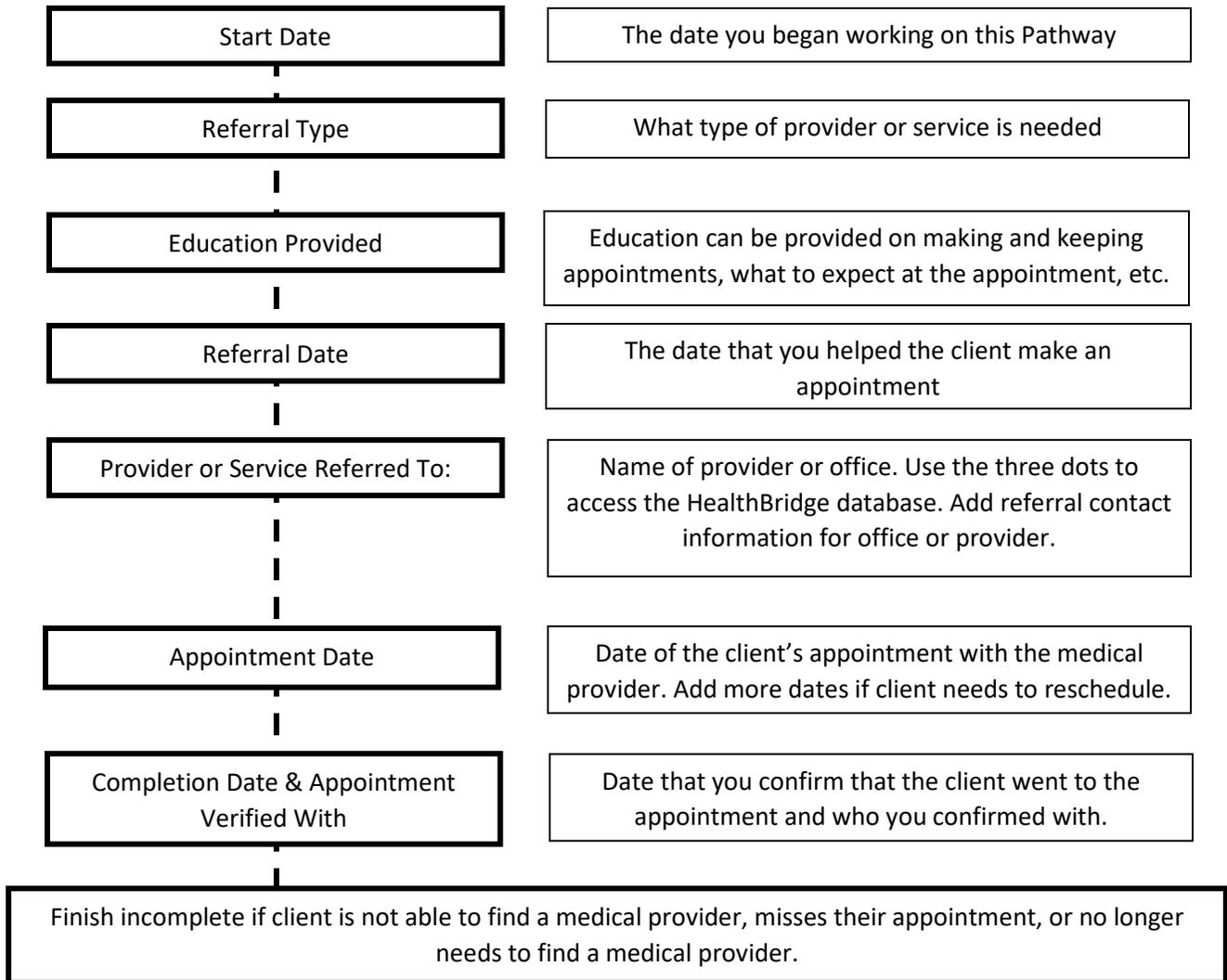


Care Coordinator's role:

- Help client find a primary care provider that takes their insurance and is appropriate for the care they need
- Assist client in making the appointment. Use an education pathway to document this.
- Help client prepare for appointment with education on talking to a doctor, knowing what to expect, and the importance of keeping the appointment
- Break down any additional barriers like transportation and insurance. Use additional pathways as needed.

