Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 7.0
Reporting Period:
January 1, 2021 – June 30, 2021
DY5 Q1-Q2

Template Release Date: March 15, 2021
# Table of contents

Table of contents .......................................................... 2
Semi-annual report information and submission instructions ........................................ 3
ACH contact information ................................................................................. 7
Section 1. ACH organizational updates ................................................................. 8
   Attestations................................................................................................. 8
   Documentation............................................................................................. 9
Section 2. Project implementation status update .................................................... 13
   Attachments.............................................................................................. 13
   Documentation........................................................................................... 14
   Narrative responses .................................................................................. 17
   Attestations.............................................................................................. 24
Section 3. Pay-for-Reporting (P4R) metrics ............................................................ 25
   Documentation........................................................................................... 25
Purpose and objectives of ACH semi-annual reporting

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

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

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

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

Achievement values

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

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

**Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period January 1 – June 30, 2021**

<table>
<thead>
<tr>
<th>Number of Projects in ACH Portfolio</th>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NC</th>
<th>NS</th>
<th>OCH</th>
<th>SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/support of Independent External Evaluator (IEE) activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Report on quality improvement plan (Replaced by COVID-19 Response)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total AVs Available</td>
<td>18</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>34</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 2. Potential P4R AVs for Project Incentives, January 1 – June 30, 2021
### Reporting requirements

The semi-annual report for this period (January 1 – June 30, 2021) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>ACH</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>3A</th>
<th>3B</th>
<th>3C</th>
<th>3D</th>
<th>Total Potential AVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Together</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Elevate Health</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
<td>5</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>HealthierHere</td>
<td>5</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>North Central ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>North Sound ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>SWACH</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
</tbody>
</table>

### Semi-annual reporting requirements (January 1 – June 30, 2021)

<table>
<thead>
<tr>
<th>Section</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1. ACH organizational updates</td>
<td>1-8</td>
<td>Attestations</td>
</tr>
<tr>
<td></td>
<td>9-11</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Key staff position changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Budget/funds flow update</td>
</tr>
<tr>
<td>Section 2. Project implementation status update</td>
<td>12-13</td>
<td>Attachments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Implementation work plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Partnering provider roster</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quality improvement strategy update</td>
</tr>
<tr>
<td></td>
<td>15-17</td>
<td>Narrative responses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- General implementation update</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Regional integrated managed care implementation update</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Scale and sustain update</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Attestations</td>
</tr>
<tr>
<td>Section 4. Pay-for-Reporting (P4R) metrics</td>
<td>22</td>
<td>Documentation</td>
</tr>
</tbody>
</table>

There is no set template for the semi annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.
While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA’s webpage. See instructions for how to format the report below.

**File format**

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

- **Main Report or Full PDF:** ACH Name.SAR7 Report.08.02.21
- **Implementation work plan:** ACH Name.SAR7 Implementation work plan.08.02.2021
- **Partnering provider roster:** ACH Name.SAR7 provider roster. 08.02.2021
- **P4R metrics:** ACH Name.SAR6 P4R metrics. 08.02.2021

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

---

**Semi-annual report submission instructions**

ACHs must submit their completed semi-annual reports to the IA **no later than August 2, 2021 at 3:00p.m. PST.**

---

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

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

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 7.”

The folder path in the ACH’s directory is:

*Semi-Annual Reports → Semi-Annual Report 7.*

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

---

**Semi-annual report submission and assessment timeline**

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2021 – June 30, 2021.

---

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period July 1 – December 31, 2020 to ACHs</td>
<td>IA</td>
<td>March 2021</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>August 2, 2021</td>
</tr>
<tr>
<td>4.</td>
<td>If needed, issue information request to ACHs within 30 calendar days of report due date</td>
<td>IA</td>
<td>August 25</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>August 26 – September 9, 2021</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>August 27 – September 24, 2021</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>October 2021</td>
</tr>
</tbody>
</table>

**Contact information**

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.
**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><strong>ACH name:</strong></th>
<th>Cascade Pacific Action Alliance (CPAA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary contact name</strong></td>
<td>Jean Clark, CEO</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>360 539-7576 x 116</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:ClarkJ@CRHN.org">ClarkJ@CRHN.org</a></td>
</tr>
<tr>
<td><strong>Secondary contact name</strong></td>
<td>Kennedy Chesoli, Director of Programs</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>360 539-7576 x 128</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:ChesoliK@CRHN.org">ChesoliK@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 template 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://wahca.box.com/s/pfesialdekjmvs6a0bhiouugxem0h26

Semi-annual reporting guidance

Reporting period: January 1, 2021 – June 30, 2021

Page 8
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>Kennedy Chesoli</td>
<td>Director of Programs (new position)</td>
<td>Oversight of CPAA and CHOICE programs</td>
</tr>
<tr>
<td>Christine Haywood</td>
<td>Director of Internal Resources (new position)</td>
<td>Oversight of HR, IT, Data, Facilities, Finance.</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>Zach Lynch</td>
<td>Prevention Coordinator (new position)</td>
<td>Leads the Substance Use Response and Youth Marijuana Prevention as program manager.</td>
</tr>
<tr>
<td>Sheena Johnson</td>
<td>Community-Based Care Coordinator (new position)</td>
<td>Assists the community-based care coordination program manager.</td>
</tr>
<tr>
<td>Vacant- 6/15/21</td>
<td>Community-Based Care Coordination Manager (Sr. pathways referral coordinator is assisting with functions)</td>
<td>Manages the community-based care coordination program.</td>
</tr>
<tr>
<td>Kwabi Amoah-Forson</td>
<td>Chronic Disease, Transitional Care, and Reproductive and Maternal Health Manager</td>
<td>Manages the Chronic Disease, Transitional Care, and Maternal/Child Health programs.</td>
</tr>
<tr>
<td>Vacant- 6/1/21</td>
<td>Community Wellness Manager (Program Director continues to manage program)</td>
<td>Manages the Bi-Directional Care Integration and oral health programs.</td>
</tr>
<tr>
<td>Connie Sowa</td>
<td>Executive Assistant and Communications Specialist</td>
<td>Provides administrative support for the CEO and BOD. Communication duties</td>
</tr>
<tr>
<td>Joshua Plaster</td>
<td>Program Support Coordinator</td>
<td>Provides administrative support for programs.</td>
</tr>
<tr>
<td>Eleanor Dovey</td>
<td>Finance Manager</td>
<td>Provides fiscal and administrative support.</td>
</tr>
</tbody>
</table>
Robert Radakovich  
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 (promotion)  
Sr. Community-Based Care Coordination Referral Coordinator (new position)  
Provides technical support for community based care coordination agencies.

Carlos Mejia Rodriguez  
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.

Patrick Suther  
Community-Based Care Coordinator  
Assists the Pathways program manager.

Caitlin Moore  
Substance Use Response and Youth Marijuana Prevention Program Manager  
Manages the Youth Marijuana Prevention and Education program and the Opioid Response Program.

CPAA expanded their staff by adding five new positions during this reporting period: 1 Coordinator and 1 Sr. Coordinator position in program 2b, 1 Coordinator position in program 3A, and 2 Director positions. Five positions were filled with new hires.

Table 2. Organizational Chart
10. **Budget/funds flow.**

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

Thank you for asking about payments made outside the financial executor portal during the reporting period for COVID-19 related payments. There were no COVID-19 related funds drawn down from the portal to make payments to vendors not registered in the portal.

No Payment Reconciliation Spreadsheet3 included.

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

Thank you for asking about payments made outside the financial executor portal during the reporting period not related to COVID-19. Please see said spreadsheets with this information entered as directed. One entry: Thurston Thrives - 4th quarter deliverables 2020 Local Forum payment for a total of $3,000.

See attached Spreadsheet4

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

---

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).
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>
<th>Actual</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Contracting from a Position of Strength: Hosted an IMC training event with Adam Falcone, held on April 18, 2019.</td>
<td>$12,000</td>
<td>$15,000</td>
<td></td>
</tr>
<tr>
<td>Hosted MCO-BHA Forum on May 8, 2019.</td>
<td>$1,950</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Provide EHR enhancement funding to support partners transitioning to IMC.</td>
<td>$330,000</td>
<td>$330,000</td>
<td></td>
</tr>
<tr>
<td>Provided interpreter Services for the IMC Provider Readiness Workgroup.</td>
<td>$1,532</td>
<td>$2000</td>
<td></td>
</tr>
<tr>
<td>Executed on-going contract with XPIO Health to provide technical assistance for up to 12 behavioral health agencies.</td>
<td>$187,337.12</td>
<td>$190,000</td>
<td></td>
</tr>
<tr>
<td>Provided UW-Caseload tracker support for 5 partners to support Collaborative Care programs</td>
<td>$31,200.00</td>
<td>$35,000</td>
<td></td>
</tr>
<tr>
<td>Contracted with the AIMS Center for BHA training series/Technical assistance</td>
<td>$38,266.00</td>
<td>$60,000</td>
<td></td>
</tr>
<tr>
<td>Contracted for psychiatric consultation services for partners implementing the Collaborative Care Model- Dr. Bhat</td>
<td>$69,912.50</td>
<td>$76,000</td>
<td></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.

See included implementation work plan spreadsheet.

13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation.\(^5\) To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

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

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

---

\(^5\) 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 organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).
b) Update partnering provider site information as needed over each reporting period.

See included partnering provider roster spreadsheet

**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

As reported in previous SARs, CPAA required all MTP Implementation Partners, including tribes and community-based organizations to complete, at the end of 2018, a Change Plan detailing their Transformation work. At the beginning of each year, partner organizations review, revise and submit for approval their Change Plan for the year. As a tool, a Change Plan defines critical paths and key dependencies, outlines all reporting requirements, helps develop MTP organizational goals specific to project areas, and measures implementation successes. The activities listed in each Change Plan detail the logical sequence of transformative events that will result in each organization achieving MTP goals and vision of improved health and wellness. The Change Plans are useable working documents.

CPAA combines all Change Plan milestones and measures into a Quarterly Reporting Tool to ensure goals and milestones are met and swift corrective action is taken if needed. 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 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.

---

6 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section.
This process also ensures that 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 A). 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. In June, CPAA held an MTP Partners meeting providing 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 the previous reporting period, as part of CPAA’s Quality Improvement Strategy, CPAA required all MTP Implementation Partners to review and modify their Change Plans as we entered 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.

