January 27, 2021

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

RE: CPAA Semi-Annual Report 6

Dear Semi-Annual Report Review Team:

Please find attached a copy of Cascade Pacific Action Alliance’s (CPAA) sixth semi-annual report for the Medicaid Transformation Project (MTP). This report summarizes CPAA’s work from July 1, 2020, through December 31, 2020, 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 healthcare delivery system transformation through cross-sector collaboration, in addition to responding to the COVID-19 pandemic. Key accomplishments during the reporting period include, but are not limited to, expanding Community CarePort to serve individuals diagnosed with COVID-19, continuing to offer numerous online training opportunities, and helping partners prepare to keep MTP project work sustainable.

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
Table of Contents

Section 1: ACH Organizational Updates .................................................................................. 5
Section 2: Project Implementation Status Update ................................................................. 9
Section 3: Value-Based Payment .......................................................................................... 22
Section 4: Pay-for-Reporting (P4R) Metrics ........................................................................ 24
Appendixes ........................................................................................................................... 25
  Appendix A: Annual Report ................................................................................................. 25
  Appendix B: Change Plan Reporting Template ................................................................. 31
  Appendix C: Change Plan Modification ............................................................................ 37
  Appendix D: Performance Improvement Plan .................................................................... 38
  Appendix E: A Review of Health Priorities ........................................................................ 41
  Appendix F: MAT Waiver Training ..................................................................................... 43
  Appendix G: Chronic Disease Self-Management Online .................................................... 44
  Appendix H: Home Health Equipment RFP ...................................................................... 45
  Appendix I: Living Well Thurston Online Workshop ........................................................ 47
  Appendix J: Collaborative Documentation Webinar .......................................................... 48
  Appendix K: Suicide Prevention in Primary Care Webinar ............................................... 49
  Appendix L: Question, Persuade, Refer (QPR) Webinar Series ......................................... 58
  Appendix M: HCA’s 2020 VBP Survey Link in Newsletter ............................................... 59
  Appendix N: HCA’s 2020 VBP Survey Link Email .............................................................. 63

*CPAA P4R Metric Reporting, Partner Roster, Updated Project Implementation Work Plan, and Payment Reconciliation Template COVID/Non-COVID Payment Reports 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.

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>Cascade Pacific Action Alliance (CPAA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Jean Clark</td>
</tr>
<tr>
<td>Phone number</td>
<td>360-539-7576 ext. 116</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:clarkj@crhn.org">clarkj@crhn.org</a></td>
</tr>
<tr>
<td>Secondary contact name</td>
<td>Kyle Roesler</td>
</tr>
<tr>
<td>Phone number</td>
<td>360-539-7576 ext. 126</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:roeslerk@crhn.org">roeslerk@crhn.org</a></td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Primary care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this <a href="https://wabca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26">template</a> or a similar format) that addresses internal controls, including financial audits.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

---

2 [https://wabca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26](https://wabca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26)

Reporting period: July 1, 2020 – December 31, 2020
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.

**Documentation**

The ACH should provide applicable documents 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.

   - Include staff names and titles in the organizational chart. For vacant positions, mark each applicable position as “vacant” on the organizational chart.
   - Provide a narrative explanation of the organizational changes.

   *If applicable, include current organizational chart.*

**Table 1: CPAA Organizational Updates**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean Clark</td>
<td>CEO</td>
<td>Provides strategic direction and oversight of the organization.</td>
</tr>
<tr>
<td><strong>Caitlin Moore</strong></td>
<td>Substance Use Response and Youth Marijuana Prevention Program Manager</td>
<td>Manages the Youth Marijuana Prevention and Education program and the Opioid Response Program.</td>
</tr>
<tr>
<td>Christine Haywood</td>
<td>HR Manager</td>
<td>Manages HR.</td>
</tr>
<tr>
<td>Ivan Rodriguez</td>
<td>Data and IT Manager, Technical Officer, and Privacy Officer</td>
<td>Provides oversight of data analytics and IT, as well as maintains security of protected health information.</td>
</tr>
<tr>
<td>Kyle Roesler</td>
<td>Lead Program Manager and Care Integration Manager</td>
<td>Lead manager for all MTP programs and manages the Bi-Directional Care Integration program.</td>
</tr>
<tr>
<td><strong>Position will not be rehired at this time</strong></td>
<td>Communications Manager</td>
<td>Manages all communication tasks.</td>
</tr>
<tr>
<td>Michael O’Neill</td>
<td>Pathways Hub Manager</td>
<td>Manages the Pathways program.</td>
</tr>
<tr>
<td>Abigail Schroff</td>
<td>Chronic Disease and Transitional Care Manager</td>
<td>Manages the Chronic Disease and Transitional Care programs.</td>
</tr>
<tr>
<td><strong>Kennedy Chesoli</strong></td>
<td>Community Wellness Manager</td>
<td>Manages Reproductive and Maternal/Child Health programs.</td>
</tr>
</tbody>
</table>
| **Megan Szabla**          | Executive Assistant and Communications Specialist | Provides administrative support for the CEO and BOD.  
*absorbed all Communication Manager duties* |
| Joshua Plaster            | Program Support Coordinator                   | Provides administrative support for programs.                        |
| Eleanor Dovey             | Finance Manager                               | Provides fiscal and administrative support.                          |
| **Jennifer Murray**       | Fiscal and Contracting Specialist             | Provides fiscal and administrative support to Finance Manager.       |
| 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. |
| **Amber Shirk**           | Community Outreach and Navigator Program Manager | Collaborates and coordinates with Tribes, outreach efforts, and local forums. Runs the Navigator program for WAHBE. |
| **Lawrence Kinnaman**     | Community Outreach Coordinator                 | Assists the Community Outreach and Navigator Program Manager.        |

a) **Financial Executor Portal activity for the reporting period.** The Independent Assessor will receive 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.**

b) The ACH is asked to provide additional context to add clarity about the portal activity payments made outside the portal.
   - For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.³

CPAA set aside $25,000 to contribute to Community CarePort’s Hunger Initiative based on emergent needs identified during COVID-19; Safeway produce vouchers are given to CarePort clients who screen positive for food insecurity. CPAA has received and paid Safeway directly for invoices totaling $23,276 for vouchers redeemed during this reporting period.

   - For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.⁴

---

³ The HCA issued COVID 19 reconciliation spreadsheet can be found at the following link: [https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx](https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx).

⁴ The HCA issued non-COVID reconciliation spreadsheet can be found at the following link: [https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx](https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx).
Financial Executor Portal activities for this reporting period are categorized appropriately, with the exception of $6,000 paid directly to Cascade Pacific Action Alliance (CPAA) to fund two local forums. These funds were drawn by CPAA and paid to the two local forum partners not registered in the Portal.

11. Incentives to support integrated managed care. Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support the region in transition to integrated managed care.

a) List of use and expenditures that reflect a cumulative accounting of all incentives distributed or projected to support the transition to integrated managed care. It is not limited to the reporting period.

   i. ACHs may use the table below or an alternative format as long as the required information is captured.

   ii. Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

   iii. Description of use should be specific but concise.

<table>
<thead>
<tr>
<th>Description of Use</th>
<th>Expenditures ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Contracting from a Position of Strength: an IMC training event with</td>
<td></td>
</tr>
<tr>
<td>Adam Falcone, held on April 18, 2019.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$12,000</td>
</tr>
<tr>
<td></td>
<td>$15,000</td>
</tr>
<tr>
<td></td>
<td>$1,950</td>
</tr>
<tr>
<td></td>
<td>$1,500</td>
</tr>
<tr>
<td>EHR enhancement funding to support partners transitioning to IMC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$330,000</td>
</tr>
<tr>
<td></td>
<td>$330,000</td>
</tr>
<tr>
<td>Interpreter Services for the IMC Provider Readiness Workgroup.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1532</td>
</tr>
<tr>
<td></td>
<td>$2000</td>
</tr>
<tr>
<td>Ongoing contract with XPIO Health to provide technical assistance for up to 12</td>
<td>$160,122</td>
</tr>
<tr>
<td>behavioral health agencies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$170,000</td>
</tr>
</tbody>
</table>
Section 2. Project implementation status update

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

Attachments

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

12. Implementation work plan

The reporting requirements for the implementation work plan updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. The submission of an updated implementation work plan is considered optional for this reporting period but is encouraged to the extent the ACH has an updated 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 information to monitor ACH activities and project implementation timelines.

- Optional: The ACH may submit an updated implementation plan reflecting progress made during the reporting period.


Table 4: Implementation Plan Work Step Status Legend

<table>
<thead>
<tr>
<th>IP Work Step Status Legend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete, Deliverable Met</td>
</tr>
<tr>
<td>Fulfilled for Quarter, Remains in Progress</td>
</tr>
<tr>
<td>Delayed, Remains in Progress</td>
</tr>
<tr>
<td>Not Started</td>
</tr>
<tr>
<td>Edited Work Step</td>
</tr>
</tbody>
</table>

13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation. To earn the

---

5 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

Reporting period: July 1, 2020 – December 31, 2020
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. ACHs should maintain the roster provided by HCA at the time of the SAR4 release for the remaining semi-annual reporting periods.

**Instructions:**

a) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.

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

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

*Submit updated partnering provider roster.*

Please see CPAA.SAR6.Partner Roster.12.31.20.

**Documentation**

The ACH should provide documentation that addresses the following:

14. **Quality improvement strategy update**

The reporting requirements for the quality improvement strategy updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. The submission of quality improvement strategy updates are considered optional for this reporting period but are encouraged to the extent the ACH has an updated quality improvement strategy to keep HCA and the IA apprised of quality improvement activities and findings. If submitting updates, ACHs may determine the format to convey this information.\(^6\)

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

---

\(^{6}\) Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section
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. 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 success; 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 regularly updated 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. 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. CPAA worked with Providence CORE (CORE) to determine what measures to be reported for each evidence-based intervention.