Medical Referral Pathway

The medical referral pathway should be used when a client needs help finding a medical specialist other than a primary care provider, or when they need help making an appointment with an established primary care provider. If the client does not have a primary care provider, use the medical home pathway first. The medical referral pathway should only be used when you are helping a client find a doctor or make an appointment. Medical appointments that you do not help set up can be documented under the Client Admit/Visit tool.

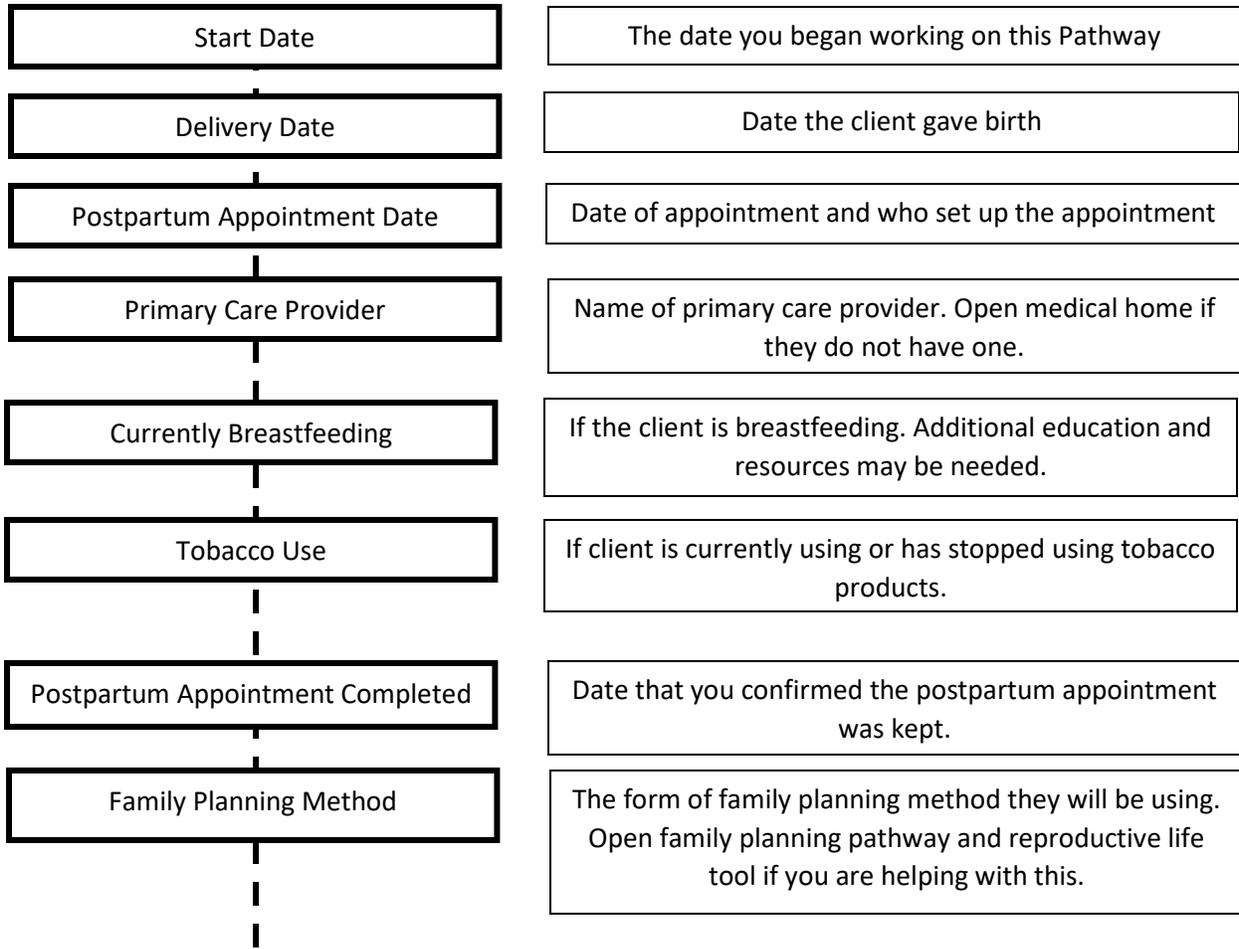


Care Coordinator's role:

- Help the client find a doctor that is appropriate for their medical needs, considering insurance, location, and availability.
- Help the client make the appointment, set up reminders, etc.
- Educate the client on how to make the appointment, how to prepare for the appointment, and help them develop any questions they might have for their provider.

Postpartum Pathway

The postpartum pathway should be used after a client is pregnant. A PHQ-9 should be used with each postpartum visit.



Finish incomplete if client does not complete postpartum appointments or does not want help with postpartum care.

Care Coordinator's role:

- Provide support to the client and find resources as needed
- Help client make and attend postpartum appointments
- Provide education as needed on smoking, breastfeeding, baby nutrition, available social service resources, etc.
- Document well baby visits with the medical referral pathway.

Pregnancy Pathway

The pregnancy pathway should be used when a client is pregnant. Follow the pregnancy checklist guideline to make sure all the steps are done in the correct order. Make sure client type is “Pregnant” and do an Initial Pregnancy Checklist before starting the pregnancy pathway. The pregnancy pathway is not closed until the pregnancy has ended.

Start Date	The date you began working on this Pathway
Education Provided	Education can be provided on health needs while pregnant, prenatal appointments, breastfeeding, etc.
1 st Prenatal Appointment	Date of the first prenatal appointment and who set up the appointment
Prenatal Care Provider	Name of provider that is providing prenatal care.
Current Est. Due Date	Name of provider that is providing prenatal care.
Concerns	List any concerns the client has about their pregnancy.
Initial Pregnancy Checklist visit	Date that you completed the initial pregnancy checklist
Estimated gestation age & Trimester at enrollment	Estimated pregnancy gestation & trimester when you did the initial checklist.
Number of prenatal appointments before the initial checklist	How many prenatal appointments the client went to before you started working with them
Confirmed prenatal appointments	Dates of any appointments while you are working with the client
Delivery information	Once the client has given birth, add in all delivery details