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

- MTP Partner meeting and orientation for new staff members.
- 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).
- One of the 7 Local Forums presents at the Bi-monthly CPAA council meeting any reported out of the 2020 Local Forum health priorities in relation to CPAA’s 2017 Regional Health Improvement Plan (Appendix B).
- 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 collaboration throughout the region into Learning Collaboratives, local community forums, and CPAA Council meeting  
• Host regular webinars, CPAA Council meetings, and Learning Collaboratives  
• Conduct MTP Implementation Partner site visits |

<table>
<thead>
<tr>
<th>Methods and Frequency of Tracking Partner QI Progress</th>
<th>QI Activities</th>
</tr>
</thead>
</table>
| **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**  
**TA partners (Xpio Health, AIMS Center) provide quarterly reports to target efforts and advise progress** |

<table>
<thead>
<tr>
<th>Process of Communicating and Implementing Adjustments to Optimize MTP Approaches</th>
<th>QI Activities</th>
</tr>
</thead>
</table>
| **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**  
**Use submitted reports to 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 develop new methods of quality improvement and partner management through professional skills building |

### Narrative responses

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

#### 15. COVID-19

a) Provide an update on COVID-19 activities. If applicable, please describe any support of vaccine efforts, or other ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., PPE, project management, communication and engagement, coordination of funding).

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

- Community CarePort expanded their isolation and quarantine client pathways by partnering with WA Department of Health’s Care Connect program increasing the caseload and resources to address isolation and quarantine clients.
- Trainings for Community Based Care Coordination Community Health Workers included:
  - Care Connect WA Training
    - Cowlitz County Cohort
    - Lewis County Cohort
    - CPAA Cohort (2/1/2021, 2/8/2021)
    - Thurston County Cohort & Grays Harbor (3/10/2021, 3/24/2021)
    - Pacific County Cohort (5/12/2021)
  - Asthma Training w/ King County/UW
Community of Practice Training on Cardiovascular Disease w/ Dept of Health
  - 6/29/2021, 45 attendees

On the Spot Training with Care Coordinators as needed
  - 2-3 Monthly with 1-4 attendees

- Food vouchers continue to be distributed across our region through CarePort Care Coordination Agencies.
- Distribution of “Care Kit” packages
  - 373 Care Kits distributed through CPAA region
- Distribution of “Food Kits”
  - 496 Food Kits distributed throughout CPAA region
- Household Assistance Requests
  - $152,845.18 in financial relief through the Household Assistance Request process for over 277 household bills.
- Grocery Orders
  - 313 grocery orders at the cost of $63,603.71.
- Updated a dedicated COVID-19 resource webpage.
- Council Meetings, site visits, and trainings remained online due to physical distancing guidelines.
- Continued to distribute PPE in the region.
- Distributed cell phones to FCS providers for client use.
- 3-part series of virtual discussions on the origins and impact of stigma in our community. (Appendix C)
- Peer workforce support meeting (Appendix D)
- MAT waiver 1/16/2021 (Appendix E)
- Mat waiver and Hep C training 2/27/2021 (Appendix F)
- Naloxone training 1/26/2021 (Appendix G)
- Health Equity RFP released to build capacity and address persistent inequities, worsened by the pandemic. (Appendix H)
- Certified peer counselor training 4/19-30/2021 (Appendix I)
- Hosted 6 Question, Persuade, Refer (QPR) webinars focused on suicide prevention (Appendix J)
- Local forum meetings in all seven counties were leveraged to share vaccine and culturally sensitive information

b) During this reporting period, has your ACH made any notable changes or decisions related to your DSRIP activities? For example, are there updates regarding your region’s balancing of COVID-19 response and activities that were already in motion?

CPAA made a decision to further expand our CarePort Community Based Care Coordination services by partnering with the Department of Health’s (DOH) WA Care Connect program.
Also, CPAA stood-up a robust COVID-19 response framework early on in the pandemic. Through our partnership with the DOH, we were able to reach more clients in our region requiring isolation or quarantine assistance due to COVID-19 with additional financial and material support as evidenced by:

- 373 Care Kits distributed through CPAA region
- 496 Food Kits distributed throughout CPAA region
- Provided $152,845.18 in financial relief through the Household Assistance Request - process for over 277 household bills.
- Provided 313 grocery orders at the cost of $63,603.71

Continuing to build out the very successful CarePort service has been a focus of CPAA and will continue to be as we balance out COVID-19 response with activities that were already in motion. Vaccine assistance has been and will continue to be a CarePort focus as additional resources are brought forth to the CarePort program with braided funding and resources from the CDC foundation.

c) Describe any updates, new approaches, or new partnerships related to how your ACH has included Tribes/IHCPs in your COVID-19 response activities.

New updates, approaches and tribal partnerships during our COVID-19 response for the reporting period include:

- CPAA will support a feasibility study for the Chehalis Tribal Medication Assisted Treatment (MAT) clinic and pharmacy assessment of approximately $130,000.00. The MAT clinic is slated to be a treatment option for tribal and non-tribal members and will increase capacity and resources in our region for those seeking MAT treatment. An invoice for this work is yet to be received.

- Our seven tribal partners receive newsletters, are invited to our council meetings. We have an engaged tribal representative on the CPAA Board of Directors to help inform the tribes of updates and opportunities.

- CPAA also participates in and provides regular updates to the Great Rivers and Thurston/Mason Area Tribal Coordination meetings.

d) Specific to partnering providers, describe any updates, new approaches regarding provider contracts, reporting, type of providers engaged, support provided, and/or payment strategies.

CPAA is keenly aware of the health disparities in our region. In April, on the occasion of the National Minority Health Month, CPAA released an open call for proposals for funding of up to $10,000 per applicant to implement strategies to promote health equity. Seventeen partners were selected, attended a kickoff meeting in June, and
have since began implementing the project. This initiative opened new partnerships with new community-based organizations that we had no previous relationship with. This offers the ACH an opportunity to expand its reach and support more people in the region.

While this project offers a modest financial support to the 17 partners, CPAA project managers will provide close technical support to facilitate effective implementation, document lessons and challenges and provide platforms for mutual learning, community-led endeavors to generate solutions, and the showcasing of evidence-based best practices and success stories. (Appendix K)

e) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access), including any notable impacts to specific providers or communities. Also highlight any mitigation strategies or activities that shifted as a result, if applicable.

CPAA convened, on May 4, 2021, a region wide meeting of stakeholders with the intent to finding sustainable solutions to the ongoing behavioral health crisis among children and youth across its seven counties and federated tribal territories. The meeting brought together more than 120 stakeholders, among them, the Washington State Medicaid Director, school principals, superintendents and teachers, pediatric and primary care providers, behavioral health agencies, Public Health departments, representatives from area hospitals and ER teams, tribal partners, researchers and scholars, nurses, caregivers, and parents.

The meeting reaffirmed the following concerns: that the strain on families attempting to cope with the pandemic and behavioral health crisis among their children was apparent; COVID-19 had hit Community support systems particularly hard, exacerbated by the region’s rural setting and relatively large number of unhoused individuals; increased need for behavioral and mental health services lay bare the inadequate access to local providers, mental health professionals, including therapists and psychiatrists in the region; longstanding transportation challenges also impeded access to care; and that whereas tele-health emerged as a bright spot and an important and critical model for providing services to those in need in more populous areas of our region, its utilization remained low and sporadic in rural areas largely due to lack of internet and broadband connectivity.

The meeting put forth seven forward-looking recommendations with a commitment from the stakeholder groups in attendance to further engage and come up with county-specific actions. CPAA continues to convene and facilitate a weekly call of a committee on the same. (Appendix L)
f) Highlight one best practice or “bright spot” that emerged during this reporting period as a result of COVID-19 response and recovery efforts, if applicable.

Thank you for asking about a “bright spot” that emerged during this reporting period as a result of COVID-19 response and recovery efforts. The following is a direct response provided verbatim from the quarter 1 report by one of our Community Based Care Coordination (2b) partners, demonstrating the effectiveness of CPAA’s management of our Certified Pathways HUB model and associated use of trusted Community Health Workers (CHW) to provide the needed personal touch and connection to clients. Keep in mind these vignettes represent real people in our region with real life changing outcomes because of our highly competent and efficient community based care coordination program.

**Client A**

“Client entered into Care Coordination while fleeing domestic violence. The client expressed concerns over employment needs and food insecurity, and also permanent housing help. The client was making progress toward sustainability goals when she contracted COVID-19, disabling her temporarily. LCCAP’s Community Health Worker was able to provide delivery services for food boxes throughout the duration of the family’s quarantine. LCCAP’s CHW helped connect the family to resources beyond food, with cleaning supplies and facial masks to help combat the spread of the virus to others. After the threat of COVID-19 transmission had passed, the CHW was able to connect the client to employment resources and funding for car registration to aid in her job search. The client and her family are now in stable housing with an ongoing housing voucher and the client has definitive planning in place to obtain her CNA licensing to be able to return to chosen field of work”.

**Client B**

“This client entered into Care Coordination with open CPS involvement and severe behavioral health issues, including allegations of child neglect and abuse. LCCAP’s CHW was able to connect this client to local counseling and parenting resources to address behavioral health concerns for the mother, and to rekindle the relationship between herself and her child. The CHW referred the client to a local WISE Team to address child’s behavioral concerns as well. The family was due to end rapid rehousing, due to program length, but the CHW was able to secure a TBRA voucher for client and address the reasonable accommodation to include a third bedroom for the family. The client and family are now in secure, permanent housing and have since been able to maintain behavioral health appointments for herself and her child. CPS has closed their CPS investigation without losing custody of her child or impacting their housing stability”.

**16. Scale and sustain update**

a) In SAR 6.0, ACHs reported on activities and/or conversations regarding the sustainability of DSRIP funded infrastructure, activities, and/or evidence-based models.
Please describe relevant updates from the reporting period. These could include (but are not limited to) board decision regarding priority ACH investments and projects, strategic planning results, community/partner engagement, sustainability planning TA or coordination, etc.

b) In SAR 6.0, some ACHs reported that P4P incentives for DY4 and DY5, to be paid out in 2022 and 2023, had been obligated, and others reported they had not been obligated. Please provide any updates based on this reporting period, or simply indicate “no updates” as applicable.

   i. Have P4P incentive funds for DY4 and DY5 (to be paid out in 2022 and 2023) been obligated?

      No updates

   ii. What types of entities are those funds obligated to?

      No updates

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

      No updates

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

      No updates

c) 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.

   Not applicable

17. Regional integrated managed care implementation update

   a) For all regions, 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?