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. During this reporting period, CHOICE Regional Health Network, the administrative support organization for CPAA, also compiled a 2019 Annual Report and distributed it to all board members, MCOs, and MTP implementation partners (Appendix A).

CPAA continues to solicit and respond to feedback from partners regarding all areas of ACH activity, including but not limited to, Change Plans, reporting, meetings, and shared learnings. CPAA also utilizes the process of multi-sector “testing” and adapts 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.

Based on partner feedback, and as part of CPAA’s Quality Improvement Strategy, the partner reporting template was revised for 2020 (Appendix B). Each partner’s Change Plan and Reporting Template is now a single, stream-lined document. With the new template, partners are able to see milestones for all quarters until the end of the Transformation. CPAA provided recorded instructions that walked partners through the new template, in addition to program managers being available to answer any questions or concerns.

At the end of this reporting period, as part of CPAA’s Quality Improvement Strategy, CPAA required all MTP Implementation Partners to review and modify their Change Plans (Appendix C) as we head into the fifth year of the MTP. Change Plan Modification encourages and supports partners as they revise their Change Plan to accurately and realistically detail project work for Year 5 that focuses on achieving sustainability in approved projects, and potentially drop interventions and project areas that aren’t successful.
As a region, CPAA needs to focus limited resources where the funding can make the biggest impact. To this end, some MTP Implementation Partners have been placed on a Performance Improvement Plan (PIP) (Appendix D). CPAA Program Managers continue to work closely with those partners as they modify their Change Plans, develop rapid improvement activities, and work towards meeting MTP milestones and fulfilling their PIPs.

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

- Change Plan Modification.
- PIP support.
- Collaborative partner calls focused on peer-to-peer learning and peer-to-peer training.
- Provider Readiness Workgroup and dedicated webpage to support transition to IMC.
- Virtual site visits with MTP Implementation Partners.
- CPAA continues to solicit and then incorporate partner feedback on reporting, meetings, and shared learnings.
- Continuing to broadly share partner success stories and highlight lessons learned.
- Continuing to host and facilitate cohort calls to address specific interventions (e.g., pediatric call, behavioral health integration call, MOUD provider group).
- Continuing to provide MTP Implementation Partners a compliance report/email following partner quarterly reporting.
- Developed a compilation of CPAA’s 2020 Local Forum health priorities in relation to CPAA’s 2017 Regional Health Improvement Plan (Appendix E).
- Project 2B: monthly community of practice meetings and monitoring and assessment of Care Coordinating Agency’s (CCAs) monthly performance on standardized metrics. Monthly meetings provide ongoing training, time to ask questions and get feedback, and great communication across CCAs.

### Regional Framework for Supporting Partnering Providers’ Quality Improvement Processes

<table>
<thead>
<tr>
<th>QI Area for Improvement</th>
<th>QI Activities</th>
</tr>
</thead>
</table>
| Structured Quality Improvement Activities and Partnering Provider Support Provided by CPAA | • 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  
• Test new quality improvement methods with partnering providers  
• Continue to embed ongoing learning opportunities, best practices, implementation successes and challenges, and |
| Methods and Frequency of Tracking Partner QI Progress | • MTP Implementation Partners report on Change Plan milestones quarterly – Excel milestone report and Word narrative report submitted to CPAA  
• MTP Implementation Partners report on metrics semi-annually - Excel milestone report and Word narrative report submitted to CPAA  
• Conduct MTP Implementation Partner site visits  
• Monitor qualitative and quantitative data for intervention/s to evaluate success of organizations’ implementation of selected evidence-based interventions  
• CPAA issues quarterly performance emails to individual MTP partners and a bi-annual report to the broad stakeholder group  
• TA partners (Xpio Health, AIMS Center) provide quarterly reports to target efforts and advise progress |
| Process of Communicating and Implementing Adjustments to Optimize MTP Approaches | • 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 project/s  
• Solicit advice from clinical experts and provider champions  
• Develop partner performance improvement plans as needed |
| Technical Assistance Provided or Facilitated by CPAA | • Use performance improvement 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 AIMS Center for partners participating in Bi-Directional Care Integration  
• Contract with Xpio Health for behavioral health partners transitioning to Integrated Managed Care  
• CPAA contracts with CCS for partners participating in Community-Based Care Coordination (Pathways) |
| Methods and Frequency of Sharing Approaches and Lessons Learned | • 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 |
Narrative responses

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

**15. COVID-19**

1. Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have changed (i.e., which projects remain on track, which projects or areas of focus have expanded, which capacity building efforts have emerged, etc.).

ACH activities in response to COVID-19 during the reporting period include:

- Community CarePort Care Connect program further developed with WA Department of Health.
- $30,000 of food vouchers distributed across our region through CarePort Care Coordination Agencies.
- Through collaboration with The Moore Wright Group (TMWG), CPAA acted as the conduit for connecting communities with resources through TMWG’s Disaster Relief program. The program helped connect and distribute over $6,402,005 throughout 21 counties, servicing more than 201,000 families and 159 organizations.
- Organized food distribution activities with TMWG.
- Updated a dedicated COVID-19 resource webpage.
- Council Meetings, site visits, and trainings remained online due to physical distancing guidelines.
- Distributed over 210,000 masks.
- MOUD (medications for opioid use disorder) Waiver Training went to a virtual format (Appendix F).
- Contracted with Canary Health to offer online Chronic Disease Self-Management program (Appendix G).
- Home Health Equipment funds released to expand remote monitoring of chronic conditions (Appendix H).
- Co-hosted Living Well Thurston online workshop series that focused managing chronic physical or mental health conditions (Appendix I).
- Hosted a webinar with the AIMS Center on Collaborative Documentation (Appendix J).
- Hosted a webinar with the AIMS Center on Suicide Prevention in Primary Care (Appendix K).
- Hosted a series of Question, Persuade, Refer (QPR) webinars focused on suicide prevention and trained over 60 community members (Appendix L).

As a result of COVID-19, DSRIP activities were impacted in a number of ways including CPAA’s partners’ capacity to continue offering certain services and the overall DSRIP timeline laid out by the HCA. COVID-19 impacts include:

- Project 2A: Numerous partners reported staff positions were furloughed and/or laid off, ranging from physicians to medical assistants and behavioral health providers to other support staff.
Three out of four of CPAA’s pediatric partners were severely affected by the COVID-19 pandemic, as a majority of their patient populations are Medicaid beneficiaries. Due to this primary single stream of revenue and not being able to serve Medicare patients, there were not other insurance reimbursement options to buffer the revenue losses from decreased patient visits.

- Project 2B: CPAA’s Community CarePort expanded its care coordination services into a new program and partnership with the WA Department of Health named Care Connect WA. Individuals that test positive for COVID-19 can access this service and receive assistance with accessing community resources and food while under quarantine.

- Project 2C: This program area remains on track, and our partners were largely unaffected by COVID-19 in this area.

- Project 3A: This program area remains on track, and our partners were largely unaffected by COVID-19 in this area.

- Project 3B: With markedly decreased patient visits, pediatric providers noted that immunization rates will be impacted. While providers have adjusted their service delivery model for well child visits, many families will not get immunizations at the same time as they would have under normal circumstances, which will impact the MTP projects aimed at increasing immunizations for children 0-2.

- Project 3B: School-based health center projects have been severely impacted given the statewide closing of schools. While some partners have been able to transition student clients to other clinics or switch to telehealth models, these sites to not offer the same benefits as the “brick-and-mortar” school-based models.

- Project 3B: Home visiting programs have been severely impacted by COVID-19 response. Nurse Family Partnership, which supports over 300 high-risk pregnant and parenting families in the CPAA region, was deemed a non-essential program, leaving these families without the critical support provided by NFP nurses.

- Project 3D: Diabetes Prevention and Chronic Disease Self-Management Programs have specifically suffered from delays in project work due to the nature of these programs requiring in-person meetings. However, some partners have explored the possibility of offering these programs virtually.

2. Describe any DSRIP activities that enabled the ACH and partners to respond to and navigate the COVID-19 pandemic (e.g., care coordination, information exchange, telehealth access, data analytics, population health training and technical assistance, etc.), as applicable. If applicable, indicate whether certain activities applied to specified sub-populations within your region. Describe any lessons learned that the ACH will use to support projects and partnerships moving forward.

CPAA continues to offer project-specific support that enabled partners to navigate the COVID-19 pandemic. Project-specific response activities include:

- Project 2B: Community CarePort adapted additional policies and procedures to allow for and promote a shift to phone-based care coordination when necessary.

- Project 2B: CarePort’s COVID-19 Community Support and Monitoring Program evolved into a
collaboration with the WA State Department of Health which is ongoing. This new program is called Care Connect WA.

- Project 2C: Participated in a Collective Medical workgroup focused on establishing transitions of care guidelines for organizations using the Collective Medical platform. Partners provided input for the completion of this document, and a final copy will be presented in 2021.

- Implementation and expansion of telehealth continued across the region for behavioral health agencies, primary care clinics, and hospitals.

- One of our behavioral health partners established a COVID phone line which is serving as a method to connect clients with community services.

3. Describe how your ACH included Tribes/IHCPs in your COVID-19 response activities. Tribes/IHCPs had the ability to access all of the COVID-19 response activities listed above.

4. Specific to partnering providers, describe how the ACH has adjusted contracts, reporting, type of provider engaged, and/or payment strategies.

Specific to partnering providers, CPAA adjusted contracts, reporting, and payment strategies to include:

- Partners on PIPs were given flexibility in completing project activities.
- Q3 and Q4 reporting resumed as normal with no negative impacts to partners.
- The process for partners to update change plans for 2021 was extended to allow an ample amount of time to make any modifications.
- Payment strategies were adjusted for Q1 and Q2 but not for Q3 and Q4.

5. Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access). Also highlight any mitigation strategies or activities that shifted as a result, if applicable. Indicate whether this applied to specified sub-populations within your region.

