



*Produced by Myers and Stauffer on behalf of the Washington Health Care Authority*

# **Medicaid Transformation Accountable Communities of Health Semi-annual Reporting Guidance**

***SAR 8.0***

***Reporting Period:***

***July 1, 2021 – December 31, 2021***

***DY5 Q3-Q4***

***Updated Template Release Date: September 8,  
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.....	12
Attachments .....	12
Documentation.....	13
Narrative responses.....	16
Attestations.....	23
Section 3. Value-based Payment .....	23
Narrative responses.....	24
Section 4. Pay-for-Reporting (P4R) metrics.....	25
Documentation.....	25
Narrative responses.....	25

## Semi-annual report information and submission instructions

### ***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 July 1 – December 31, 2021*

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

Table 2. Potential P4R AVs for Project Incentives, July 1 – December 31, 2021

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	5	4	-	-	5	-	-	4	18
Cascade Pacific Action Alliance	5	4	4	-	5	4	-	4	26
Elevate Health	5	4	-	-	5	-	-	4	18
Greater Columbia ACH	5	-	4	-	5	-	-	4	18
HealthierHere	5	-	4	-	5	-	-	4	18
North Central ACH	5	4	4	4	5	-	-	4	26
North Sound ACH	5	4	4	4	5	4	4	4	34
Olympic Community of Health	5	-	-	4	5	4	4	4	26
SWACH	5	4	-	-	5	-	-	4	18

### Reporting requirements

The semi-annual report for this period (July 1 – December 31, 2021) includes three sections as outlined in the table below.

Semi-annual reporting requirements ( July 1 – December 31, 2021)		
Section	Item num	Sub-section components
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-11	Documentation <ul style="list-style-type: none"> <li>- Key staff position changes</li> <li>- Budget/funds flow update</li> </ul>
<b>Section 2. Project implementation status update</b>	12-13	Attachments <ul style="list-style-type: none"> <li>- Implementation work plan</li> <li>- Partnering provider roster</li> </ul>
	14	Documentation <ul style="list-style-type: none"> <li>- Quality improvement strategy update</li> </ul>
	15-17	Narrative responses <ul style="list-style-type: none"> <li>- General implementation update</li> <li>- Regional integrated managed care implementation update</li> <li>- Scale and sustain update</li> </ul>
	18	Attestations
<b>Section 3. Value-based Payment</b>	19-21	Narrative responses
<b>Section 4. Pay-for-Reporting (P4R) metrics</b>	22	Documentation
	23-24	Narrative responses

**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.SAR8 Report.01.31.22
- *Implementation work plan:* ACH Name.SAR8 Implementation work plan. 01.31.22
- *Partnering provider roster:* ACH Name.SAR8 provider roster. 01.31.22
- *P4R metrics:* ACH Name.SAR8 P4R metrics.01.31.22

***Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA's [Medicaid Transformation resources webpage](#).***<sup>1</sup>

### ***Semi-annual report submission instructions***

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2022 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/>.

**ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "Semi-Annual Report 8."**

The folder path in the ACH's directory is:

*Semi-Annual Reports* → *Semi-Annual Report 8*.

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

---

<sup>1</sup> <https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents>

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

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1 – December 31, 2021.

<b>ACH semi-annual report 8 – submission and assessment timeline</b>			
<b>No.</b>	<b>Activity</b>	<b>Responsible party</b>	<b>Anticipated timeframe</b>
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2021 to ACHs	IA	August 2021
2.	Submit semi-annual report	ACHs	January 31, 2022
3.	Conduct assessment of reports	IA	February 1, 2022– February 24, 2022
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	February 24 – March 1 , 2022
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	February 25 – March 11, 2022
6.	If needed, review additional information within 15 calendar days of receipt	IA	February 25 – March 28, 2022
7.	Issue findings to HCA for approval	IA	April 2022

### ***Contact information***

Questions about the semi-annual report template, submission, and assessment process should be directed to [WADSRIP@mslc.com](mailto: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.