   There remains a persistent shortage of qualified mental and behavioral health providers. Providers are unable to either attract or retain this category of staff for many reasons, including uncompetitive wages and large rural territory. The region has experienced considerable staff changes among partners that are participating in the program. CPAA continues to convene and facilitate a monthly integrated managed care work group in conjunction with the HCA. While the primary purpose of this meeting is for partners to update each other on their activities, it has become an important platform to share ideas, seek clarification from the HCA and ask for support from peers.

   Also, CPAA continues to work with HCA, and disseminates trainings opportunities for
peer counselors. We are also in regular consultations with partners around finding solutions to more urgent and persistent needs, such as addressing the issue of fewer and inadequate providers. We have explored and will soon support a behavioral health mobile clinic in Pacific and Wahkiakum Counties. The unit will provide screening, treatment, prescription and referral services. While funds for this project will come from a separate grant, we anticipate leveraging MTP dollars to support the project for a period of 18-24 months.

b) 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 supports the implementation of strategies to address gaps and barriers in health and well-being by participating and contributing to different discussion groups around integrated managed care. We are, for instance, fully engaged in the Great Rivers Region Integrated Care Leadership Committee, as well as in the Great Rivers and Thurston/Mason Area Tribal Coordination meetings. CPAA’s Local Forums, one in each of the seven counties, continue to support local consultations and discussions.

Following the successful hosting of the CPAA Children’s Behavioral Health Task Force meeting of May 2021, the subcommittee has continued to meet on a weekly basis to prepare a work plan and suggest activities and strategies for a broad, grassroots engagement in all counties. It is envisaged that the Local Forums will be utilized to bring together different stakeholder groups at county levels to foster improved care coordination for children’s behavioral health.

CPAA shares and encourages partners to undertake timely completions of surveys, attend events and participate in technical assistance and training opportunities provided by HCA and other partners. Perhaps, one of the most significant survey and discussions that happened during the reporting period was one convened for HCA/Comagine Health to review care delivery performance and variation across multiple payers in the CPAA region. Comagine shared measures related to two social determinants of health and other measures broken out by children and adults. As an ACH, CPAA continues to arrange for technical support and work with partners to review strategies and address areas of weakness that were highlighted in this process.

c) For all regions, what challenges or opportunities has the ACH identified during the reporting period tied to clinical integration measurement and assessment?

COVID-19 continues to exert immense pressure on the region’s health
infrastructure. The pandemic has exacerbated the behavioral health crisis, highlighted gaps in care and provided the impetus to undertake needed changes. It has also validated the significance of bi-directional care integration. There is increased need for community engagement to understand health challenges, systemic weaknesses, and barriers to care. Additionally, there is a renewed impetus to engage decision and policymakers for funding and other support to communities to meet their health needs. There is also a notable decrease in stigma related to mental health, with families and students signaling a readiness to accept support.

In the CPAA region, behavioral health care is increasingly being provided by primary care physicians, especially pediatrics, due to the persistent shortage of mental and behavioral health providers. While this arrangement has the potential to accelerate integration and narrow the gap, there are concerns that the provision of these services (by primary care doctors) is not well compensated, and there is an opportunity to mainstream and support these efforts. For instance, it has been suggested that pediatricians work with the school nurses to provide physical and behavioral health screening and other upstream care to reduce ED visits. This is an idea that CPAA, as an ACH is interested in exploring.

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><strong>18. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation.</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH support or engagement may include, but is not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
<td></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>X</td>
<td></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. Pay-for-Reporting (P4R) metrics

19. 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.

Narrative responses:

20. If the ACH is not providing updates on the MeHAF this reporting period, please describe what, if anything, the ACH is doing to assess partnering provider implementation progress at a clinic/site level?

Review and approval of the 2021 Change Plan and Quarter 1 report revealed a need to provide partners an opportunity to learn and understand how CPAA supports them to implement, monitor, track and report progress related to project implementation. This need was occasioned by significant staff changes experienced by several of partners. The presence of new partner staff made it necessary for us to arrange a training/orientation.

https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121
At the June 2021 interactive MTP Partners meeting, CPAA provided the background to and contextualized the MTP work. We reviewed how Change Plans are developed and updated along with other quarterly reports: narrative report, MeHAF, Metrics (internal) etc. Partners found this information, together with the overall process around contracting and payment to be extremely useful. This meeting was greatly appreciated by partners, who observed that COVID-19 had created new demands, creating confusion and ambiguity about MTP work, processes and reports.

MeHAF Survey was shared to partners to complete. However, by this report’s deadline, only a handful (12 of 24 partners) had completed and reported back. We wish to ask for a little more time to receive feedback from the rest, then analyze and communicate findings before the end of August 2021.

21. If the ACH is providing updates on the MeHAF this reporting period, please provide any additional context if applicable.

As indicated above, due to COVID-19 and competing priorities, half of the partners managed timely completion of MeHAF survey responses. Despite delayed collection, CPAA continues to request survey results from our integrated managed care partners allowing for demonstration of progress and challenges in the region. We seek to analyze data and provide findings before the end of August 2021.

Optional: The ACH may submit P4R metric information
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 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</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3/31/2020</td>
<td>6/30/2020</td>
<td>9/30/2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/31/2020</td>
<td>3/31/2021</td>
<td>6/30/2021</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9/30/2021</td>
<td>12/31/2021</td>
<td>3/31/2022</td>
</tr>
</tbody>
</table>

**SMART Goal:**

How confident are you that you will achieve your SMART goal? Please select a confidence level for the quarter.

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>200</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>80</td>
<td>90</td>
<td></td>
<td>200</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>250</td>
<td></td>
<td>70</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td></td>
<td></td>
<td>70</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
<td></td>
<td>70</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
<td></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>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</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.
# 2021 Local Forum Partner Agreement

## PARTNER INFORMATION

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Address</th>
<th>Federal ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mason County Health Coalition Local Forum</td>
<td>P.O. Box 1580, Shelton, WA 98584</td>
<td>91-2078385</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Contact</th>
<th>Title</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melissa Casey</td>
<td>Community Health Specialist</td>
<td>360-427-9670 Ext. 406</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signer Name</th>
<th>Title</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Windom</td>
<td>Director, Mason County Community Services</td>
<td>360-456-7757</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signer Email Address</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:dwindom@co.mason.wa.us">dwindom@co.mason.wa.us</a></td>
<td>360-427-7787</td>
</tr>
</tbody>
</table>

## CPAA INFORMATION

<table>
<thead>
<tr>
<th>Program Contact</th>
<th>Title</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean Clark</td>
<td>Chief Executive Officer</td>
<td>(360) 539-7576 x116</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:ClarkJ@crhn.org">ClarkJ@crhn.org</a></td>
<td>(360) 943-1164</td>
</tr>
</tbody>
</table>

## AGREEMENT

This agreement is made between [PARTNERING AGENCY NAME], hereinafter called "PARTNER" and CASCADE PACIFIC ACTION ALLIANCE, hereinafter called "CPAA". It is mutually understood and agreed by and between the undersigned contracting parties to satisfy the deliverables stated in this agreement. The parties agree as follows:

A. The timeframe for this agreement is from the date of execution through January 31, 2022.
B. Signed versions of this contract transmitted by facsimile copy or electronic mail shall be the equivalent of original signatures on original versions.

<table>
<thead>
<tr>
<th>Partner Signature</th>
<th>CPAA Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Windom</td>
<td>Director</td>
<td>3/17/21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jean Clark</td>
<td>jc</td>
<td>3/23/2021</td>
</tr>
</tbody>
</table>
EXHIBIT A

Local Forum Scope of Work for Cascade Pacific Action Alliance for January 1 – January 31, 2022

Overview

Each county (Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum) in the Cascade Pacific Action Alliance (CPAA), Accountable Community of Health (ACH) region, will host a Local Forum to bring together diverse cross-sector partners at the local level to address community health needs, identify issues or gaps in services, and develop local health improvement strategies. The mission of the Local Forum is to identify local health priorities, adopt shared local priorities that align with the regional action agenda, align activities between stakeholders, and implement local action. Key partners in the Local Forum include physical health, behavioral health, public health, law enforcement, education, social support and community-based organizations, and at least one community member to address a wide range of community health improvement needs.

The administrative support organization for CPAA, CHOICE Regional Health Network, will provide a staff member to attend meetings as requested, and coordinate activities between local communities as necessary.

I. Local Forum will:

1. Provide the presenters and resources necessary for hosting one virtual CPAA Council Meeting in 2021. (see schedule below).

   o Work in collaboration with CPAA to develop a Council Meeting presentation using presentation outline template. Begin coordination with CPAA Community Liaison 30 days in advance.

   o Coordinate a 75-minute presentation focusing on the Local Forum’s community health improvement summary submitted to CPAA. The presentation should follow outline template provided by CPAA and include: 1. Description of health priorities within the county, 2. strategies to address those health priorities, and 3. local action already underway. With assistance from CPAA, the format should include 4. engagement with meeting attendees using small or large group discussion.

   o Submit presentation slides and supporting documents to CPAA no later than one week prior to the meeting.

   o Encourage organizations involved in the Local Forum to attend all CPAA Council Meetings.
CPAA Council Meeting Hosting Schedule

| Wahkiakum Local Forum | April 8, 2021  
|                       | 1:00-3:00 |
| Lewis County Community Health Partnership  
(Lewis)  | June 10, 2021  
|                       | 1:00-3:00 |
| Health and Human Services Advisory Board –  
Health Sub Committee (Pacific)  | August 12, 2021  
|                       | 1:00-3:00 |
| Mason County Health Coalition Local Forum  
(Mason) & Summit Pacific (Grays Harbor)  | October 14, 2021  
|                       | 1:00-3:30 |
| Thurston Thrives Coordination Council  
(Thurston)  | December 9, 2021  
|                       | 1:00-3:00 |

2. Host a minimum of four Local Forum meetings per year (at least one meeting per quarter) with a group of diverse community partners and local community members (consumers) to identify local health needs and strategize local community health improvement. Help disseminate information about CPAA events, newsletters, and meeting dates.

3. Recruit at least one consumer who has lived experience as a recipient or caregiver of a recipient of Medicaid to be a community and consumer voice at Local Forum meetings. Promote the Local Forum meeting to encourage participation by additional consumers.

4. Maintain a designated point of contact with CPAA who is responsible for sharing communication from CPAA with local forum members. The designated point of contact will subscribe to relevant CPAA email list-serves and forward information about training and funding opportunities made available by CPAA to local forum members.