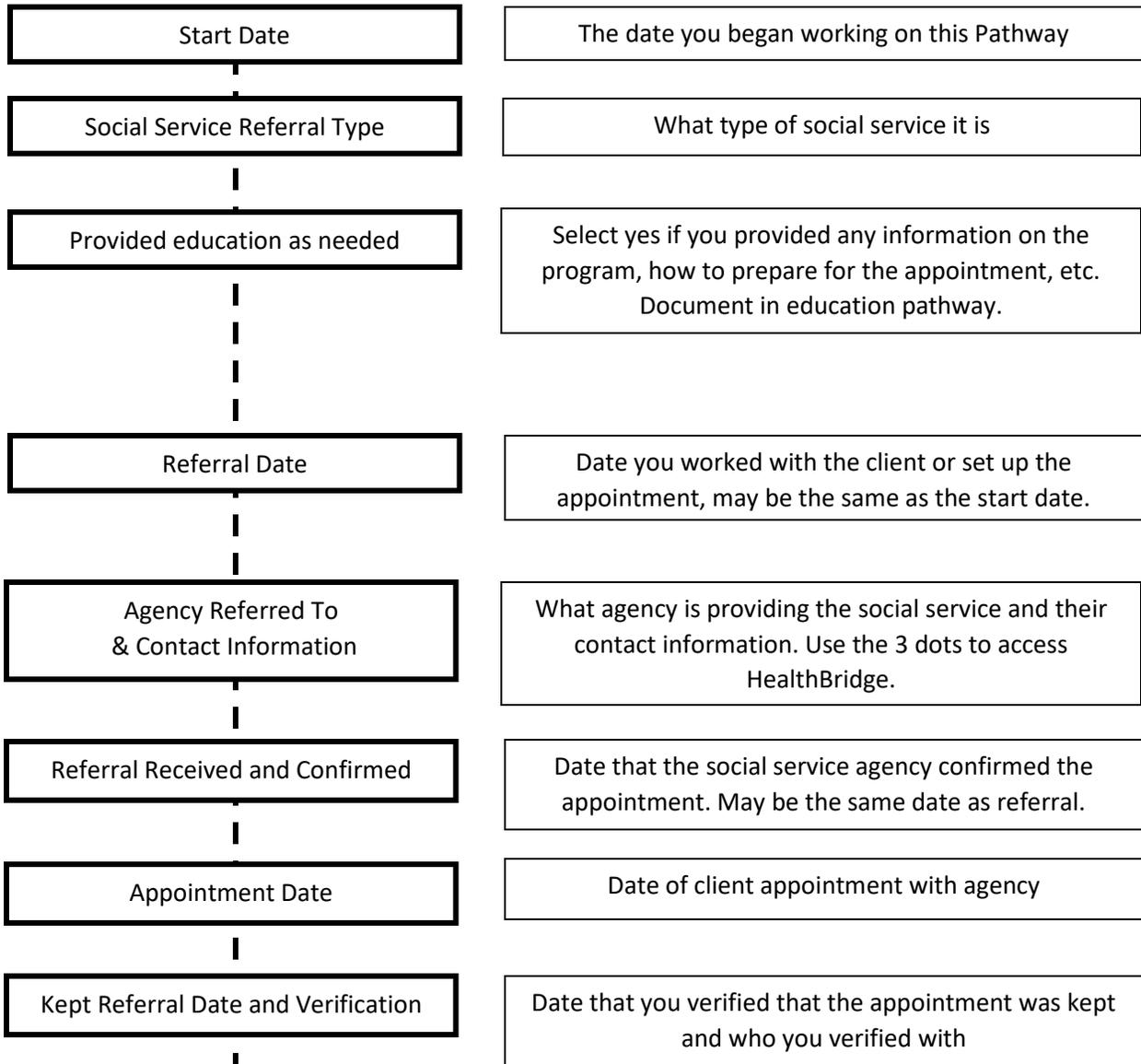
Finish incomplete if client does not want any assistance with their pregnancy or if the pregnancy ends other than a healthy weight baby.

Care Coordinator’s role:

- Help the client find prenatal care, access resources, and prepare to have a baby.
- Track prenatal care and any pregnancy needs the client has.
- Provide education on nutrition, health, pregnancy, breastfeeding, safe sleep, etc. At least one education should be provided with each visit.
- Take special notice if the client has a situation that will not allow her to keep her baby after delivery. Other resources may be needed.

Social Service Pathway

The social service pathway should be used any time you are helping your client access a social service resource. These referrals should help break down barriers that are affecting the client's health and wellbeing.