During this reporting period, the following challenges still exist:

- Workforce shortage/not enough providers, particularly in rural areas, and staff turnover and furloughs
- High demand for services/not enough capacity, particularly around MOUD and behavioral health
- Transportation barriers for recipients of services, particularly in rural areas
- Lack of affordable housing for recipients of services and rental pressures
- High demand/not enough access to legal services for recipients of services
- Costs and training associated with quickly transitioning to telehealth/remote services while maintaining quality of care due to COVID-19 and physical distancing requirements
- Financial challenges, including precarious funding sources/reimbursement rates and reduced income due to reduced clinic services that jeopardize/interrupt continuity of care during a crisis (i.e., COVID-19), especially for clinical partners, behavioral health/SUD services, and smaller stand-alone clinics
• A decrease in utilization of behavioral health services for children and adolescents who are not being identified and referred to services through traditional avenues such as schools.

• State-wide school closings, which caused a decrease in reporting of child abuse, increase risk of domestic violence, and a decrease in utilization of youth services.

• A decrease in well child visits creates concerns about immunization rates and spread of preventable diseases other than COVID-19.

While CPAA was not able to mitigate all the challenges partners identified during this reporting period, the ACH did:

• Remain flexible with partner reporting requirements.

• Adapt meetings and trainings to an online/virtual format.

• Provide telehealth trainings to quickly increase capacity.

• Focus many Pediatric Collaborative Calls on COVID-19 response in pediatrics across the CPAA region.

6. Highlight one best practice or “bright spot” that emerged during this reporting period as a result of COVID-19, if applicable.

The following “bright spot” was shared by one of our partners in the Q3 report.

Patient is 41 year old female, who was being seen in our internal addiction department. She is in the process of getting her RN license back, and has her CADC, currently working for a health care system as a care coordinator, part time. She is married, looking to change jobs again soon, and has amazing insight into her own behaviors. Her situation and entry into MOUD in PC, was not exactly to plan, but it showcases the strengths of having suboxone in primary care, and having navigator to assist with problem solving and managing this transition.

Her origin of OUD, was due to a motor vehicle accident, that left her dependent on pain medication, and she ended up on heroin. She originally started using a Medicaid integrated healthcare system, with substance use treatment, mental health, that included some transitional housing. Unfortunately, this first attempt did not go smoothly for her. The program focused more on her inabilities, and focusing on using public safety net systems, rather than bringing her back into employment, and the community as a whole. She was not successful and relapsed a few time.

She then began Suboxone, and has been stable on it for over 4 years, with occasional THC use, although has stopped that, as of last April as well.

Due to employment disruptions, her insurance had changed to Medicaid. Patient was assigned to a PCP in the clinic she attends to provide suboxone, and to become her PCP. While she had been very engaged with our internal addiction medicine team, most medical care was sporadic, and not through primary care. Follow up for those health care needs, was never really followed, leaving some things to still be addressed.

She had originally connected to our internal addiction medicine from another MAT provider and had already gone through a MAT provider switch that was stressful for her. When she was informed of the possibility of receiving medication through primary care, and that this was a new program, she felt relieved it could still take place within Kaiser, and didn't need to go back to a higher level or care MAT provider in the community, but was hesitant about medical bias, and some past bad experiences with
the pharmacy and other medical staff that really impacted her belief that she would be treated with equity and respect.

Patient did meet with her new provider, and the appointment, was a bit unnerving for her. The initial appointment did not go quite to plan, and the patient was very nervous about having someone look into her actual healthcare and not just around her suboxone. This made her feel a bit wary, especially due to past bias she has felt from medical community. She was also concerned about why this was occurring, and whether it was a good fit with this provider. She reached out to Navigator about the situation very upset through a message. The next day nav and patient talked at length, and she apologized for some of her statements, and stated that COVID and remote work, had been really taking a toll, and she felt she may have overreacted. Navigator stated that patient still was correct to reach out with any concerns, and they were valid. Patient showed amazing insight into her own behaviors and thought processes as well as identifying some key factors that could have influenced how she was feeling about the situation. Navigator, listened, and empathized, and patient was presented with choices, if she felt this provider was not a good fit. Patient decided to stay with the provider, as she was aware of her own sensitivity around MAT due to past bad experiences, and stated “I just think I was shocked that anyone cared about my health care”. She had some health care needs, that she had never followed up on, and this provider had identified this, along with some ongoing other health issues. She also identified that the provider comes from a different cultural background, and she reflected that maybe her concerns were due to a differences in communication style as well. Navigator expressed gratitude towards this insight, but wanted to make sure she felt comfortable. Navigator had already begun to think about how to explore patient lens with these new provider of suboxone, to assist in creating positive patient experiences with this work, and patient was happy to help. Having her feeling heard by health care was very important to her, and to our providers.

It was pleasing to see a situation that started on the wrong foot, easily transition into a supportive health care relationship for her. Her voice and concerns were heard, she had support and offered choices as to her own health care needs, and helped us identify future educational needs, and the importance of patient lens, when it comes to this work. Bias is something, many of these patients feel in healthcare, and to be able to start a new relationship with patients, that have often felt ignored, is one of the best steps we can take. To see patients start engaging and taking proactive steps towards addressing their health, is a huge step forward for her, and for Kaiser.

16. Scale and sustain update

Per the Project Toolkit, ACH SAR 6 must include a section on scale and sustain activities undertaken by ACHs during the reporting period. This section will appear in each SAR thereafter, with questions revised and added to reflect the current phase of work. In answering these questions, please focus on activities that took place during the six-month reporting period. Recognizing P4P incentives for DY4 and DY5 will be paid out in 2022 and 2023, have these funds been obligated? In addition to answering yes/no, please provide relevant context regarding this question and each of the following components.

CPAA has not fully obligated how P4P incentives for DY4 and DY5 will be paid out in 2022 and 2023. Further financial analysis by CPAA, in collaboration with the CPAA Finance Committee and Board of Directors, will be needed to make this determination.

i. What types of entities are those funds obligated to?
This has not been determined yet.

ii. Will the ACH retain some of this funding for post-2021 admin?

This has not been determined yet.

iii. Are providers receiving any of these funds for P4P or for future deliverables?

This has not been determined yet.

a) If applicable, describe how any other P4R or P4P funds (already earned or to be earned before the end of the DSRIP period) have been obligated for ACH or provider payments post-2021.

N/A

b) Assessment of DSRIP sustainability:

i. Describe activities and/or conversations, if any, your ACH has supported with partners related to sustainability priorities and mechanisms. For example, have there been activities or conversations around defining sustainability, evaluating results, or establishing criteria to determine what DSRIP activities would continue post-DSRIP funding?

CPAA has kept the topic of sustainability at the forefront of our conversations and project work with MTP partners since the beginning of 2020 (DY4). CPAA Program Managers conducted virtual site visits with MTP partners in this reporting period and dedicated a section of those site visits to discussing sustainability. During the site visits, CPAA made it clear that partners must consider and plan for how DSRIP activities will be sustainable or identify specific DSRIP activities that are at risk of discontinuation post-2021. CPAA broadly defined sustainability to include project work that MTP partners will continue to perform post-2021 without funding from CPAA. The majority of MTP partners expressed confidence that most DSRIP activities will be sustainable due to DSRIP activities being included in standard operations.

MTP partners were required to review their Change Plans going into 2021 with the goal of updating milestones to accurately and realistically reflect sustainable work activities for 2021. All change plans must be approved by CPAA Program Managers before partners can receive DY5 payments. In the change plan review process, a high priority is being placed on ensuring MTP partners demonstrate they are working on sustainability. If change plans do not pass the initial round of review, they will be returned to partners with feedback on making improvements.

ii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation of DSRIP funded activities (e.g., capacity building, practice transformation, and collaboration among partners), beyond waiver funding. If you have not supported related activities and/or conversations during the reporting period, please explain why.

As stated above, CPAA is keenly aware of the importance of sustainability, and had conversations with MTP partners regarding the importance of sustainability in MTP project work for 2020 and 2021. CPAA discussed sustainability with partners during virtual site visits, partner-based collaborative calls,
individual partner meetings, and CPAA Council meetings. In addition to these activities, CPAA regularly asked for feedback from partners on how CPAA could best help partners transition their DSRIP activities beyond waiver funding.

iii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation and/or scaling of specific DSRIP project toolkit evidence-based models and/or pilots (e.g. Community Based Care Coordination, CoCM). If you have not supported related activities and/or conversations during the reporting period, please explain why.

In conversations with MTP partners, CPAA placed an emphasis on scaling the models of care listed below in 2021. The models listed below represent examples of project work that have shown promising practices and improvements in care delivery. All of these models have been implemented in a variety of partners and have continued to scale the number of individuals being served as well as increasing the number of staff supporting these programs.

- The Collaborative Care Model
- Community CarePort
- Chronic Disease Self-Management
- School-based health centers
- MOUD programs in primary care

17. Regional integrated managed care implementation update

a) For **2020 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?

After the transition to IMC on January 1, 2020, organizations in the CPAA region continued to experience a number of challenges including, but not limited to, claims being denied, claims reconciliation taking longer than expected, reimbursements being delayed, billing code modifier confusion, interpreter services dropping jobs at the last minute, prior authorization confusion, and data sharing confusion.

CPAA sought to address these challenges by facilitating an IMC Provider Workgroup that created a forum for behavioral health agencies to discuss IMC issues with MCOs and the HCA. In advance of each meeting, CPAA compiled questions submitted by behavioral health agencies in a tracker document that would later be discussed. These questions were shared with MCOs and the HCA before the meeting to allow adequate preparation time. In addition, CPAA developed a dedicated IMC-specific webpage to keep a record of relevant news stories, document updates, and stakeholder information.

b) For **all early- and mid-adopters**, briefly describe any challenges the region continues to experience due to the implementation of integrated managed care. What steps has the ACH taken during the reporting period, or what steps does the ACH plan to take, to address these challenges?

c) For **all regions**, what steps has the ACH taken, or what steps does the ACH plan to take, to support coordination with local, regional and statewide partners to design and
implement strategies to address gaps and barriers impacting the health system in response to integrated managed care implementation?