5. Submit quarterly reports to reporting@cpaawa.org that include the completed quarterly report template (Addendum A), meeting agenda(s), and meeting summary(s) for the previous quarter. If the quarterly report is not received within 30 days of due date, the Local Forum forfeits that quarterly payment.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Months</th>
<th>Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>January – March</td>
<td>April 30, 2021</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>April – June</td>
<td>July 31, 2021</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>July – September</td>
<td>October 31, 2021</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>October - December</td>
<td>January 31, 2022</td>
</tr>
</tbody>
</table>
II. CPAA will:

- Provide total compensation in the amount of $10,420 during the contracted period.
  - Quarterly payments in the amount of $2,605 will be made within 30 days of receipt of approved quarterly report, dependent on the availability of the Financial Executor Portal. If the quarterly report is not received within 30 days of due date, the Local Forum forfeits that quarterly payment.
- Provide oversight of the CPAA Council Meeting by:
  - Collaborating on development of agenda and presentation(s).
  - Provide a presentation outline template
  - Creating final agenda.
  - Distributing agenda to Council Members and regional partners.
  - Providing a standardized template and staff members to aid in meeting facilitation.
  - Consolidating presentation slides.
  - Managing the virtual meeting.
  - Providing a written meeting summary.
- Attend Local Forum meetings when requested.
- Provide template for quarterly reporting.
- Determine right to renew contract annually.

Agreement Duration
The timeframe for this agreement is from the date of execution through January 31, 2022.

Compliance with Laws
The Local Forum shall comply with all applicable federal, state and local laws, rules, and regulations in performing this Agreement.

Hold Harmless and Mutual Indemnification
Each party agrees to indemnify, defend and hold harmless the other Party and its directors, officers, subcontractors, workforce members, affiliates, agents, and representatives from and against any and all claims, damages, losses and expenses (including attorneys’ fees) arising out of or resulting from any claim, action, or other proceeding (including any proceeding by any employees, agents or contractors) under or in connection with this Agreement to the extent that such costs and liabilities are proximately caused by the negligence or willful misconduct of the Indemnifying Party. This Section shall survive the termination of this Agreement.
Attachment A – Local Forum Quarterly Reporting Template

Instructions: To fulfill CPAA reporting requirements, the quarterly report must be completed and emailed to reporting@cpawa.org. If the quarterly report is not received within 30 days of due date, the Local Forum forfeits that quarterly payment.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Months</th>
<th>Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>January 1 – March 31</td>
<td>April 30, 2021</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>April 1 – June 30</td>
<td>July 31, 2021</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>July 1 – September 30</td>
<td>October 31, 2021</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>October 1 – December 31</td>
<td>January 31, 2022</td>
</tr>
</tbody>
</table>

Local Forum Name:

Primary Contact Name:

Email:

Phone:

1. Describe any successes or new partnerships developed through the Local Forum during this reporting period.

2. Describe any challenges or gaps in services identified by the Local Forum during this reporting period.

3. Describe the strategies you are taking to address your local health priorities.

4. List of attendees
Attestation:

1. A Local Forum meeting was held during this reporting period.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Date(s)</th>
</tr>
</thead>
</table>

2. Meeting agenda(s) and summary(s) is attached for all Local Forum meetings held during this reporting period.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

3. A community member was present at the Local Forum meeting.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

4. Did you host a CPAA Council Meeting during this reporting period?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
[Insert Image Here]

Local Forum Name Presentation
Local Forum PowerPoint Template

• For each of your identified health priorities listed in the accompanying “Local Forum CHIP Summary”, please address the following points in your presentation.
  • Description of health priorities within the county based on your CHIP
  • Strategies to address those health priorities
  • Local Action already underway
  • Engagement with meeting attendees using small or large group discussion (CPAA can assist with this)
A Review of Local Forums

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.
Access to Care

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 & Integration

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%

Prevent & Manage Chronic Disease

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%

Prevent and Mitigate ACEs

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.

Enhance Economic & Educational Opportunities

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

Substance Use Response

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 Housing

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%
CHOICE/CPAA and Lewis Lives Healthy are sponsoring the following virtual events:

How has stigma affected your community?

Join CHOICE/Lewis Lives Healthy on Thursday, June 24 for a 3-part series of virtual discussions on the origins and impact of stigma in our community.

A panel of passionate individuals serving our local communities will discuss the impacts of stigma in their work and its origins.

Click this link to register for the webinar series starting on June 24th at 10:30am

Day 1: Thurs June 24, 10:30am - noon; How does substance use/mental health stigma show up in your work and how does it impact outcomes?

Day 2: Fri June 25, 10am - 11:30am; Where do you think substance use/mental health stigma comes from and how do we combat it?

Days 1 and 2 will include: Introductions and opening thoughts from each panelist (25min), a panel discussion (50min), Q&A (15min)

Day 3 (Tues June 29, 2 - 3:30pm) will see the return of some panelists and allow most of its 90min duration for participants to discuss in small groups the ideas discussed in the prior sessions and reflect on their own experiences.
Peer counselors play a very important and unique role in our communities as they support others in their recovery efforts and treatment experiences. Some brainstorming has begun regarding ways to support our local peer workforce in their professional development and to offer resources to help them make the biggest impact in their work - but we want to hear from peers directly!
Peer counselors play a very important and unique role in our communities as they support others in their recovery efforts and treatment experiences.

Both new and experienced peers are encouraged to bring their ideas and insights to shape efforts to create new programs and projects to support peers!

Please join us to participate in case-conferencing, networking, and professional development opportunities!

FRI JULY 30, 2021 - 12 - 1:30PM - VIRTUAL VIA ZOOM

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

When
Saturday, January 16, 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

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
Joint Accreditation Statement: In support of improving patient care, this activity has been planned and implemented by the American Academy of Addiction Psychiatry and Cascade Pacific Action Alliance. American Academy of Addiction Psychiatry is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Interprofessional Continuing Education (IPCE) Designation Statement: This activity was planned by and for the healthcare team, and learners will receive 8 (eight) Interprofessional Continuing Education credits for learning and change.

Physician Designation Statement: American Academy of Addiction Psychiatry designates this Other activity (one portion of this course is an independent online activity and another portion of this course is a live face-to-face educational exchange with a clinical expert trained to present this material) for a maximum of 8 (eight) AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nursing Designation Statement: American Academy of Addiction Psychiatry is an approved provider of nursing continuing education through AAAP's Joint Accreditation provider # 4008192. This program is approved for up to 8 Nursing Contact Hours.

PA Designation Statement: American Academy of Addiction Psychiatry has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 8 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.
**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, February 27, 2020
9:00am-1:00pm Waiver Training
1:00pm-2:00pm HepC Training

**Where:** Zoom

**CME:** This training is free of charge. See below for specific CME accreditation information for Waiver Training

**Educational Objectives**

**Waiver training:**
- 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.

**HepC training:**
- Be familiar with direct-acting antivirals (DAAs) and key steps in treatment.
- Be aware of local and global hepatitis C elimination campaigns and that prior authorization requirements and provider restrictions have been lifted.

[Click Here to Register]
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

**Joint Accreditation Statement:** In support of improving patient care, this activity has been planned and implemented by the American Academy of Addiction Psychiatry and Cascade Pacific Action Alliance. American Academy of Addiction Psychiatry is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

**Interprofessional Continuing Education (IPCE) Designation Statement:** This activity was planned by and for the healthcare team, and learners will receive 8 (eight) Interprofessional Continuing Education credits for learning and change.

**Physician Designation Statement:** American Academy of Addiction Psychiatry designates this Other activity (one portion of this course is an independent online activity and another portion of this course is a live face-to-face educational exchange with a clinical expert trained to present this material) for a maximum of 8 (eight) *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Nursing Designation Statement:** American Academy of Addiction Psychiatry is an approved provider of nursing continuing education through AAAP’s Joint Accreditation provider # 4008192. This program is approved for up to 8 Nursing Contact Hours.

**PA Designation Statement:** American Academy of Addiction Psychiatry has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 8 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.
Naloxone Training

You can save a life

Tuesday January 26, 2021
11:00-11:30am on Zoom
https://www.eventbrite.com/e/naloxone-training-tickets-136526876563 to sign up
or email Zach Lynch at lynchz@crhn.org

Participants will
- Learn about opioids and their effects
- Learn how to recognize and respond to an opioid overdose
- Learn how to administer nasal Naloxone (Narcan)
- Be eligible to receive a free rescue kit including nasal Narcan.

WA State law RCW 69.50.315 allows anyone “at risk for having or witnessing a drug overdose” to obtain naloxone and administer it in an overdose.
RFP for Advancing Health Equity in the CPAA Region

April 15, 2021

Introduction

Health equity continues to garner attention for it is at the heart of every vibrant community and efforts to achieve a good life for all. There are moral and political justifications for promoting health equity. It has been observed that promoting health equity could afford considerable economic, national security, and other benefits. However, recent research demonstrates that worsening social, economic, and environmental factors are affecting the public’s health in serious ways that compromise opportunity for all. Communities across the United States are responding to this problem by developing and implementing a range of strategies to reduce health inequities. To illustrate health equity considerations by the Federal Government, President Joe Biden recently created, as part of the National Strategy to combat the COVID-19 pandemic, a twelve-member Task Force\(^1\) to provide recommendations to help inform Federal response and recovery, address health inequities caused by the pandemic, and for effective outreach and communication to underserved and minority populations.

The World Health Organization (WHO) defines\(^2\) health equity as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically. Many health disparities are related to social determinants of health: the conditions in which people are born, grow, live, work and age. According to the Centers for Disease Control and Prevention (CDC), health equity is when everyone has the opportunity to be as healthy as possible. The CDC has observed that the identification and awareness of differences among populations regarding health determinants and health outcomes are essential steps toward reducing health disparities. In order to advance health equity, the CDC has prepared a number of studies and tools, among them: the publication, Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health; and A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease.

In their 2017 Report, Pathways to Health Equity, the National Academies of Sciences, Engineering and Medicine considered the evidence on the status of health disparities and research examining the underlying conditions that lead to poor health and health inequities. That


\[^2\]https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3
The push for Health Equity is important because the US Health System is unequal. Minority populations face troubling health disparities in outcomes, care, and access. These disparities affect individuals across many dimensions, including race and ethnicity, socioeconomic status, gender, and sexual orientation, among others. As an example of this imbalance, African American infants are 3.8 times more likely to die from complications related to low birthweight than non-Hispanic White infants. It is, therefore, not surprising when the Commonwealth Fund ranked the US last among industrialized nations when they compared Health Equity dimensions.