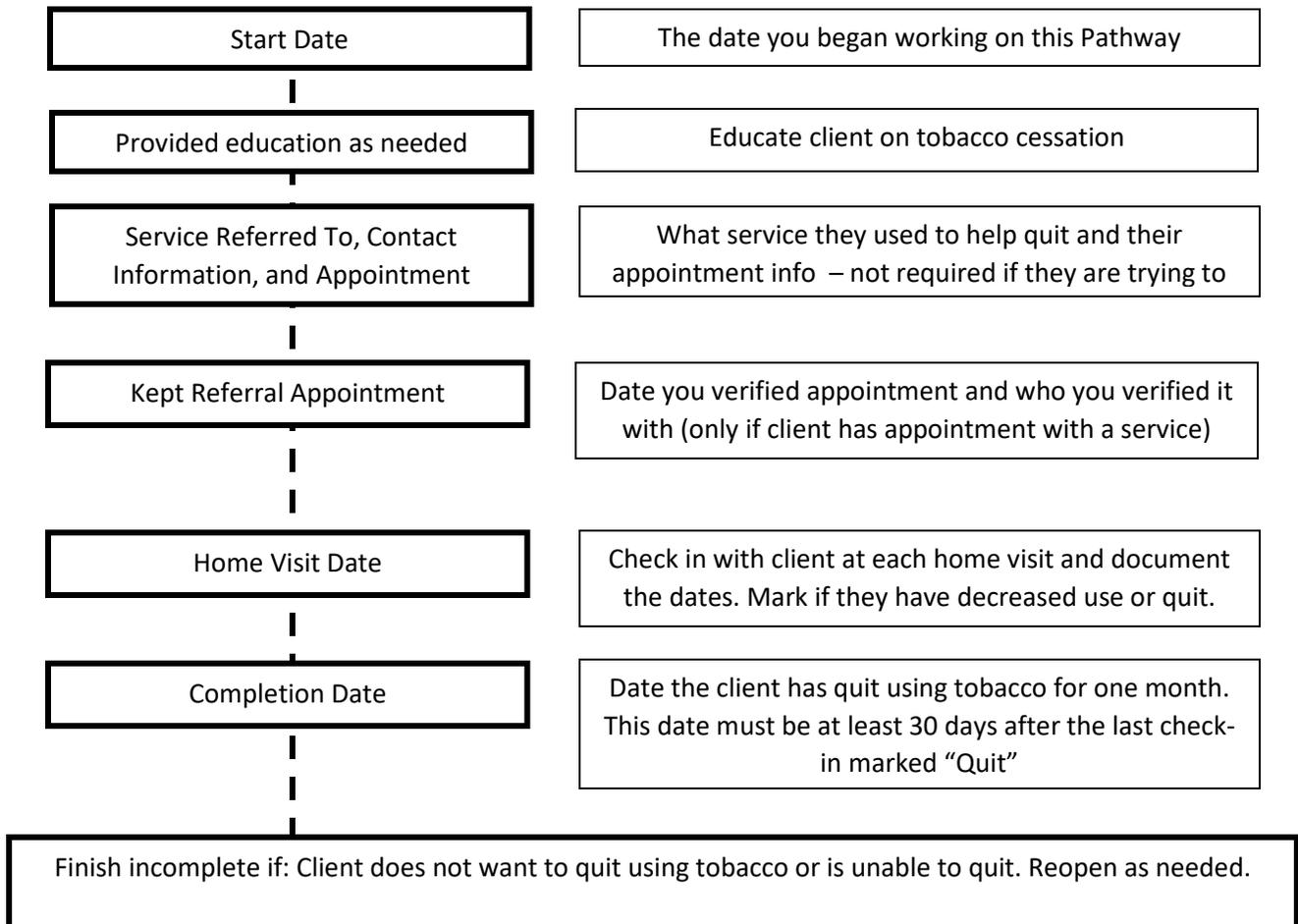
Finish incomplete if: Client no longer needed the social service referral, did not go to their appointment, or the social service could not be accessed.

Care Coordinator's role:

- Find appropriate resources and connect client
- Teach client how to find resources and make appointments
- Prepare client for the appointment – help organize or fill out paperwork, explain program, etc.
- Provide education as needed

Tobacco Cessation Pathway

The tobacco cessation pathway should be used any time a client tells you they would like to quit using tobacco products. This pathway will automatically open if the initial checklist shows that they use tobacco. If clients do not have an interest in this pathway, finish incomplete. If it is something they may be interested in, leave open until they are ready to work on it.