CPAA is supporting coordination with local, regional and statewide partners to address gaps and barriers to care by facilitating an IMC Provider Workgroup that provides a forum for behavioral health agencies to discuss IMC issues with MCOs and the HCA. In advance of each meeting, CPAA compiled questions submitted by behavioral health agencies in a tracker document that would later be discussed. These questions were shared with MCOs and the HCA before the meeting to allow adequate preparation time. Another benefit of this workgroup is that it provides a venue for cross-sector stakeholders to network, share organizational updates, and coordinate services. Any gaps and barriers impacting the health system are discussed during the meeting and oftentimes addressed in follow-up communications. In addition to hosting this meeting, CPAA staff attend the Interlocal Leadership Structure meetings in both the Great Rivers and Thurston-Mason ASO regions to further collaborate with regional and statewide partners. Furthermore, CPAA extended a contract with Xpio Health to provide ongoing technical assistance to behavioral health agencies who continued to struggle with IMC billing and administrative operations.

d) For all regions, how are you supporting efforts to measure and report on clinical integration?

The primary method that CPAA used to support the region in measuring and reporting on clinical integration was by facilitating the IMC Provider Workgroup. The workgroup regularly discussed data reporting, data collection methods, and specific metrics. CPAA also coordinates and shares any relevant information on data reporting put out by MCOs and the HCA to behavioral health agencies. Lastly, CPAA collects MeHAF Site Self-Assessments from all Project 2A partners which assesses the level of integrated physical and behavioral health services twice per year.

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.

<table>
<thead>
<tr>
<th>18. 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:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

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 4, Q4.

Note: The reporting period for VBP milestones cover the full calendar year (January 1 through December 31, 2020).

Narrative responses

19. Identification of barriers impeding the move toward value-based care

   a) Describe the barriers the region is facing regarding implementation of value-based care and methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

   Barriers to implementing value-based care

   The implementation of value-based care across the CPAA region varied between organization types. Organizations that experienced the largest barriers included behavioral health agencies, rural health centers, and pediatric primary care clinics. In the CPAA region, behavioral health agencies were new to IMC so there was not any historical data to support a value-based contract. Managed Care Organizations have stated that value-based contracts are not possible until there is substantial historical data on standardized metrics, which were not universally being tracked by behavioral health agencies. Additionally, there was insufficient patient volume by payer to take on clinical risk and a lack of access to comprehensive data on patient populations.

   Rural Health Centers (RHC) have been slow to adopt value-based contracts due to the favorable encounter rates allocated to clinics with the RHC designation. This was not so much a barrier, but rather a disincentive to transition to value-based contracts. Additionally, rural clinics reported a lack of access to comprehensive data on patient populations, insufficient patient volume by payer to take on clinical risk, and difficulty developing a medical home culture with engaged providers. Pediatric primary care clinics were facing some of the same barriers including a lack of access to comprehensive data on patient populations and a lack of timely cost data to assist with financial management.

   Methods the ACH used to identify providers

   The primary method of identifying providers struggling to implement practice transformation and move toward value-based care was the annual HCA Value-Based Payment Survey. The HCA survey covered all the primary information that CPAA as an ACH would gather independently. Although CPAA incentivized completion of the survey, an adequate depiction of regional data was not gathered due to lower-than-expected survey completion. Additionally, CPAA gathered information on struggling providers in collaborative calls and individual meetings.

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

   a) Describe how the ACH has helped providers overcome barriers; indicate if the scope or intensity of support has been different for small providers (25 FTEs or fewer), or behavioral health providers.

   CPAA sought to help providers overcome barriers to moving toward value-based care by providing educational materials, encouraging providers to discuss VBP with MCOs, and offering opportunities to
discuss VBP in open forums. These methods have been consistent across all of our partners. At the
guidance of HCA VBP documents, CPAA has not played an integral role in VBP-specific conversations
between providers and MCOs.

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

a) Provide an example of the ACH’s efforts to support completion of the state’s 2020
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.

Examples:
1. Provided $500 to each partner organization that completed the 2020 HCA VBP Survey.
2. Provided $1500 to each partner that completed the 2020 survey and showed improvement in
the percentage of VBP contracts from 2019.
3. Posted the HCA’s 2020 VBP Survey link to the CPAA webpage.
4. Included the HCA’s 2020 VBP Survey link in CPAA’s monthly newsletters (Appendix M).
5. The HCA’s 2020 VBP Survey was individually emailed to all CPAA partners (Appendix N).

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 HCA’s 2019 and 2020 annual 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. CPAA shared information with these providers
and offered to help in a further capacity as requested by the provider.
Section 4. Pay-for-Reporting (P4R) metrics

22. P4R Metrics

The reporting requirements for the P4R Metrics updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. ACHs may use discretion, and will not be penalized, surrounding the timing and volume of P4R metric data collection during the COVID-19 pandemic. For example, an ACH may choose to delay data collection, make participation optional, or target participation. The submission of P4R Metrics are considered optional for this reporting period but are encouraged.

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. 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.

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.”

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.

Optional: The ACH may submit P4R metric information.

Please see CPAA.SAR6.P4R Metric Reporting 1.31.2021

https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121

---

7 https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121
Our Mission:
To improve community health through collective planning and action of leaders of health.
As of November 2019, CPAA led the state in ACH distribution of MTP funds to partnering providers, with 69.68% of earned funds distributed.

What a year for CHOICE Regional Health Network and Cascade Pacific Action Alliance (CPAA), the region’s Accountable Community of Health (ACH) supported by CHOICE and administering the Medicaid Transformation Project (MTP).

As we reflect on 2019, it’s important to remember that the region’s accomplishments are more than just bullet points, although they culminate in an impressive list we’re proud to share. Every success story, every training, every dollar of funding, every new and renewed partnership, and every completed milestone has deep and lasting impacts on the region’s most vulnerable populations.

CHOICE partners, stakeholders, and community members are dedicated, inspired, and working hard to transform the healthcare delivery system. Never before have so many cross-sectors come together to improve community health. The shared successes, challenges, innovations, and lessons learned have all contributed to our region’s transformation.

FINANCIAL OVERVIEW*

CHOICE is optimistic as we look ahead to the work still to be done and we move strategically towards achieving sustainability and scaling up successful projects to impact more lives. We have a solid foundation of shared vision to ensure the work continues for many years to come.

Jean Clark, CHOICE CEO, Looks Back on 2019

*The Financial Overview encompasses both CHOICE and CPAA, LLC. The CHOICE fiscal year ended September 30, 2019. CHOICE received an unmodified audit for the year.
PARTNER STORY: UNION GOSPEL MISSION

Staffed by volunteer dental professionals, the Olympia Union Gospel Mission Dental Clinic provides no-fee dental care to over 1,800 patients a year. As part of the Thurston Oral Health Network (TOHN), the Mission treats uninsured, diabetic seniors. The dental care is paired with education about the relationship between oral health and diabetes. In 2019, the Mission demonstrated that providing dental care has improved clients' oral health and diabetes, and also improved overall quality of life for their patients. One participant of the program explained that after losing her two front teeth, she felt embarrassed about smiling. After receiving care at the Mission, she immediately started smiling.

NAVIGATOR HEALTH INSURANCE

- During Open Enrollment, the CHOICE network of Navigators hosted or attended over 20 sign-up events around the region.
- Throughout 2019, Navigators enrolled or renewed over 8,000 people into Washington Apple Health (Medicaid) and Qualified Health Plans.

ORAL HEALTH PROGRAMS (ABCD, OHC, TOHN)

- Thurston Oral Health Network (TOHN) provided dental care to 215 individuals.
- Oral Health Connections (OHC) launched January 1, 2019. OHC focuses on pregnant women and adults with diabetes who are enrolled in Washington Apple Health. 182 individuals were enrolled in OHC and over 125 providers became OHC-certified.
- 634 children were enrolled in Access to Baby & Child Dentistry (ABCD).
- Over 200 providers participated in Opioid Safety Training for dentists.

OPIOID USE REDUCTION & RECOVERY (OURR) ALLIANCE

- 191 participants have been served by OURR Alliance.
- OURR Alliance piloted the first-ever Certified Peer Counselor (CPC) training with a specific focus on peers who have been impacted by opioid use disorder. More than 60 peers have graduated.

YOUTH MARIJUANA PREVENTION & EDUCATION PROGRAM (YMPEP)

- Dr. Jason Kilmer from the University of Washington started speaking around the region to educate parents, teachers, and community members about the impacts of marijuana on the developing brain.
6 Building Blocks

- Quality Improvement
- Trauma, Toxic Stress, and Staff Retention
- One Key Question: Pregnancy Intention Screening
- Certified Peer Counseling
- The Language of Stigma
- Medication Assisted Treatment Waiver Training
- Integrated Managed Care
- Opioid Harm Reduction
- Opioid Prescribing for Dental Providers
- Evaluating and Treating Hepatitis C

2,190 Completed and In-Progress Partner Milestones*

29 Trainings & Events with 1,786+ Participants

11 Care Coordinating Agencies
863 Active Enrolled Clients
8,946 Completed Pathways

73.7% Regional Compliance*

*Regional Compliance is a weighted average of complete and in-progress milestones out of all possible milestones

*MTP partners self-identified milestones to track progress towards project implementation
OBC continues their great work providing low-barrier medication assisted treatment (MAT) for people experiencing opioid use disorder (OUD) at the Capital Recovery Center in downtown Olympia. Low-barrier access means walk-in patients receive their prescription the same day, and the medication is always free to patients.

Peers, who've been through recovery themselves, provide support and help patients access other resources like counselling and housing. “Every day using buprenorphine instead of heroin is a safer day,” says Dr. Lucinda Grande, director of OBC. OBC has received national media coverage by the Associated Press and U.S. News and World Report.