The Washington State Department of Health has acknowledged the existence of health inequalities in many communities that are driven and dependent on race, culture, identity, or location. It has also observed health inequities exist when there is a difference in health outcomes across different groups of people, and that difference is caused by something that is systematic, avoidable, unfair, and unjust. The work of Cascade Pacific Action Alliance (CPAA) across the seven counties is guided largely by the Regional Health Improve Improvement Plan (RHIP). This strategic document identifies priority health needs, gaps, systemic as well as extrinsic barriers to good health. A range of interventions adopted through the ongoing Medicaid Transformation Project (MTP) that is led and coordinated by CPAA respond to these challenges.

**Diversity, Equity, and Inclusion at CPAA**

Diversity, Equity, and Inclusion (DEI) are central to the internal and external workings of CPAA and its backbone agency, CHOICE Regional Health Network. Since its establishment in 1995, CHOICE has strived to eliminate barriers to health through projects and programs designed around a key health priority. Together with its partners, CHOICE has strived to address barriers to care by responding directly to the needs of the population it serves - among them; low-income households; marginalized populations; Tribal partners; rural communities; persons with chronic illnesses; and at-risk populations to substance use disorder.

As part of the growing Accountable Communities of Health (ACHs), CPAA has a range of cross-sector partnerships that aim to improve health outcomes for vulnerable populations by

---

addressing social determinants of health, such as food and housing insecurity. Our ability to convene partner forums and foster coordinated, integrated, and improved health care stems from established partnerships and collaborations with health care providers, social service organizations, public health departments, schools, partners in the Tribal communities, and other stakeholders. We believe that it is imperative for ourselves and our partners to prioritize health equity, broaden health equity’s scope, invest in the structures and processes that improve health equity, and dismantle institutionalized racism and biases.

Everyone can play a role in advancing Health Equity. Our health care provider partners, including Primary Care Providers and Behavioral Health Agencies, can shift towards a more “upstream” perspective by embracing the reality that individual’s health behaviors are often shaped by their context and the conditions of their lives, including Adverse Childhood Experiences (ACEs). Adopting a holistic perspective can help providers work with patients to develop culturally appropriate treatment plans as well as goals that acknowledge an individual’s current context and support system.

In recent months, CPAA/CHOICE staff members have undertaken activities and trainings aimed at deepening their understanding and appreciation for DEI. Besides definitions, there is consensus around the role of DEI at the workplace and in the program work. On Diversity, CPAA seeks to foster a culture that accepts differences. It intentionally seeks to attract talent and partner with those with diverse backgrounds. It also seeks to demonstrate appreciation, awareness and understanding of the diverse groups it serves. Regarding equity, CPAA resolves to pursue intentional action towards an equitable work culture and community access to programs. It aspires to accomplish this by identifying and eliminating barriers that prevent equitable opportunities to access, attend, share, and benefit from its work. Finally, it seeks to foster inclusion by intentionally seeking to identify and hear voices of all who may be impacted, involving them in planning to glean varying perspectives. It will do this by developing various endeavors geared towards understanding the needs and perspectives of underserved populations.

**Request for Proposal (RFP)**

As the Medical Transformation Project (MTP) enters its fifth year, CPAA wishes to further improve the delivery of healthcare services by embedding Diversity, Equity, and Inclusion (DEI) perspectives. At CPAA, we believe that advancing health equity means challenging systemic and transient power imbalances and all forms of oppression in all our work — both internally in our policies and practices, and externally in how we work with our partners, communities, and funders. This year, CPAA will dedicate $250,000 towards supporting a total of 25 potentially game changing health equity initiatives in its seven counties of Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum. Against this backdrop, CPAA wishes to announce an RFP for a US $10,000 grant for purposes of advancing Health Equity in our region. Applicants are encouraged to complete and submit applications by **Monday May 17, 2021.** Late submissions will NOT be considered.
This RFP is organized around a set of strategies that could foster organization-wide or community-level changes to systematically transform health equity practices. Whereas efforts have been made to identify these initiatives, partners may, in some limited cases, use the grant to scale up an existing health equity undertaking provided it meets all the requirements. Several strategies in this document require internal capacity building, and a deliberate will to act on the social determinants of health and health equity. Others require developing and strengthening relationships and collaborations with, and mobilizing communities, government, and other partners to advocate for action.

**Areas of Interest**

1. Making Health Equity a Leader-Driven Priority
2. Developing Structures and Processes that Advance Health Equity
3. Addressing Social Determinants of Health
4. Combating Institutionalized Racism & Stereotypes Within Agency, and
5. Forging Platforms and Partnerships.

**Application Criteria**

CPAA wishes to invite agencies and organizations operating in the seven countries of Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum to apply for a grant of $10,000 to initiate or scale up relevant health equity activities. A total of 25 partners will be selected to participate in this 12-month project. Organizations may only submit one application (as defined by EIN). Successful applicants can use these funds to implement activities related to the approved strategies only.

This RFP is open to CPAA’s 25 active Medicaid Transformation Project (MTP) partners, and other community organizations not currently implementing MTP activities. Organizations founded by and/or serving minorities, disadvantaged or marginalized groups and populations are highly encouraged to apply. CHOICE Regional Health Network and CPAA employees are not permitted to apply on behalf of organizations that they support or are affiliated with.

**Grant Award**

Eligible agencies and organizations as per the above criteria are invited to apply for a grant of $10,000. A total of 25 successful partners will share CPAA’s Health Equity grant of $250,000. Payments would be made in three instalments: upon signing of the contract; successful completion of mid-project milestones; and on project close out with submission of completed deliverables.

**Submission Requirements**

**Project Narrative and Work Plan**

Upon selecting a suitable strategy to implement, please provide clear and concise responses to these questions in order:
i. Which three interventions (indicate the correlating strategy) are you applying for from Appendix A? You are not required to select from just one strategy area.

ii. Provide an overview of your proposed project that includes the following:
   a. Identify and describe the population (racial, ethnic groups, people with disabilities, LGBTQ+ etc), income and poverty incidences, and beneficiaries that your strategy will target.
   b. Is this an effort to scale up an existing initiative or a new undertaking?
   c. Has your organization already received funding for a similar health equity initiative? If so, how would you avoid possible duplication and co-mingling of funds?
   d. Describe the problem or a need gap you intend to address.
   e. What are the anticipated impacts from this initiative? How would you measure them?
   f. Ideas regarding the scale and sustain plans for the initiative.
   g. Good data is important: What kind of data would you collect and analyze?

iii. Provide three possible outputs from your project. They should be tangible or measurable (see some examples in the table below).

iv. Provide three possible project outcomes (see examples in the table below).

v. Describe how the initiative will benefit your organization and/or community and advance health equity. If possible, please quantify the reach of your proposal.

vi. Provide a preliminary work plan (Appendix B) that includes the following:
   a. Project goals
   b. Objectives
   c. Action steps
   d. High-level timeline

**Budget narrative and proposed budget**

The maximum funding amount is $10,000 for up to 12 months. Funds may only be used to support project activities and direct expenses. They are not to be used for operational support of existing projects, or activities not directly related to the proposed project. CPAA may request additional supportive documentation to process payment. Due to a limited amount of funding, your proposal may only receive the total amount of $10,000. Please provide an explanation of how grant funds will be used.

**Submission instructions and formatting**

Applications will be submitted through Formsite5.

When completing the Health Equity RFP, your response will be saved when you advance to the next page. You can save your form and return to it later; however, to do so, you must first create an account by following the link on the first page. CPAA strongly encourages all applicants to

5 https://www.formsite.com/
create an account. Please note: If you close your browser before saving or before moving to another page, your input will be lost. If you choose not to create an account, you would not be able to return to or review your answers later.

Review Criteria

Award recipients will be determined by a review panel based on the following criteria:

i.   General description of the project, including all the required components.
ii.  Clarity of the project design, including the work plan.
iii. Overall ability of the project to advance health equity.
iv.  Feasibility of the project timeline and budget
v.   Readiness to implement the project.

Key Tasks and Deliverables

Grantees will be required to:

i.   Assign one staff person as a point-of-contact for the entire grant period.
ii.  Attend a mid-grant virtual meeting with CHOICE/CPAA staff to discuss progress on the project.
iii. Submit a written end-of-project report covering challenges, successes, lessons learned, and impact.
iv.  Participate in an end-of-project meeting with other grantees to share lessons with peers. Some selected initiatives would be invited to be showcased at a CPAA’s Health Equity Summit.

Timelines

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFP released</td>
<td>April 15, 2021</td>
</tr>
<tr>
<td>Q&amp;A webinar</td>
<td>April 29, 2021</td>
</tr>
<tr>
<td><strong>RFP submission deadline</strong></td>
<td><strong>May 17, 2021</strong></td>
</tr>
<tr>
<td>Anticipated award announcement</td>
<td>May 31, 2021</td>
</tr>
<tr>
<td>Agreements in place</td>
<td>June , 2021</td>
</tr>
<tr>
<td>First payment released</td>
<td>July , 2021</td>
</tr>
<tr>
<td>Mid-project Check in</td>
<td>January 2022</td>
</tr>
<tr>
<td><strong>Mid-project Payments</strong></td>
<td><strong>January 2022</strong></td>
</tr>
<tr>
<td>Final report due</td>
<td>June 30, 2022</td>
</tr>
<tr>
<td>End-of-Project Meeting</td>
<td>June 30, 2022</td>
</tr>
<tr>
<td>Final payment released</td>
<td>July , 2022</td>
</tr>
<tr>
<td><strong>CPAA Health Equity Summit</strong></td>
<td><strong>July, 2022</strong></td>
</tr>
</tbody>
</table>
Q&A

CPAA will host a virtual Q&A webinar on **Thursday April 29, 2021** to answer questions about the application process, project timeline and requirements, and Health Equity Strategies. Please note that CPAA is unable to answer questions about specific project eligibility during this time.

**Contact Information**

For questions and requests to discuss proposal ideas, please email reporting@cpaawa.org with the subject line: “Health Equity RFP”. Emails will be responded to within 3 business days.