Care Coordinator's role:

- Use motivational interviewing to help understand motivation for quitting smoking
- Find resources to help client quit – some free services and support groups are available
- Support client in their progress
- Help break down any barriers they are facing
- Educate client on healthy changes, goal setting, and the benefits of quitting

POSLT Survey

1. What is your job title and organization?

2. Is your organization currently using Physician's Orders for Life-Sustaining Treatment ([POLST](#)) forms to summarize wishes of an individual regarding life-sustaining treatment? (Click here for [WA POLST form](#))

- Yes
- No
- I don't Know

3. If you are not currently using POLST forms, are you using a different form that collects this information?

- N/A
- I don't know
- No
- Yes

4. How widely are POLST forms implemented in your organization?

- Entire Facility
- Specific Department
- Specific Unit
- Not at all
- I don't know

5. Who usually initiates advance care planning with patients/residents?

- Physician
- NP/PA
- Social Services
- Nursing
- Care Managers/Patient Navigators

- Patient comes in with form
- N/A

6. What, if any, is your greatest concern about the use of the POLST form in clinical practice?

- Takes too long to complete
- Undermines patient autonomy
- Forms will get lost
- Forms will not be filled-out properly
- Patients/families will not understand the forms
- Physicians will not follow the instructions on the forms
- No concerns
- Other (please specify)

7. If you do not use the POSLT form, do you have plans to use it in the future?

- Yes
- No
- N/A

Chart 1.

Q5 Who usually initiates advance care planning with patients/residents?

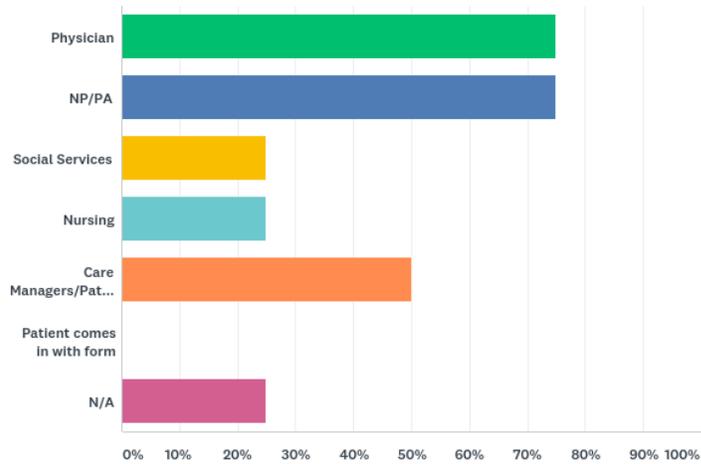
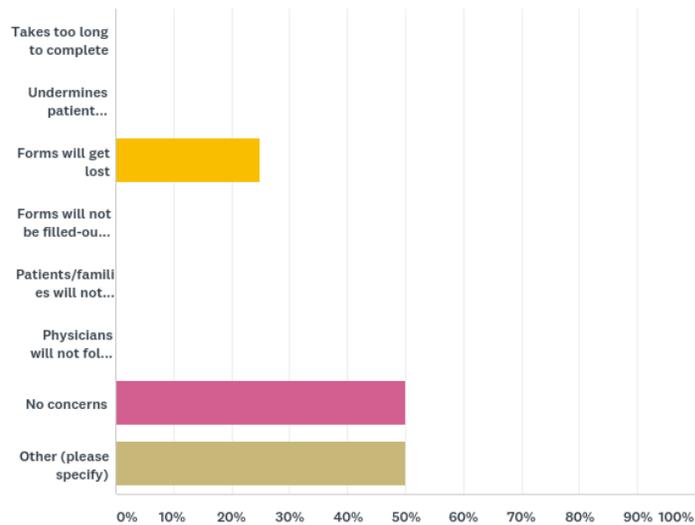


Chart 2.

Q6 What, if any, is your greatest concern about the use of the POLST form in clinical practice?



October 8

12:00pm – 1:00pm

A Path Forward: Evaluating and Treating Hepatitis C

Despite advances in care, the hepatitis C virus (HCV) remains a global health problem, requiring continued collaborative action to elevate awareness, increase diagnosis and improve linkage to care for all people living with the disease. In the past few years, medications have become available that cure HCV, and Washington State is taking strides to increase access to treatment options and care.

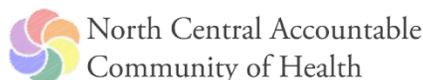
Please join us for a webinar to learn about the prevalence of HCV in Washington State, and learn about strategies to address barriers to treatment. Our lead presenters include Julio Gutierrez, MD, Medical Director of the Liver Transplantation Department at St. Vincent's Multi-Organ Transplant Center, and Molly Koch, Account Executive with AbbVie.