INTEGRATED MANAGED CARE (IMC)

As an on-time adopter, the CPAA region transitioned to IMC January 1, 2020. While the ACH did not receive funding to support IMC, CPAA made targeted investments to help partners successfully make the transition:
- EHR Enhancement for behavioral health providers
- Monthly Provider Readiness Workgroup comprised of both the Great Rivers and Thurston-Mason regions
- "Managed Care Contracting from a Position of Strength" training with Adam Falcone
- Contract with Xpio Health for partner technical assistance

INCENTIVES TO SUPPORT TRANSITION TO IMC

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>$1,532</td>
</tr>
<tr>
<td>EHR Enhancement</td>
<td>$13,950</td>
</tr>
<tr>
<td>Contract with Xpio Health for Partner TA</td>
<td>$102,296</td>
</tr>
<tr>
<td>Interpreter Services for IMC Provider Readiness Workgroup</td>
<td>$270,000</td>
</tr>
</tbody>
</table>

TRANSFORMATION STORY: COASTAL COMMUNITY ACTION PROGRAM (CAP)

There is an undeniable link between poverty and poor health. For those living in poverty, factors such as trauma, homelessness, substance use, food insecurity, and low health knowledge levels contribute to health issues. Coastal CAP works with low income individuals and families in Grays Harbor and Pacific counties. Through Community CarePort, CPAA’s community-based care coordination program, Coastal CAP has been able to provide social support, connections with community resources, and access to medical services to enhance their existing services.

Craig Dublanko, Executive Director of Coastal CAP
CHOICE prioritized social media in 2019, successfully implementing a strategy to increase engagement and reach.*

![Social Media Engagement Chart](image)

*Growth shown in percent increase. 100% represents reaching all Facebook followers.

CHOICE has 20 employees. Pictured during the summer staff retreat, CHOICE is committed to staff self-care and promotes telework, professional development, wellness activities, regular potlucks, and Furry Friend Fridays.

Eric Moll, Chair
CEO, Mason General Hospital & Family of Clinics

Josh Martin, Vice-Chair
CEO, Summit Pacific Medical Center

Larry Cohen, Secretary
CEO, Ocean Beach Hospital

Laurie Tebo, Treasurer
CEO, Behavioral Health Resources

Tom Jensen, Past Chair
CEO, Grays Harbor Community Hospital

Medrice Coluccio
CEO, Providence SW Washington Region

Winfred Danke
Executive Director, Providence St. Peter Hospital

Jane Geraci
MD, Primary Care Chief, Providence Medical Group

Mary Goelz
Director, Pacific County Public Health & Human Services

Karolyn Holden
Director, Grays Harbor Public Health

Matthew Kempton
CEO, Willapa Harbor Hospital

Melanie Matthews
CEO, Physicians of Southwest Washington

Harshiem Ross
VP Medical Ops, Sea Mar Community Health Centers

Schelli Slaughter
Director, Thurston County Public Health & Social Services

Gaelon Spradley
CEO, Valley View Health Center

Richard Stride
CEO, Cascade, A Behavioral Health Agency

Mark Turner
CEO, Capital Medical Center

David Windom
Director, Mason County Community Services

1217 4th Avenue East, Suite 200 • Olympia, WA 98506-4246
www.crhn.org • www.cpaawa.org
Appendix B

Medicaid Transformation Quarterly Report

Change Plan Reporting Contents

Your organization’s Change Plan and reporting template are now one document. All 2020 - 2021 milestones are included in this Change Plan Reporting Template. Reporting must be completed quarterly and returned to reporting@cpaawa.org by 07/31/2020, 10/31/2020, and 1/31/2021. Submit your final documents in the format that they were sent. Please submit your Report as an Excel file using the naming convention CP2020_ organization name. Please submit your completed Narrative Report as a Word document using the naming convention NR2019Q2_ organization name.

For detailed instructions on how to complete your reports, watch this short video: [insert link]

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

1. **Milestone Report**: located in this Change Plan are your organization’s approved Change Plan milestones. For this reporting period, you will report on milestones with due dates between 01/01/2020 - 06/30/2020 (DY4 Q1-Q2).

2. **Narrative Report**: provides additional context and information about your organization’s MTP activities. 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. **Note: Due to COVID-19, metric reporting is canceled for the reporting date of 07/31/2020.**

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. 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.

Instructions for Milestone Report

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

1. Select the progress indicator:
   - **Completed** – The milestone has been completed, and the implementation partner is able to provide supporting documentation regarding the completion of the deliverable upon request.
   - **Fulfilled In Progress** – Actions were taken towards achieving the work step deliverable, but the deliverable has a target end date in the future.
   - **Delayed In Progress** – Actions were not taken towards achieving the work step deliverable during the reporting period, but the deliverable has a target end date in the future. Delayed milestones will automatically be moved to the subsequent quarter.
   - **Not Started** – Work step has not been started.
   - **Update Status** – A gray ‘update status’ box indicates the milestones’ self-identified due date. You must select a progress indicator for each gray box marked in the reporting quarter with one of the options above.

2. If the milestone is completed, do not provide notes. For all other progress indicators, write a brief description in your narrative report.
   - If in progress, please briefly provide a status update and state any barriers encountered.
   - If not started, please identify any barriers encountered, provide a brief description of how you are moving forward, and state the revised due date for the milestone.
   - If needs to be revised, provide the new milestone, rationale, and the new date if applicable.

Instructions for Narrative Report

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

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

Note: Due to COVID-19, metric reporting is canceled for the reporting date of 07/31/2020.

Self-reported baseline and end year targets were recorded for each metric. CPAA 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 was completed through a separate survey on a different timeline. There is no further action required from you at this time.
<table>
<thead>
<tr>
<th>Project Area</th>
<th>Intervention Description</th>
<th>Milestone</th>
<th>Reporting Quarter End Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SMART Goal:**

How confident are you that you will achieve your SMART goal for the quarter?

**Change Plan Legend:**

- 50% milestone achievement standard in effect, per quarter
- Milestone achievement standard TBD
<table>
<thead>
<tr>
<th>ID_Metric</th>
<th>Metric</th>
<th>2017 Baseline</th>
<th>2019-Mid Year Actual</th>
<th>2019-Actual</th>
<th>2019-Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A030</td>
<td>% Universal BMI [2A030]</td>
<td>0</td>
<td>56.75</td>
<td>51.18</td>
<td>70</td>
</tr>
<tr>
<td>2A040</td>
<td>% Universal blood pressure screening [2A040]</td>
<td>0</td>
<td>56.75</td>
<td>51.18</td>
<td>70</td>
</tr>
<tr>
<td>2C010</td>
<td># Clients in Patient Navigator Service [2C010]</td>
<td>0</td>
<td>63</td>
<td>198</td>
<td>150</td>
</tr>
<tr>
<td>2C060</td>
<td># of transports to healthcare [2C060]</td>
<td>0</td>
<td>7</td>
<td>14</td>
<td>200</td>
</tr>
<tr>
<td>2C070</td>
<td>% consumers who rebook [2C070]</td>
<td>0</td>
<td>33</td>
<td>66</td>
<td>50</td>
</tr>
<tr>
<td>2C080</td>
<td>% of transportation service within 7 days [2C080]</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>2C220</td>
<td># unique clients receiving services at SSC [2C220]</td>
<td>0</td>
<td>337</td>
<td>479</td>
<td>200</td>
</tr>
<tr>
<td>2020-Mid Year Actual (Q2)</td>
<td>2020-Actual (Q4)</td>
<td>2020-Target</td>
<td>2021-Mid Year Actual (Q2)</td>
<td>2021-Actual (Q4)</td>
<td>2021-Target</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80</td>
<td>80</td>
<td>90</td>
<td>80</td>
<td>90</td>
<td>250</td>
</tr>
<tr>
<td>200</td>
<td>200</td>
<td>250</td>
<td>70</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>70</td>
<td>70</td>
<td>100</td>
<td>225</td>
<td>250</td>
<td></td>
</tr>
</tbody>
</table>
# 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 NR2020Q3_organizationname.

To fulfill CPAA reporting requirements, both the Narrative Report and the Change Plan Milestone Report must be completed and emailed to reporting@cpaawa.org by **October 31, 2020**.

**Reporting period:** July 1, 2020 - September 30, 2020

<table>
<thead>
<tr>
<th>Organization</th>
<th>Primary Contact Name</th>
</tr>
</thead>
</table>

**Narrative Questions**

1. Please describe any delays or significant challenges in implementing any project work for this reporting period. Please be project specific.

2. If you have not yet implemented certain elements of the project work you selected, how will you implement these activities in Q4 2020?

3. What lasting impacts from COVID-19 are you anticipating within your organization?

4. How has COVID-19 changed any of your organization’s health improvement priorities?

5. When the Medicaid Transformation Project ends, how will this affect the projects you’ve developed within your organization?

6. Please share a success story during the reporting period.
Dear MTP Partner,

CPAA is aware that the end of year is a busy time and the COVID-19 pandemic has disrupted many aspects of your work. We ask that you please carefully read this email in its entirety.

Change Plan Modification

Heading into the final year of the MTP, CPAA is requiring all MTP Partners to review and update their Change Plans for 2021. Milestones in 2021 should reflect sustainability and/or scalability of approved projects. If projects have not been fully implemented or have struggled to make progress, it’s time to make hard decisions about the future of projects and interventions by potentially dropping interventions and/or project areas. Alternatively, if a project is nearing completion to a point when no further milestones can be added, we ask that you mark the project complete.

CPAA will be reviewing all Change Plans prior to contract amendments going out starting in January 2021. 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.

Instructions for Modifying the 2021 Change Plan

Your attached Change Plan reflects progress reported through Q3 2020. Please do not make any changes to Q4 2020 milestones and focus only on 2021 milestones.

- To add milestones, please list them in the empty cells provided to you or right-click to add additional rows as needed under the appropriate project area and intervention. Please use the last column titled, “Indicate any modifications to milestones” to include the due date.
- To remove or modify existing 2021 milestones, please indicate the desired change in the last column titled, “Indicate any modifications to milestones”.
- You must have at least one milestone, per project, per quarter listed on your change plan.