**Applicants must complete and submit applications by Monday May 17, 2021. Late submissions will NOT be considered.**

**List of Appendices**

Appendix A: Health Equity Initiative menu
Appendix B: Work Plan Template

**Contact Information**

Email: reporting@cpaawa.org
# Appendix A: Health Equity Strategy Menu

<table>
<thead>
<tr>
<th>STRATEGY AREA</th>
<th>JUSTIFICATION</th>
<th>POSSIBLE INTERVENTIONS</th>
<th>EXAMPLES OF DELIVERABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I: Making Health Equity a Leader-Driven Priority</strong></td>
<td>Leadership and decisionmakers can prioritize, articulate and champion health equity and promote favorable institutional change.</td>
<td>Review/revise mission and vision statements, develop inclusive recruitment policies and protocols.</td>
<td>Designating a Health Equity champion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify, address, and dismantle internal structures, practices, policies, and norms perpetuating race-based advantages.</td>
<td>Develop and implement new policies, practices, tools that advance equity and sustain it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop fit-for-purpose equity metrics for performance evaluation, funding decisions, and/or mobilizing community support</td>
<td>Health Equity metrics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Train staff to ensure they can provide culturally and linguistically appropriate care. Support partners on the same</td>
<td>Health Equity training program</td>
</tr>
<tr>
<td><strong>II: Develop Structures and Processes that Advance Health Equity</strong></td>
<td>Work related to championing Health Equity needs to be structured, entrenched, and resourced within agencies.</td>
<td>Develop structures, including governance, processes, and dedicated resources to promote, oversee and sustain health equity.</td>
<td>Health Equity workgroups, Peer-learning and coaching sessions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incorporate innovative, objective, and actionable non-medical assessments or screenings to identify factors influencing health outcomes.</td>
<td>Include Social Determinants of Health, discrimination, or violence info into screening.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incorporate Adverse Childhood Experiences (ACEs) and trauma information in designing care.</td>
<td>Show how ACEs is mainstreamed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collect and publish data highlighting local health equity issues and develop community-based solutions</td>
<td>Collect and analyze REAL (Race, Ethnicity and Language) data. Using data develop a supporting action plan.</td>
</tr>
<tr>
<td><strong>III: Addressing Social Determinants of Health</strong></td>
<td>To support disadvantaged individuals requires eliminating/lowering barriers to health care by taking concrete actions that close the gap.</td>
<td>Establishing a mentorship, internship, training and/or career development initiative targeting low income, minorities, and individuals from the Tribal communities.</td>
<td>Create &amp; implement a Career Development Plan of Action.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide low-cost opportunities for physical activity to advance community health.</td>
<td>Organize “Fun Races”, “Play Streets” for kids, and other physical activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess and identify barriers to healthcare. Provide enhanced and differentiated support based on assessment results to the disadvantaged to achieve and sustain desired results</td>
<td>Offer transportation support; mobile services; home visits; interpretation; open longer hours.</td>
</tr>
</tbody>
</table>
### IV: Combating Institutionalized Racism & Stereotypes Within Agency

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and address both individual and agency biases towards various racial groups. Using relevant data identify community locations where health inequity is exacerbated.</td>
<td></td>
</tr>
<tr>
<td>Assess and identify services, needs or other additional assistance various racial groups, low-income and non-English speaking populations may benefit from to get the care they need.</td>
<td></td>
</tr>
<tr>
<td>Develop inclusive recruitment policies and protocols for hiring, retaining, and promoting individuals from minority populations, persons with disabilities, and/or with criminal records.</td>
<td></td>
</tr>
<tr>
<td>Adopt new ways that redistribute power and/or resources across different populations within and outside your organization.</td>
<td></td>
</tr>
<tr>
<td>Health inequities are not simply the result of choices or random occurrences but largely the result of structural racism and discrimination.</td>
<td></td>
</tr>
</tbody>
</table>

- Develop & implement a plan to complete bias assessments with a subsequent training plan for how to manage bias.
- Design culturally tailored education material, instructions, and FAQs in the patient’s primary language.
- Design an action plan based on assessed needs, implement initiatives and measure progress.
- Policy changes
- Develop a targeted recruitment strategy based on statistical data of agency and measure effectiveness of various initiatives
- New decision-making metrics

### V: Forging Platforms and Partnerships

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build new local, Public-private partnerships to support positive community outcomes by leaning on each other’s expertise</td>
<td></td>
</tr>
<tr>
<td>Establish new support groups and community-based approaches to connect members with services they need</td>
<td></td>
</tr>
<tr>
<td>Mobilize whole community through social media campaigns and platforms that engage minority groups and Tribal partners</td>
<td></td>
</tr>
<tr>
<td>Develop new referral relationship with Community CarePort Hub⁶, identify and refer clients who could benefit from care coordination services</td>
<td></td>
</tr>
<tr>
<td>Health inequity is multifaceted and multisectoral. Collaboration leverages resources and competencies yielding sustainable outcomes.</td>
<td></td>
</tr>
</tbody>
</table>

- Create and formalize new Partnerships
- Support new groups
- Develop vibrant multi-language groups on Facebook, Twitter, Instagram, and other platforms.
- CarePort participation

---

# Appendix B: Work Plan Template

<table>
<thead>
<tr>
<th>Work Steps</th>
<th>Responsible</th>
<th>Work Step Status</th>
<th>Year 2021/2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Objective X: Addressing Social Determinants to Health; Promoting nutrition and health diet among low-income households in xx neighborhood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Step 1: Mapping out (race, ethnicity, etc), selecting, and onboarding into the initiative families that are most in need.</td>
<td>Program Manager (PM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Step 2: Creating and translating information and education material on diet, nutrition, food markets etc. Create budget and establish outreach, information, and training schedule.</td>
<td>Program Manager (PM)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Action Step 3: Sourcing and distributing healthy nutrient-fortified food products for babies and children under 10.</td>
<td>Program Officer (PO)</td>
<td>X X X X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Action Step 4: Sourcing and distributing packages of fresh vegetables and fruits.</td>
<td>Program Officer (PO)</td>
<td>X X X X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Action Step 5: Conducting Nutrition classes/Sessions</td>
<td>PM/PO</td>
<td>X X X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Action Step 6: Demonstrate Scale and sustain measures</td>
<td></td>
<td>X X X X X X X X X</td>
<td></td>
</tr>
</tbody>
</table>

**Objective 1:**
- Action Step 1
- Action Step 2
- Action Step 3
- Action Step 4
- Action Step 5

**Objective 2:**
- Action Step 1
- Action Step 2
- Action Step 3
- Action Step 4
- Action Step 5
<table>
<thead>
<tr>
<th>Objective 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Step 1</td>
</tr>
<tr>
<td>Action Step 2</td>
</tr>
<tr>
<td>Action Step 3</td>
</tr>
<tr>
<td>Action Step 4</td>
</tr>
<tr>
<td>Action Step 5</td>
</tr>
</tbody>
</table>
Become a Certified Peer Counselor

Free training April 19–30th, 2021
Limited spaces available – sign up now!

Certified Peer Counselors draw upon their own personal experiences in recovery to help other people find hope and support. Your life experience uniquely qualifies you to take this training and learn how to provide support, encouragement, and resources to those currently experiencing challenges with mental health and substance use disorders.

How to get involved:
1.) Complete an online prerequisite course
2.) Complete the peer counseling application found on HCA peer support page
3.) Be accepted for the HCA-approved CPC training with WSU Peer Workforce Alliance
4.) If you wish, apply for a small scholarship offered through CHOICE
5.) Complete the virtual training in April
6.) Take and pass the state CPC oral and written exams (currently also virtual)
7.) Enjoy a new career path helping others with your unique knowledge and skillset!

Email lynchz@crhn.org for additional information!
Suicide Prevention Training

QPR TRAINING DATES

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

Wednesday, February 10
1:30 - 3:00pm

Tuesday, March 2
10:00 - 11:30am

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

Ask a Question, Save a Life

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

Learn the warning signs of suicide

QPR TRAINING DATES

Tuesday, April 13
10:00 - 11:30am

Thursday, May 13
1:00 - 2:30pm

Question
Persuade
Refer

Three steps anyone can learn to help prevent suicide

Ask a Question, Save a Life

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/pporrmbmiel/index.html
QPR stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide.

Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. Each year thousands of Americans, like you, are saying "Yes" to saving the life of a friend, colleague, sibling, or neighbor.

Like CPR, QPR is part of a system designed to increase the chance of survival in the event of a crisis.

This training is free for registrants and made possible by the sponsorship provided by Family Education & Support Services, CHOICE and CPAA. Please feel free to share this information.
For more information or questions, please contact Kwabana Amoah-Fortson at amoahk@crhn.org.
Call to Action, Call to Collaboration: Advancing coordination between systems of care across the CPAA region to address the youth behavioral health crisis

**PROGRAM**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00-3:05 PM</td>
<td><strong>Introduction:</strong> Kurt O’BRIEN, Independent Consultant and Senior Lecturer, Department of Health Services Master in Healthcare Administration (MHA), University of Washington</td>
</tr>
<tr>
<td>3:05-3:10 PM</td>
<td><strong>Welcome Remarks:</strong> Jean CLARK, CEO, CHOICE Regional Health Network &amp; Cascade Pacific Action Alliance (CPAA)</td>
</tr>
<tr>
<td>3:10-3:25 PM</td>
<td><strong>Keynote Address:</strong> MaryAnne LINDEBLAD, Washington State Medicaid Director</td>
</tr>
<tr>
<td></td>
<td><strong>Panel Speakers</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Behavioral Health Agencies:</strong> Lauren FARMER, Director of Children, Youth, and Family Outpatient Services, Behavioral Health Resources</td>
</tr>
<tr>
<td></td>
<td><strong>Public Health:</strong> Dr. Anthony CHEN, Director of Health of Tacoma-Pierce County Health Department.</td>
</tr>
<tr>
<td></td>
<td><strong>School Districts:</strong> Kevin WILSON, Assistant Principal at Rochester High School.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospital ERs:</strong> Dr. Erik PENNER, Emergency Medicine Specialist, Providence St. Peter Hospital.</td>
</tr>
<tr>
<td></td>
<td><strong>Tribes:</strong> Harvey WHITFORD, Superintendent of Wah He Lut Indian School</td>
</tr>
<tr>
<td></td>
<td><strong>Pediatric and Primary Care:</strong> Dr. Sheryl MORELLI, General Pediatrics, Seattle Children’s Hospital and Clinical Professor Center for Clinical and Translational Research.</td>
</tr>
<tr>
<td>3:25-4:05 PM</td>
<td><strong>Topic I: Understanding a Range of Behavioral Health Systems of Care in CPAA Region</strong></td>
</tr>
<tr>
<td>4:05-4:30 PM</td>
<td>Breakout Session</td>
</tr>
<tr>
<td>4:30-4:35 PM</td>
<td>Stretch Break</td>
</tr>
<tr>
<td>4:35-5:05 PM</td>
<td><strong>Topic II: Re-imagine CPAA’s Youth Behavioral Health Collaborative System of Care and Crisis Response</strong></td>
</tr>
<tr>
<td>5:05-5:20 PM</td>
<td>Breakout Session</td>
</tr>
<tr>
<td>5:20-5:50 PM</td>
<td>Breakout Groups Share Ideas</td>
</tr>
<tr>
<td>5:50-5:55 PM</td>
<td><strong>Closing:</strong> Rapporteur’s Report, Elizabeth TINKER, PhD. Clinical Nurse Advisor/MCH Consultant, Clinical Quality Care Transformation</td>
</tr>
<tr>
<td>5:55-6:00 PM</td>
<td><strong>Closing:</strong> Next Steps, Jean CLARK, CEO, Cascade Pacific Action Alliance (CPAA)</td>
</tr>
</tbody>
</table>
Call to Action, Call to Collaboration: Advancing coordination between systems of care across the CPAA region to address the youth behavioral health crisis

SPEAKERS

CONVENER – Jean CLARK
CEO, Cascade Pacific Action Alliance

Jean is the CEO of CHOICE and CPAA with a three-decade track record of successful leadership in multiple large healthcare organizations. She has overseen physician enterprise development, clinical quality including patient experience and staff engagement, clinical operations, strategic service line development, consolidation of services, recruitment with retention, and state and national health policy development. Previously, Ms. Clark served as Chief Executive Officer at Kindred Hospital Seattle, a Fortune 500 company and the leading provider of post-acute healthcare delivery systems in the United States. Prior to joining Kindred Healthcare, she was Chief Nursing Officer at Astria Sunnyside Hospital where she also provided oversight to 6 hospital-owned clinics.