Who Providers (MD, DO, PA or ARNP) and any others who have patient contact (e.g., nurses, medical assistants, pharmacists, psychologists, social workers, community and public health workers, peers)

When Tuesday, October 8, 2019, from 12:00-1:00pm

Where Online webinar

[Click Here to Register](#)

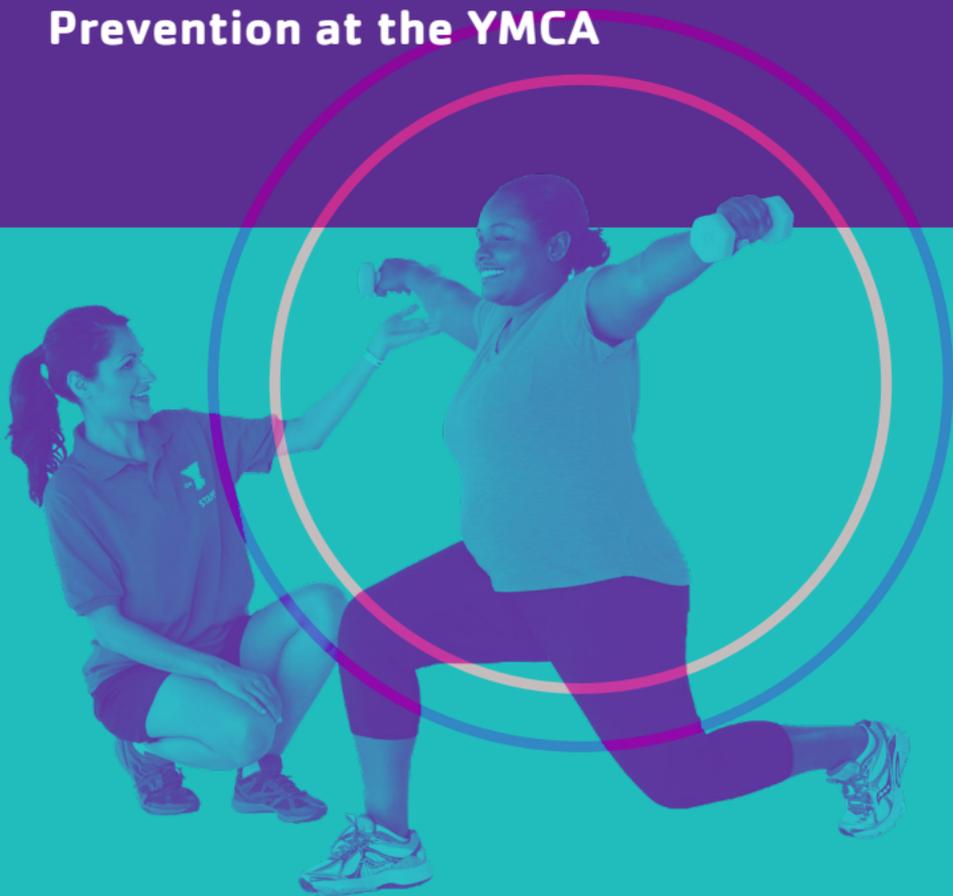


Appendix BB:
Co-Branded Patient Materials

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**



PeaceHealth





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).

February 8

9:00 am – 1:00 pm

MAT Waiver Training

Hosted by Cascade Pacific Action Alliance

Who Providers interested in prescribing buprenorphine (you are qualified if you are an MD, DO, PA or ARNP) and any others who have patient contact (e.g., nurses, medical assistants, pharmacists, psychologists, social workers, community health workers, peers). Having waived prescribers is important, but MAT is a team sport.