Reviewed and modified Change Plans must be completed and returned to reporting@cpaawa.org by January 15, 2021. Submit your final document as an Excel file using the naming convention CP2021_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.

Performance Expectations

For Q1-Q4 in 2021, there will be a performance component to reporting, with a minimum requirement of 60% milestone completion per project per quarter. If milestone completion is below 60% for any one project area, a Performance Improvement Plan (PIP) may be initiated. PIPs currently in effect will carry over to 2021, as necessary.

Take care,
Performance Improvement Plan

Organization Name
CEO/Executive Director
Transformation Lead
Lead Contact Information

Purpose
The purpose of this Performance Improvement Plan (PIP) is to define areas of concern and/or gaps in a partner’s performance, iterate CPAA’s expectations going forward, and allow the partner an opportunity to demonstrate rapid improvement following quarterly reporting. To facilitate sustained improvement, the 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.

Performance Improvement Process
Overview
Upon execution of this document, your organization will be placed on a PIP. Your organization has to satisfy each of the improvement expectations in the timeframe listed below in order to complete the PIP. If expectations are not met within the timeframe, an extension may be granted. Until the PIP is completed, quarterly payments may be delayed.

PIP Timeframe: 30 days after CPAA receives signed PIP.

Steps
1. Once CPAA establishes that a partner’s performance is below the quarterly milestone completion target, CPAA will meet with the partner to discuss the PIP process.
2. CPAA will complete the PIP form and send it to the partner for execution.
3. The partner and CPAA will work together during the PIP time period on performance monitoring and to document the partner’s progress.
4. After 30 days, CPAA will assess whether the partner has met the improvement expectations outlined below. If the PIP has been completed to satisfaction, CPAA will meet with the partner to formally close the PIP and release any delayed quarterly payments. If sufficient improvement has not occurred, an extension may be granted or your organization may be dropped from a project area or as a Medicaid Transformation Partner.

Areas of Concern
☐ 2A     ☐ 3A     1. Below 50% compliance on Q3 milestones.
☐ 2B     ☐ 3B
☐ 2C     ☐ 3D

Improvement Expectations
1. Develop a list of activities* to complete unmet milestones or a list of activities to satisfy a related scope of work if unmet milestones cannot be met. These activities will be documented in a new tab in the partner’s Change Plan, provided by CPAA.
2. Activities should adequately reflect the scope of work being implemented.
3. Achieve 90% compliance of completed activities by the end of the PIP timeframe.
4. At the end of the PIP timeframe indicated above, attend a meeting with CPAA Program Managers to discuss progress.
*Activities may include, but are not limited to, work on MTP projects that was completed in place of milestones that were delayed or not started, work steps showing progress toward completing unmet milestones, immediate actions that can be taken if the milestone timeline needs to be delayed, and actions that were required due to unforeseen circumstances.

Attestations

1. I agree to continue working in the following project areas.
   - ☐ 2A
   - ☐ 2B
   - ☐ 2C
   - ☐ 3A
   - ☐ 3B
   - ☐ 3D

2. I agree to drop the following project areas.
   - ☐ 2A
   - ☐ 2B
   - ☐ 2C
   - ☐ 3A
   - ☐ 3B
   - ☐ 3D

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

   Yes               No

Partner Organization Authorizing Authority

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## LOCAL FORUM HEALTH PRIORITIES

### GRAYS HARBOR
- Improve Health Care Access
- Improve care coordination & integration
- Prevent and manage chronic disease

### COWLITZ
- Housing
- Substance abuse/mental health
- Education
- Adverse Childhood Experiences (ACEs)

### PACIFIC
- Improve access to care
- Housing opportunities
- Transportation barriers

### MASON
- Access to behavioral health care
- Affordable housing
- SUD and drug overdoses
- Chronic Health management

### WAHKIAKUM
- Access to health care
- Substance Use and Abuse
- High poverty and low housing
- Environmental Impacts

### THURSTON
- Housing
- Economic vitality
- Education
- Access to care

### LEWIS
- Substance Use and abuse
- Maternal Health and teen pregnancy
- Economic development and workforce

---

## Cascade Pacific Action Alliance and the Local Forums

The Cascade Pacific Action Alliance (CPAA) Accountable Community of Health has been working with local forums for over two years across the CPAA region. Each county in the CPAA region hosts a local forum to bring together cross-sector partners at the local level to address community health needs. Local forums are focused on identifying county health priorities, adopting shared regional priorities, aligning activities between stakeholders, and implementing local action.

In 2019, each local forum produced a summary of community health needs that are detailed individually and presented alongside shared regional health priorities from the CPAA Regional Health Improvement Plan (RHIP) developed in 2017. CPAA engages with local forums by participating in local meetings and connecting with stakeholders to truly understand the challenges, solutions, and priorities of our seven counties.

Aligning local forum health priorities with CPAA’s RHIP will provide a more complete picture of community health needs and areas to focus on going forward. CPAA intends to use this consolidated information for strategic planning as we prepare to implement Blue Zones in 2021.
Adequate access to physical and behavioral health care is a problem throughout our region, but is particularly severe in our rural communities where the number of health care providers is below the WA State average.
PCP Ratio - WA: 1183:1, CPAA: 1852:1
Mental Health Provider Ratio - WA: 268:1, CPAA: 318:1

Care coordination and integrated care services have improved in the CPAA region over the past several years, but behavioral health prevalence is expected to rise over the next year. System fragmentation still exists.
% Adults w/ Depression (2018): WA: 24%, CPAA: 26%

Adult and adolescent smoking and obesity rates for the overall population are higher than the State average; residents have less access to exercise opportunities and healthy foods.
% Adults w/ Obesity (2020) - WA: 28%, CPAA: 33%
% Physically Inactive (2020) - WA: 17%, CPAA: 20%
% Adults w/ Diabetes (2020) - WA: 9%, CPAA: 11%

Adverse childhood experiences (ACEs) are potentially traumatic events in a child's life that can have negative and lasting effects on health and well-being. The CPAA region has a high burden of ACEs, which are likely contributing to the prevalence of chronic diseases and other poor health outcomes.

A lack of education and high rates of unemployment are contributing to poor health. Five of the seven counties rank in the top ten worst counties for unemployment rates in WA State.
% Unemployed (2020) - WA: 4.5%, CPAA: 5.6%
Median Household income (2020) - WA: $74,023, CPAA: $62,963

The rates of drug overdose deaths, adult smoking, and marijuana use are higher in several CPAA counties than the State average. There is also a shortage of behavioral health providers throughout the CPAA region.
Drug Overdose Mortality Rate (2020) - WA: 15%, CPAA: 15%
F/U after ED for Alcohol and Drug Abuse 30 days (2020) - WA: 28%, CPAA: 21%

Access to affordable housing and effective homelessness prevention programs remain as ongoing challenges throughout the region.
Occupied Housing Units - WA: 91.4%, CPAA: 85.9%
% Severe Housing Problems - WA: 17%, CPAA: 16%
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 waivered prescribers is important, but MAT is a team sport.

When  Saturday, August 22, 2020 from 9:00am-1:00pm

Where  Zoom

CME  This waiver training is free of charge. Physicians, nurses, physician assistants, and pharmacists are eligible for CME after completing the second half of the training. 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 confidentially.
- 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 [CPAAWaiverTraining.eventbrite.com](http://CPAAWaiverTraining.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.

[www.pcssNOW.org](http://www.pcssNOW.org)
Feel Better in 6 Weeks

Group support is proven to improve health. This **FREE** and anonymous 6-week online workshop helps you:

- lower blood sugar
- reduce anxiety and depression
- increase physical activity

Click to see how it works:

Register

Already enrolled? Click here to log in.

Questions?

---

**Learn. Connect. Feel Better.**

Learn new practical ways to deal with pain, fatigue and stress.

Connect with others just like you. Log in anytime that fits your schedule.

Get guidance from trained leaders with similar health challenges.
Appendix H

Request for Proposals (Home Health Equipment)

I. Overview
The Cascade Pacific Action Alliance (CPAA) is supporting organizations who plan to use home health equipment and/or remote patient technology to promote and expand health improvement activities that align with the Medicaid Transformation Project (MTP). Through this Request for Proposals (RFP), CPAA will sponsor current MTP partners to purchase remote or home health equipment that will advance their service delivery and increase the health of hard-to-reach clients.

Funding is limited to the purchase of home health equipment for individuals living with chronic conditions or to purchase remote patient monitoring systems which use digital technologies to collect health information from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendation.

II. Eligibility
a. Only CPAA MTP Partners that have a current contract with CPAA may apply. *CHOICE Regional Health Network employees may not apply on behalf of organizations that they support or are affiliated with.*
b. Funds cannot be used retroactively. Applications for past equipment purchases will not be considered.
c. Funding from this award may not be used for related expenses that are already being supported through another funding source.
d. Examples of equipment to be considered include, but are not limited to:
   i. Blood Glucose Monitoring Devices
   ii. Heart rate monitor
   iii. Body Weight Scale
   iv. Pulse oximeter
   v. Blood Pressure monitor
   vi. Spirometer
   vii. Continuous surveillance monitors
   viii. Automated health information tracker (any technology that facilitates patient monitoring as well as the timely transfer of patient-generated data from patient to care team and back.)
   ix. Other:
III. Application Process and Guidelines
   a. Applicants must submit a completed application in order to be considered for funding, which is available along with the application instructions on the CPAA website.
   b. Applications should be submitted no later than 12/04/2020.
   c. Announcement of successful applicants will be made no later than 12/18/2020.
   d. Funds for approved applications will be distributed through the financial portal unless otherwise noted.
   e. CPAA Partners may request between $7,500-$10,000 in funding. Only one application can be submitted per organization.