KEYNOTE SPEAKER - MaryAnne LINDEBLAD, BSN, MPH
Washington State Medicaid Director

Ms. Lindeblad oversees Washington’s Apple Health (Medicaid) program, which provides more than 2 million Washington residents with integrated physical and behavioral health services. She serves on the executive committees of both the National Association of Medicaid Directors and the National Academy for State Health Policy and chairs the Centers for Medicare & Medicaid Services (CMS) Managed Care Technical Advisory Committee. She also co-chairs the Statewide Children and Youth BH Workgroup (CYBHWG) which provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families.
Lauren FARMER, MA, MHP, LMFT, CMHS
Director of Children, Youth, and Family Outpatient Services
Behavioral Health Resources (BHR)

Ms. Farmer earned her BA in Psychology from the University of Michigan (2006), and MA in Psychology from Antioch University, Seattle (2009). She has worked professionally in New York, Minnesota and as the Children’s Long-term Inpatient Program (CLIP) Liaison for Kitsap County in Washington. She has experience in managing outpatient departments, serving youth and adult clients from diverse backgrounds, and is actively involved in workgroups supporting improved access to services throughout the Puget Sound region. She believes that early intervention is necessary for successful outcomes, and is passionate about preparing the next generation of mental health professionals for work in the field. Lauren joined BHR in 2016.

Kevin WILSON, Assistant Principal
Rochester High School

Mr. Wilson holds a Bachelor's Degree from Central Washington University, Master's Degree in Education and Administrative Certification from Heritage University. He began his educational career in the Mossyrock School District in 2001 as a high school teacher, coach, and Athletic Director. He spent eight years as a CTE teacher before accepting the principal position at Mossyrock High School. In 2014, he served as assistant principal at Rochester High School. His educational experiences have afforded him the opportunity to collaborate with a diverse group of people to meet the common goal of increasing student achievement and well-being. His educational philosophy is based on his uncompromising belief that all students can learn, given a positive learning environment, strong and knowledgeable leadership, a committed and focused educational team, an encouraging community, and a supportive family.

Dr. Erik PENNER, Emergency Medicine Specialist
Providence St. Peter Hospital

Dr. Penner a medical doctor who grew up in Longview, Washington and has 3 kids (2 in college, 1 in high school). He is a board certified Emergency Physician practicing with Olympia Emergency Services at Providence St. Peter Hospital. He obtained his undergraduate degree at the University of Washington and went to Vanderbilt Medical School where he was in the medical honor society AOA and received their award from Humanism in Medicine. He did residency at Oregon Health Sciences University in Portland and was Chief Resident. He is a long time youth coach and mentor and has an award from Washington Youth Academy for Best Mentor. His interest in the youth behavioral health crisis is as a parent, longtime advocate for kids and as an ER MD who sees firsthand the tragic cases and mental health crisis in the ER and limited resources to help these kids for acute and long term needs.
Dr. Sheryl MORELLI, MD, MS, FAAP
Chief Medical Officer, Seattle Children’s Care Network, Section Chief, Community Pediatrics, Seattle Children’s Hospital, Clinical Professor of Pediatrics, University of Washington School of Medicine

Dr. Morelli is the Medical Director for Seattle Children’s Accountable Care and the Chief Medical Officer of Seattle Children’s Care Network. She serves as a key medical leader, principal clinical communicator and clinical operational architect of Seattle Children’s accountable care strategies including care management for population health. She is the CMO of SCCN, a clinically integrated network bringing together more than 200 independent primary care pediatricians, 600 CUMG specialty providers and Seattle Children’s Hospital. Dr. Morelli graduated Cum Laude from Ohio State University in 1991 and 1993 with bachelor and master’s degrees in early childhood development. A Wright State University Medical School graduate in 2000, and pediatric residency in 2003. She is board certified in both pediatrics and clinical informatics. In 2008, Dr. Morelli relocated to Seattle Washington accepting positions with the University of Washington School of Medicine Department of Pediatrics, Division of General Pediatrics and with Seattle Children’s Hospital as an informatics physician.

Dr. Anthony CHEN, Director of Health
Tacoma-Pierce County Health Department

As the Chief health strategist for Pierce County, Dr. Chen promotes a policy, systems and environmental change approach to advance the Health Department’s vision of healthy people and healthy communities. Dr. Chen has a passion for health equity, bringing a personal commitment to the health department’s mission: to protect and improve the health of all people and places in Pierce County. During his career, he has developed expertise in Community health planning and program development, Quality and systems improvement, Access to healthcare, Cross-cultural medicine and cultural competency in healthcare. Dr. Chen serves on state and national public health committees; regional planning bodies; and local, state and congressional district committees on healthcare access and reform.

Beth TINKER, PhD.
Clinical Nurse Advisor/MCH Consultant

Beth is a Clinical Nurse Consultant/Nurse Advisor at the Washington State Health Care Authority. Her nursing experience is in Pediatrics, Obstetrics, Public Health, home visiting, and management. Beth completed her PhD in Nursing Science at the University of Washington in 2019, where she was awarded the Robert Wood Johnson Scholar Award for doctoral studies. Her research interests include health disparities, infant mental health, protective factors for children and families living with complex adversity, breastfeeding, early intervention, home visiting and public health nursing. At the Health Care Authority, she focuses on clinical programs and policies across the reproductive health continuum and care for children and families, with a focus on perinatal and infant mental health.
Harvey WHITFORD  
School Superintendent, Wah He Lut Indian School

Kurt O'BRIEN  
Independent Consultant and Senior Lecturer

Kurt is an independent consultant and a senior lecturer with the University of Washington’s Department of Health Services Master in Healthcare Administration (MHA) program. He has over twenty years of experience in the field of organizational development and eighteen years of direct leadership experience. His primary focus is on providing innovative ways for individuals, teams and organizations to learn and develop. Specifically, he works with leaders to help them more fully develop their leadership craft – their capacity to lead their teams and organizations through the complex challenges they face. Kurt is a highly skilled group facilitator, and specializes in the areas of leadership development and coaching, interpersonal skills development, team development, strategic planning, and conflict resolution. Prior to joining the UW he spent twelve years as an active duty officer in the U.S. Coast Guard. Kurt received his Master’s in Human Resources and Organization Development (MHROD) from the University of San Francisco in 1997. He recently co-authored a book for healthcare leaders titled, Leading Adaptive Teams in Healthcare Organizations, has written or contributed to various articles, and is often invited to speak at conferences on a range of leadership topics.
Report of the CPAA’s Children’s Behavioral Health Meeting

May 19, 2021

Introduction

Cascade Pacific Action Alliance (CPAA), one of Washington’s nine Accountable Communities of Health (ACH), convened a regionwide meeting of stakeholders on May 4, 2021 with the intent to find sustainable solutions to the ongoing behavioral health crisis among children and youth across its seven counties and Federated tribal territories. Held against the backdrop of the COVID-19 pandemic, the meeting brought together more than 100 stakeholders, among them, the Washington State Medicaid Director, school principals, superintendents and teachers, pediatric and primary care providers, behavioral health agencies, Public Health departments, representatives from area hospitals and ER teams, tribal partners, researchers and scholars, nurses, caregivers, and parents.

Convened under the theme “Call to Action, Call to Collaboration: Advancing coordination between systems of care across the CPAA region to address the youth behavioral health crisis” this meeting was also held, in part as a response to Governor Jay Inslee’s directive for stakeholders to draw up recommendations for tackling the problem that he aptly described as a “crisis”. This report presents key themes and messages along with recommendations that were put forward in the spirit of generating community-led solutions, including a call for the establishment of mechanisms that would promote increased collaboration between all stakeholders providing care to children and youth.

Behavioral Health Crisis in the Cascade Pacific Region

COVID-19 has worsened youth behavioral and mental health challenges across seven counties that comprise the CPAA region. For a region underserved by medical and behavioral health providers, the pandemic created new challenges to the healthcare system that was already stretched thin. The loss of school supports, including access to teachers and counselors, during lockdowns and closures, denied kids and their parents vital services. The inability to associate with friends and family members created anxiety, loneliness, and a host of other mental health challenges. There were reported spikes in substance abuse and substance use disorder, suicidal...
ideation, anxiety attacks, and depression. The unprecedented rise in behavioral health needs, which outstripped licensed behavioral health clinics and agencies required primary care providers, including pediatricians, to provide this care.

The strain on families attempting to cope with the pandemic and behavioral health crisis among their children was apparent. Community support systems were particularly hit hard, exacerbated by the region’s rural setting and relatively large number of unhoused individuals. Increased need for behavioral and mental health services lay bare the inadequate access to local providers, mental health professionals, including therapists and psychiatrists in the region. Longstanding transportation challenges also impeded access to care. Whereas tele-health emerged as a bright spot and an important and critical model for providing services to those in need in more populous areas of our region, yet its utilization remained low and sporadic in rural areas largely due to lack of internet and broadband connectivity.