When Saturday, February 8, 2020 from 9:00am-1:00pm

Where Providence St Peter Hospital | 413 Lilly Rd NE, Olympia | 200 Rooms, Second Floor

CME This waiver training is **free of charge** and continuing medical education (CME) credits are available for physicians, nurses, physician assistants, and pharmacists. AAAP is the DATA 2000 Sponsor for this training.

Educational Objectives

- Screen and identify patients with OUD and define evidence-based treatments.
- Discuss the pharmacology of opioids as it relates to treatment of opioid use disorder (OUD) patients.
- Describe the fundamentals of office-based opioid treatment including the treatment of the co-morbid patient.
- Explain the process of buprenorphine induction as well as stabilization and maintenance.
- Discuss all FDA approved antagonist and agonist medications to treat OUD.
- Discuss basic office protocols including medical record documentation and confidentiality.
- Utilize evidence-based resources to ensure providers have the confidence to prescribe buprenorphine for patients with OUD.
- Recognize the importance of obtaining a waiver to begin treating patients with OUD.

To register, visit OlyBupeWaiver.eventbrite.com



Funding for this initiative was made possible (in part) by grant no. 1H79TI081968 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

March 14

9:00 am – 1:00 pm

MAT Waiver Training

Hosted by Cascade Pacific Action Alliance

Who Providers interested in prescribing buprenorphine (you are qualified if you are an MD, DO, PA or ARNP) and any others who have patient contact (e.g., nurses, medical assistants, pharmacists, psychologists, social workers, community health workers, peers). Having waived prescribers is important, but MAT is a team sport.

When Saturday, March 14, 2020 from 9:00am-1:00pm

Where Providence Centralia Classroom | 914 S Scheuber Rd | Centralia, WA 98531

CME This waiver training is **free of charge** and continuing medical education (CME) credits are available for physicians, nurses, physician assistants, and pharmacists. AAAP is the DATA 2000 Sponsor for this training.

Educational Objectives

- Screen and identify patients with OUD and define evidence-based treatments.
- Discuss the pharmacology of opioids as it relates to treatment of opioid use disorder (OUD) patients.
- Describe the fundamentals of office-based opioid treatment including the treatment of the co-morbid patient.
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- Recognize the importance of obtaining a waiver to begin treating patients with OUD.

To register, visit CentraliaWaiverTraining.eventbrite.com



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www.pcssNOW.org

Cascade (CPAA)

July 1, 2019- December 31, 2019

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A	\$ -	\$ 891,242.00	\$ 891,242.00
Project 2B	\$ -	\$ 612,729.00	\$ 612,729.00
Project 2C	\$ -	\$ 362,067.00	\$ 362,067.00
Project 3A	\$ -	\$ 111,405.00	\$ 111,405.00
Project 3B	\$ -	\$ 139,257.00	\$ 139,257.00
Project 3D	\$ -	\$ 222,810.00	\$ 222,810.00
Integration	\$ -	\$ -	\$ -
VBP	\$ -	\$ -	\$ -
Total	\$ -	\$ 2,339,510.00	\$ 2,339,510.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	\$ 13,223.76	\$ 15,249.38	\$ 28,473.14

Table 3: distribution of funds for shared domain 1 partners

	Q3	Q4	Total
Shared domain 1	\$ -	\$ -	\$ 1,826,655.00

Table 4: incentive funds distributed, by use category

	Q3	Q4	Total
Administration	\$ -	\$ -	\$ -
Community health fund	\$ -	\$ -	\$ -
Health systems and community capacity building	\$ 389,933.00	\$ 129,975.50	\$ 519,908.50
Integration incentives	\$ -	\$ -	\$ -
Project management	\$ -	\$ -	\$ -
Provider engagement, participation, and implementation	\$ 851,365.00	\$ 246,898.00	\$ 1,098,263.00
Provider performance and quality incentives	\$ 1,260,078.00	\$ 1,423,176.00	\$ 2,683,254.00
reserve/contingency fund	\$ -	\$ -	\$ -
Total	\$ 2,501,376.00	\$ 1,800,049.50	\$ 4,301,425.50

Source: Financial Executor Portal

Prepared by: Washington State Health Care Authority