IV. Review Criteria
CPAA will consider the following factors in selecting proposals most qualified to receive funding:
   a. Applicant’s description of how the equipment or technology supports CPAA’s identified projects in care coordination, care integration, chronic disease, transitional care, maternal and child health, reproductive health, and/or opioid epidemic response. (25 points)
   b. Supportive documentation that will provide better clarification on the equipment to be purchased such as an itemized equipment list, cost breakdown, or technology quote should be included. (15)

Application

   a. Name of organizations
   b. Active MTP projects
   c. Narrative: Description of how funds will be spent
   d. Narrative: Description of how equipment or technology will increase access to care, support current project work, and/or improve patient care.
   e. Attachments:
      a. Equipment list
      b. Cost breakdown
      c. Other relevant material
Now offered as a free online workshops series!

Living Well Thurston

Learn ways to manage your chronic physical or mental health condition with:

- Action planning
- Medication management
- Making informed decisions
- Pain & fatigue management
- Working with your health care system
- Future health care planning
- Ways to improve healthy eating and physical activity

Register online at www.surveymonkey.com/r/LivingWellThurston

or

Contact Lesley Price: (360) 480-4654
Lesley.Price@co.thurston.wa.us

Register by: September 29, 2020

Online Workshop Series

Tuesdays, October 6 - November 17, 2020
9:00 AM - 11:30 AM

Workshops held on Zoom with breaks throughout each session.

Includes a Living a Healthy Life with Chronic Conditions book

The Living Well Thurston workshops are offered by Thurston County Public Health and Social Services under a licensed agreement with the Self-Management Resource Center.
Healthcare providers are burdened by documentation requirements, which are inevitably made more burdensome by interaction with the electronic health record. The set of techniques known as Collaborative Documentation can reduce the time spent on record-keeping, and improve the experience of clinical work. Dr. John Kern will present these concepts followed by breakout rooms for discussion. Attendees will be able to begin practicing these techniques immediately.

THURSDAY, AUGUST 20, 2020
9:00 - 10:00 AM

CLICK HERE TO REGISTER

AIMS CENTER
UNIVERSITY of WASHINGTON
CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY
Appendix K

Suicide Prevention in Primary Care
December 1st, 2020

As you join please chat in your: Name(s), Org/Site, & Role(s)

Zoom Housekeeping

- This call is being recorded and will be made available with slides after the presentation.
- Please mute when not speaking.
- Audio & video controls in lower left corner

AIMS Center Introductions

Anna Hink, MSW, LICSW
- Clinical Trainer

Sara Barker, MPH
- Associate Director for Implementation

Providence SW WA Introductions

Annie McGuire, MS, LMHC
- Clinical Director of BHI

Manvi Smith, PsyD
- Behavioral Health Specialist
Learning Objectives

• By the end of this session, participants should be able to:
  – Identify key components of a suicide prevention protocol in primary care
  – Illustrate how Providence SW WA put into place suicide protocols and training for their primary care and behavioral health teams
  – List suicide prevention resources and trainings free in WA State

“Suicide is both a preventable outcome and a public health issue with a long-lasting and profound effect on family members, friends, and clinical providers.”

– The Bree Collaborative, 2018

Why Suicide Prevention in Primary Care

• 50% of all people who die by suicide see a primary care provider in the month prior to their death
• Suicide is that leading cause of death for
  – middle-aged men
  – people aged 10-24
• On average, someone dies by suicide every eight hours in WA State and
  – almost half are carried out with a firearm

Suicide Prevention and COVID-19

• Suicide risk factors exacerbated by pandemic:
  – Access to firearms
  – Hopelessness
  – Loneliness/Social isolation
  – Unemployment

• One in four young adults (18-24) say they've considered suicide in the past month because of the pandemic
The Bree Collaborative
Suicide Report & Recommendations

- Worked closely with and built from the WA DOH Suicide Prevention Plan released in 2016
- Goal:
  - “integration of implementable standards for suicide care, assessment, management, treatment, and supporting suicide loss survivors into clinical care pathways...”
- Developed recommendations
  - Focus on clinical settings
  - Applicable to in- and out-patient care

Suicide Care Recommendation Checklist

6 Recommended Focus Areas

<table>
<thead>
<tr>
<th>Identification of Suicide Risk</th>
<th>Assessment of Suicide Risk</th>
<th>Suicide Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annual screening of all patients over 13 for BH conditions &amp; substance use</td>
<td>• Further identify risk of suicide with validated tool and additional risk factors</td>
<td>• Support patients in timely path to adequate care, address lethal means safety, collaborative safety planning intervention</td>
</tr>
<tr>
<td>Suicide Risk Treatment</td>
<td>Follow up &amp; support after suicide attempt</td>
<td>Follow up &amp; support after suicide death</td>
</tr>
<tr>
<td>• Use effective evidence-based treatments that target suicidal thoughts and behaviors, document care, and provide referrals when needed</td>
<td>• Provide support and assistance with evidence-based treatment</td>
<td>• Offer support to patient’s family, friends and providers, including screening for BH and SU conditions</td>
</tr>
</tbody>
</table>

PUTTING IT INTO PRACTICE
Suicide Protocol Development at Providence SW WA

Slides used with Permission from Providence MG SW WA.
Background/Why?

- COVID
- ↑ virtual visits
- ↓ in depression screening

Opportunities!

1. Auto-Assignment of Depression Screening
   - PHQ-2 Assigned via MyChart 1 calendar day prior to scheduled visit
     - Positive PHQ-2 cascades to PHQ-9
   - ALL patients due for annual depression screening
   - ALL visits, regardless of visit type (virtual and in-person)

2. Revamp Suicide Protocol for applicability across ALL visit types

3. Depression Interventions

Patient Experience:
PHQ Auto-Assignment

Patient has a scheduled visit and is due for their annual depression screen → Patient Assigned PHQ2 in MyChart → Score is Positive → Cascades to PHQ9 → Non-Zero → Patient receives resources and crisis numbers. Scores are submitted when patient acknowledges receipt of resources.

Response to Q #9

- Zero → Complete

Patient Experience: non-zero answer to Q#9

Patient cannot submit their PHQ without clicking the acknowledgment button. This activity is recorded by Epic.
MA Receives Notification of SI

MA Staff via Provider Pool InBasket

Indicates suicide ideation reported by patient

Used with Permission from Providence MG SW WA.

MA Role: assigned screen incomplete

Patient attends scheduled visit, but did not complete assigned PHQ2

PHQ2 is Negative
Complete PHQ2 at rooming
Save results to EPIC

PHQ2 is Positive
Cascades to PHQ9

Q9 is Zero
Save results to EPIC

Q9 is a non-zero answer
Complete C-SSRS
Save results to EPIC
Alert PCP to positive SI

Used with Permission from Providence MG SW WA.

Workflow: Suicide Protocol

1
PHQ-9
Patient endorses Question #9

2
Complete C-SSRS

3
Intervention SmartPhrase

Used with Permission from Providence MG SW WA.
Approach & Rationales

- Requirements for Joint Commission Accreditation
- Evidence-based interventions
- Risk assessment determines level of intervention
- Safety plan (verses no harm contract)

Step 1: PHQ-9 Indicates SI

Step 2: Complete Risk Assessment C-SSRS

Columbia Suicide Severity Rating Scale (C-SSRS)

- Designed to quantify severity of SI and behavior
- The only screening tool that assesses the full range of evidence-based suicidality and provides criteria for what to do next

- **Who can administer?**
  - Anyone!

- **When to administer?**
  - When a patient endorses question #9 on the PHQ-9
    - Any non-zero answer
    - Can be administered over the telephone
Step 3: Intervention

- EPIC SmartPhrase: .SUICIDERSKSAFETYPLAN

Suicide Protocol Recommendations
- One protocol for all visit types
- Minimal steps
- Make it a policy (verses recommendation)
- Everyone plays a role
- Buy-in is critical!

Depression Interventions
- Close the loop! Address positive PHQ-9
- EPIC SmartPhrase: .PHQ9INTERVENTIONS
- Depression Intervention:
  - Date of Last Screening & Total Score
  - Interpretation of Total Score:
    - 1-4 = Minimal depression, 5-9 = Mild depression, 10-14 = Moderate depression, 15-19 = Moderately severe depression, 20-27 = Severe depression
  - Intervention(s)
Select Intervention(s)

Score 0-9
- Watchful waiting
- Discussion of depression symptoms
- Repeat PHQ-9 on follow-up
- Referral to Providence Depression and Anxiety Group

Score 15-19
- Repeat PHQ-9 on follow-up
- Referral to Collaborative Care
- Referral to community mental health agency
- Pharmacological therapy

Score 10-14
- Repeat PHQ-9 on follow-up
- Referral to Collaborative Care
- Referral to community mental health agency
- Pharmacological therapy

Score of 20 and above
- Repeat PHQ-9 on follow-up
- Referral to Collaborative Care
- Referral resources to community mental health agency
- Referral to community mental health for medication management
- Pharmacological therapy

QUESTIONS & DISCUSSION

Resources

- Safety Plan Template: [www.suicidesafetyplan.com](http://www.suicidesafetyplan.com)

ALL PATIENTS SAFE

Suicide Prevention Training for Health Care Professionals

All Patients Safe is a three- or six-hour interactive self-paced training course designed to address the public health crisis and provide the necessary tools to health care professionals for preventing and educating patients about suicide.

This course meets state licensure requirements for all health care professionals.

[Free for WA state healthcare professionals! Register today at opsafe.uw.edu](http://opsafe.uw.edu)
How Are We Doing?

- We rely on you to let us know how we can best support your work!
- Send questions, feedback, and topic requests to our Clinical Trainer, Anna Hink (ajhink@uw.edu)

THANK YOU!
Suicide Prevention Training

QPR TRAINING DATES

Thursday, November 12
1:00pm -3:00 pm

Tuesday, December 8
10:00am -12:00pm

Tuesday, January 19
6:00pm -7:30pm

Learn the warning signs of suicide

QPR Suicide Prevention Training provides individuals with the skills to identify the warning signs, learn how to interrupt the crisis, and know how to direct that person to proper care. This 2 hour training is offered free to anyone to help our community recognize the warning signs of suicide and assist others in need.