Both COVID-19 and the behavioral health crisis have helped highlight gaps in care and provided the impetus to undertake needed changes. They also validated the significance of the ongoing bidirectional care integration of physical and behavioral health by several CPAA partners under the Medicaid Transformation Project (MTPs). There is increased need for further community engagement to understand health challenges, systemic weaknesses, and barriers to care. Additionally, there is a renewed impetus to engage decision and policymakers for funding and other support to communities to meet their health needs. Participants further observed notable decrease in stigma related to mental health with families and students signaling a readiness to accept support. The following are some of the recommendations that came out of the taskforce meeting.

**Recommendations**

i) Embrace “whole person approach to care” and impactful collaboration between different systems of care. CPAA will continue to convene and facilitate regionwide and county-level stakeholder dialogues with a view of bridging the gap between different systems of care and establishing a common framework and language for advancing comprehensive care for children.

ii) Emphasizing collaboration over competition among providers. While scarce resources, limited qualified personnel and heightened demand for services may serve as incentives for unhealthy competition, there is the potential for partners to achieve better health outcomes through collaboration.

iii) Continued integration of care. Ongoing bidirectional integration of behavioral and physical health initiatives under MTP are beginning to bear results. There is a need to continue supporting these efforts, address observed challenges including supporting
primary care providers including pediatricians to recruit and retain therapists and psychiatrists. The uncompetitive rates for behavioral health personnel in the CPAA region coupled with high demand for these skills elsewhere remain a major barrier to integration. There is also a need to expand integration, to include oral health and other services.

iv) Prioritizing upstream and preventive care coupled with health equity dimensions. Post-COVID rebuilding of the healthcare system in the CPAA region should stress prevention and early intervention, equity, and access to care. There was a call to pay attention to equity, appropriate diagnosis, and resourcing for Black, Indigenous, and People of Color (BIPOC) youth.

v) Overcoming distance and transportation barriers through tele-health. The pandemic has revealed anew the potential for technology to reduce access barriers, especially for rural and isolated communities. Unfortunately, lack of high-speed internet and broadband connectivity remains a major challenge. Low reimbursement rates for virtual and tele-health may further blunt its prospects. There is an opportunity for private sector actors, especially in telecommunications, to improve health outcomes by making infrastructure investments in the region. Additionally, there are fears that the return to in-person classroom attendance, and the recalling of chrome books and tablets provided to learners by schools may erase gains made in tele-medicine.

vi) Need for more state and federal funding. Inadequate investments in healthcare across the CPAA region calls for new and enhanced resources to support providers, caregivers, school districts and other community support actors. Making Federal dollars available to help PCPs embed mental and behavioral health experts in the clinics and the use of school capitation to support school nurses were mentioned as two high priority areas.

vii) The meeting recommended a structured approach to keeping people engaged and creating incentives to encourage and support career development in behavioral and mental health fields. CPAA will continue to convene and steer discussions around addressing social determinants to health, fostering health equity, and eliminating barriers by promoting the use of familiar languages and providing care that is culturally appropriate.

For more information write to reporting@cpaawa.org
Report of the CPAA’s Children’s Behavioral Health Meeting

May 19, 2021

Introduction

Cascade Pacific Action Alliance (CPAA), one of Washington’s nine Accountable Communities of Health (ACH), convened a regionwide meeting of stakeholders on May 4, 2021 with the intent to find sustainable solutions to the ongoing behavioral health crisis among children and youth across its seven counties and Federated tribal territories. Held against the backdrop of the COVID-19 pandemic, the meeting brought together more than 100 stakeholders, among them, the Washington State Medicaid Director, school principals, superintendents and teachers, pediatric and primary care providers, behavioral health agencies, Public Health departments, representatives from area hospitals and ER teams, tribal partners, researchers and scholars, nurses, caregivers, and parents.

Convened under the theme “Call to Action, Call to Collaboration: Advancing coordination between systems of care across the CPAA region to address the youth behavioral health crisis” this meeting was also held, in part as a response to Governor Jay Inslee’s directive for stakeholders to draw up recommendations for tackling the problem that he aptly described as a “crisis”. This report presents key themes and messages along with recommendations that were put forward in the spirit of generating community-led solutions, including a call for the establishment of mechanisms that would promote increased collaboration between all stakeholders providing care to children and youth.

Behavioral Health Crisis in the Cascade Pacific Region

COVID-19 has worsened youth behavioral and mental health challenges across seven counties that comprise the CPAA region. For a region underserved by medical and behavioral health providers, the pandemic created new challenges to the healthcare system that was already stretched thin. The loss of school supports, including access to teachers and counselors, during lockdowns and closures, denied kids and their parents vital services. The inability to associate with friends and family members created anxiety, loneliness, and a host of other mental health challenges. There were reported spikes in substance abuse and substance use disorder, suicidal
ideation, anxiety attacks, and depression. The unprecedented rise in behavioral health needs, which outstripped licensed behavioral health clinics and agencies required primary care providers, including pediatricians, to provide this care.

The strain on families attempting to cope with the pandemic and behavioral health crisis among their children was apparent. Community support systems were particularly hit hard, exacerbated by the region’s rural setting and relatively large number of unhoused individuals. Increased need for behavioral and mental health services lay bare the inadequate access to local providers, mental health professionals, including therapists and psychiatrists in the region. Longstanding transportation challenges also impeded access to care. Whereas tele-health emerged as a bright spot and an important and critical model for providing services to those in need in more populous areas of our region, yet its utilization remained low and sporadic in rural areas largely due to lack of internet and broadband connectivity.

Both COVID-19 and the behavioral health crisis have helped highlight gaps in care and provided the impetus to undertake needed changes. They also validated the significance of the ongoing bidirectional care integration of physical and behavioral health by several CPAA partners under the Medicaid Transformation Project (MTPs). There is increased need for further community engagement to understand health challenges, systemic weaknesses, and barriers to care. Additionally, there is a renewed impetus to engage decision and policymakers for funding and other support to communities to meet their health needs. Participants further observed notable decrease in stigma related to mental health with families and students signaling a readiness to accept support. The following are some of the recommendations that came out of the taskforce meeting.

**Recommendations**

i) Embrace “whole person approach to care” and impactful collaboration between different systems of care. CPAA will continue to convene and facilitate regionwide and county-level stakeholder dialogues with a view of bridging the gap between different systems of care and establishing a common framework and language for advancing comprehensive care for children.

ii) Emphasizing collaboration over competition among providers. While scarce resources, limited qualified personnel and heightened demand for services may serve as incentives for unhealthy competition, there is the potential for partners to achieve better health outcomes through collaboration.

iii) Continued integration of care. Ongoing bidirectional integration of behavioral and physical health initiatives under MTP are beginning to bear results. There is a need to continue supporting these efforts, address observed challenges including supporting
primary care providers including pediatricians to recruit and retain therapists and psychiatrists. The uncompetitive rates for behavioral health personnel in the CPAA region coupled with high demand for these skills elsewhere remain a major barrier to integration. There is also a need to expand integration, to include oral health and other services.

iv) Prioritizing upstream and preventive care coupled with health equity dimensions. Post-COVID rebuilding of the healthcare system in the CPAA region should stress prevention and early intervention, equity, and access to care. There was a call to pay attention to equity, appropriate diagnosis, and resourcing for Black, Indigenous, and People of Color (BIPOC) youth.

v) Overcoming distance and transportation barriers through tele-health. The pandemic has revealed anew the potential for technology to reduce access barriers, especially for rural and isolated communities. Unfortunately, lack of high-speed internet and broadband connectivity remains a major challenge. Low reimbursement rates for virtual and tele-health may further blunt its prospects. There is an opportunity for private sector actors, especially in telecommunications, to improve health outcomes by making infrastructure investments in the region. Additionally, there are fears that the return to in-person classroom attendance, and the recalling of chrome books and tablets provided to learners by schools may erase gains made in tele-medicine.

vi) Need for more state and federal funding. Inadequate investments in healthcare across the CPAA region calls for new and enhanced resources to support providers, caregivers, school districts and other community support actors. Making Federal dollars available to help PCPs embed mental and behavioral health experts in the clinics and the use of school capitation to support school nurses were mentioned as two high priority areas.

vii) The meeting recommended a structured approach to keeping people engaged and creating incentives to encourage and support career development in behavioral and mental health fields. CPAA will continue to convene and steer discussions around addressing social determinants to health, fostering health equity, and eliminating barriers by promoting the use of familiar languages and providing care that is culturally appropriate.

For more information write to reporting@cpaawa.org
Cumulative snapshot

<table>
<thead>
<tr>
<th>Funds Earned</th>
<th>$58,496,657.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Distributed</td>
<td>$43,671,340.41</td>
</tr>
<tr>
<td>Funds available</td>
<td>$14,825,316.75</td>
</tr>
</tbody>
</table>

### Table 1: Incentive Funds earned

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>-</td>
<td>$1,992,860.00</td>
<td></td>
<td>$1,992,860.00</td>
</tr>
<tr>
<td>Project 2B</td>
<td>$</td>
<td>-</td>
<td>$1,326,415.00</td>
<td></td>
<td>$1,326,415.00</td>
</tr>
<tr>
<td>Project 2C</td>
<td>$</td>
<td>-</td>
<td>$692,285.00</td>
<td></td>
<td>$692,285.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>-</td>
<td>$267,156.00</td>
<td></td>
<td>$267,156.00</td>
</tr>
<tr>
<td>Project 3B</td>
<td>$</td>
<td>-</td>
<td>$325,824.00</td>
<td></td>
<td>$325,824.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>-</td>
<td>$456,343.00</td>
<td></td>
<td>$456,343.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$35,053.00</td>
<td>$</td>
<td>$150,000.00</td>
<td></td>
<td>$185,053.00</td>
</tr>
<tr>
<td>Bonus pool/High Performance Pool</td>
<td>$1,135,050.00</td>
<td>$</td>
<td>$</td>
<td></td>
<td>$1,135,050.00</td>
</tr>
</tbody>
</table>

**Total**

|                   | $35,053.00 | $6,345,933.00 |     |     | $6,380,986.00 |

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$35,236.50</td>
<td>$</td>
<td>$</td>
<td></td>
<td>$35,236.50</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$214,161.00</td>
<td>$634,528.00</td>
<td>$</td>
<td></td>
<td>$848,689.00</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$1,000,462.00</td>
<td>$848,741.00</td>
<td>$</td>
<td></td>
<td>$1,849,203.00</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$</td>
<td>-</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
</tbody>
</table>

**Total**

|                   | $1,249,859.50 | $1,483,269.00 |     |     | $2,733,128.50 |

Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on July 21, 2021 to accompany the seventh Semi-Annual Report submission for the reporting period January 1 to June 30, 2021.