As a QPR Gatekeeper, you will:
- Recognize the warning signs of suicide
- Know how to offer hope
- Know how to get help and save a life

To register for a FREE QPR training session, click the link below
https://fs27.formsite.com/crhn/pporrbmiel/index.html

Question
Persuade
Refer

Three steps anyone can learn to help prevent suicide

Ask a Question, Save a Life
MTP Implementation Partners should have received their 2020 Reporting Template. Click here to access the recorded webinar to walk you through the updated template. If you have not received your template, or if you have any questions or concerns about Q1 and Q2 reporting, please contact reporting@cpaawa.org. Completed reports are due by July 31, 2020.

Thank you to everyone who participated in the June Council Meeting. Click here to access the Council documents. Please contact Joshua Plaster if you have questions or concerns: plasterj@crhn.org.

Guided by the CDC, Department of Health, and our state government, staff continue to work remotely. But no matter where we are, we are here to support you: please don’t hesitate to contact us if we can be of assistance.

CPAA Updates

COUNCIL MEETING
AUGUST 13
1:00 - 3:00PM
DETAILS WILL BE EMAILED

HCA GOLDEN THREAD OF DOCUMENTATION SERIES
THURSDAYS: JULY 30 - AUG 13
CLICK HERE

WASHINGTON LISTENS
COVID-19 SUPPORT:
833-681-0211

CARES ACT FUNDING FOR MEDICAID PROVIDERS:
CLICK HERE

BEHAVIORAL HEALTH INSTITUTE RESOURCES:
CLICK HERE TO VIEW

WA STATE HOSPITAL ASSOCIATION: NEED CARE?
GET CARE.
CLICK TO LEARN MORE
The HCA is asking all Behavioral Health Providers to take their PPE survey by July 10. This survey is intended to quantify the outstanding need for PPE by Behavioral Health Providers in Washington State. Click here to access the PPE survey.

CPAA’s community-based care coordination program, CarePort, is partnering with local systems to support community members who must self-isolate due to COVID-19 while managing other hardships in their lives. Contact Michael O’Neill for more information about how to refer patients to a care coordinator: oneillm@crhn.org.

Community Outreach Liaison Amber Shirk represented CHOICE, in partnership with The Moore Wright Group, Goodwill, Power Up Pierce County, and NW Furniture Bank, at a recent event that gave out over $200k of resources to community organizations. A similar event is being discussed for Cowlitz County. Contact shirka@crhn.org with questions or for more information.

OPPORTUNITIES & RESOURCES
- Rural Communities Opioid Response Program - Neonatal Abstinence Syndrome HRSA Funding Opportunity is due July 30. Click for more information.
- Chronic Disease Self-Management Education: Better Choices. Better Health, is an online group workshop that focuses on chronic disease management, decision making, problem-solving, and action-planning. If you work with clients who would be interested, contact Abigail Schroff for more information: schroffa@crhn.org.
- Are you caring for someone with memory loss who lives in a rural area? If so, the University of California, San Francisco (UCSF) invites you to take part in a free 6-week online workshop and study for caregivers. You will learn skills to help reduce your stress, manage difficult behaviors, take better care of yourself, and plan for the future. Click to learn more and to register.
- The Dept. of Commerce’s Housing Finance Unit has a funding opportunity for organizations seeking capital funding to develop affordable community housing. Applications will be considered for projects that build housing centered around the development of a persistent supportive community for individuals or households presently experiencing homelessness. Applications are due by September 29, 2020. Click here to learn more.

Call the UW Psychiatry Consultation Line.
Free, fast, on-demand consultations connecting prescribing providers to psychiatrists at the University of Washington.

877.WA.PSYCH (877-927-7924) PCLWA@UW.EDU

CPAA maintains a COVID-19 webpage with verified resources and information for partners and community members: http://www.cpaawa.org/covid19/
Join CPAA and the AIMS Center on Thursday, August 20, from 9:00 - 10:00 am for a webinar: Collaborative Documentation: Reducing the Time Burden for Documentation. Dr. John Kern will present techniques to reduce the time spent on record-keeping and improve the experience of clinical work. Attendees will be able to begin practicing these techniques immediately.

- Click here to register.
- Contact Sara Rainer with questions: rainers@crhn.org

With COVID cases on the rise throughout the state, Governor Inslee recently announced some changes to “Safe Start” to target activities data have shown increase risk of COVID-19 exposure. We miss seeing our partners in person, but we will continue to prioritize health and safety: CPAA staff are working remotely and our meetings will be held virtually. But we are here for you, no matter where we are; please don’t hesitate to reach out if we can be of assistance.
Take the annual Health Care Authority’s VBP Survey by August 31. Click here to complete the survey. The survey is designed to be filled out by an administrative leader, with only one response per organization. **CPAA is helping promote the completion of the 2020 survey by offering financial incentives to clinical MTP partners:** $500 for completing the 2020 survey and an additional $1000 for demonstrating an increase in the percentage of your organization’s VBP contracts from the 2019 survey. Contact Abigail Schroff with questions: schroffa@crhn.org

Call the UW Psychiatry Consultation Line.
Free, fast, on-demand consultations connecting prescribing providers to psychiatrists at the University of Washington.
877.WA.PSYCH (877-927-7924) PCLWA@UW.EDU

CPAA’s community-based care coordination program, CarePort, is partnering with local systems to support community members who must self-isolate due to COVID-19 while managing other hardships in their lives. Contact Michael O’Neill for more information about how to refer patients to a care coordinator: oneillm@crhn.org

The Little Red School House Project serves families in need, foster children, and homeless children living in Thurston County. In 2019, they provided no-cost back to school supplies for nearly 2700 students. Their Radio Day fundraiser will be Friday, August 14, donate at their website www.redschool.org, or you can mail a check to Little Red Schoolhouse Project at PO Box 6302, Olympia, WA 98507.

**OPPORTUNITIES & RESOURCES**

- If you missed CPAA’s Motivational Interviewing series, register for HCA’s How to Start with Motivational Interviewing webinar on Thursday, August 20, from 8:30 -10:00am. Click here to learn more.

- DBHR will hold a webinar every other week from Tuesday, July 28, to September 22, at 9:00am. The webinar will feature information about COVID-19 and other behavioral health topics. Click here to learn more.

- Chronic Disease Self-Management Education: Better Choices. Better Health. is an online group workshop that focuses on chronic disease management, decision making, problem-solving, and action-planning. If you work with clients who would be interested, contact Abigail Schroff for more information: schroffa@crhn.org.

- The Dept. of Commerce’s Housing Finance Unit has a funding opportunity for organizations seeking capital funding to develop affordable community housing. Applications will be considered for projects that build housing centered around the development of a persistent supportive community for individuals or households presently experiencing homelessness. Applications are due by September 29, 2020. Click here to learn more.

CPAA maintains a COVID-19 webpage with verified resources and information for partners and community members: http://www.cpaawa.org/covid19/
Good morning,

The Health Care Authority (HCA) is seeking participation in their annual value-based payment (VBP) survey. CPAA is helping to promote the completion of this survey by offering the following financial incentives to CPAA Medicaid Transformation Project (MTP) Partners:

- By completing the 2020 VBP survey, your organization will earn $500
- Your organization can earn an additional $1000 by demonstrating an increase in the percentage of your organization’s VBP contracts shown through previous survey completion (categories 2C-4D in the Alternative Payment Model Framework for Value-based Purchasing).

Please complete the survey by 5:00 p.m. on Monday, August 31.
The survey is designed to be filled out by an administrative leader, with consultation from clinicians as necessary. HCA is seeking only one response per organization. The survey should take no more than 30-45 minutes to complete.

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.

Please don’t hesitate to contact me with any questions.

Thank you,
Cascade Pacific Action Alliance
### Cumulative snapshot

<table>
<thead>
<tr>
<th>Funds Earned</th>
<th>$ 52,115,671.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Distributed</td>
<td>$ 40,938,211.91</td>
</tr>
<tr>
<td>Funds available</td>
<td>$ 11,177,459.25</td>
</tr>
</tbody>
</table>

### Table 1: Incentives earned

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>$ 926,394.00</td>
<td>$ 926,394.00</td>
</tr>
<tr>
<td>Project 2B</td>
<td>$</td>
<td>$ 636,896.00</td>
<td>$ 636,896.00</td>
</tr>
<tr>
<td>Project 2C</td>
<td>$</td>
<td>$ 376,348.00</td>
<td>$ 376,348.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>$ 115,799.00</td>
<td>$ 115,799.00</td>
</tr>
<tr>
<td>Project 3B</td>
<td>$</td>
<td>$ 144,749.00</td>
<td>$ 144,749.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>$ 231,599.00</td>
<td>$ 231,599.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$ 2,431,785.00</td>
<td>$ 2,431,785.00</td>
</tr>
</tbody>
</table>

### Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

### Table 3: Incentive funds distributed, by use category

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adminstration</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$ 748,487.00</td>
<td>$</td>
<td>$ 748,487.00</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$ 2,257.00</td>
<td>$ 71,000.00</td>
<td>$ 73,257.00</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$ 92,195.00</td>
<td>$ 121,744.00</td>
<td>$ 213,939.00</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$ 548,420.00</td>
<td>$ 995,631.00</td>
<td>$ 1,544,051.00</td>
</tr>
<tr>
<td>Reserve/contigency fund</td>
<td>$ 467,804.00</td>
<td>$</td>
<td>$ 467,804.00</td>
</tr>
<tr>
<td>Total</td>
<td>$ 1,859,163.00</td>
<td>$ 1,188,375.00</td>
<td>$ 3,047,538.00</td>
</tr>
</tbody>
</table>

---

**Note:** Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 22, 2021 to accompany the sixth Semi-Annual Report submission for the reporting period July 1 to December 31, 2020.
Reporting period July 1 to December 31, 2020.