<b>ACH name:</b>	Cascade Pacific Action Alliance
<b>Primary contact name</b>	Jean Clark, CEO
<b>Phone number</b>	360 539-7576x 116
<b>E-mail address</b>	ClarkJ@CRHN.org
<b>Secondary contact name</b>	Kennedy Chesoli, Director of Programs
<b>Phone number</b>	360 539-7576x128
<b>E-mail address</b>	ChesoliK@CRHN.org

## Section 1. ACH organizational updates

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

### Attestations

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

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Behavioral health providers</li> <li>• Health plans, hospitals, or health systems</li> <li>• Local public health jurisdictions</li> <li>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</li> <li>• Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.</li> </ul>	X	
4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH’s decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this <a href="#">template</a> or a similar format) that addresses internal controls, including financial audits. <sup>2</sup>	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach, and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	X	

<sup>2</sup> <https://wahca.box.com/s/nfesjalde5m1ve6aobhiouu5xemeoh26>

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.

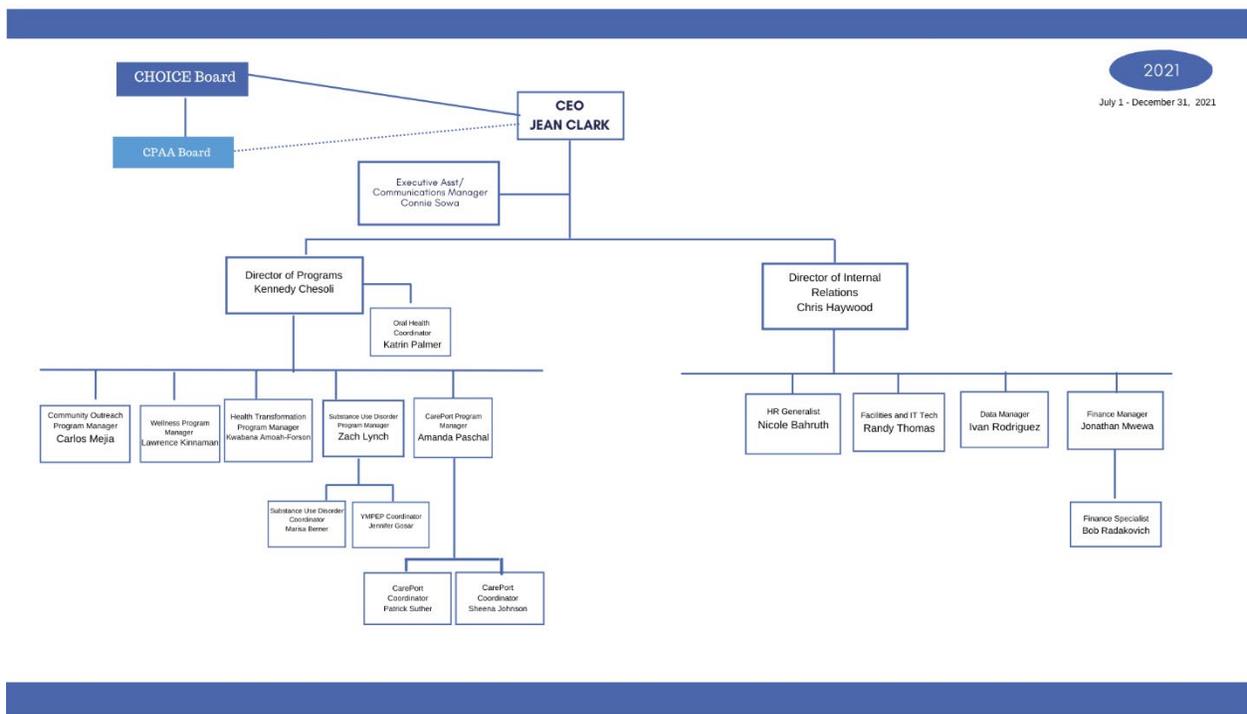
***If applicable, include current organizational chart.***

***Table 1, CPAA organizational Updates***

<b>Name</b>	<b>Position</b>	<b>Role</b>
Jean Clark	CEO	Provides strategic direction and oversight of the organization.
Kennedy Chesoli	Director of Programs	Oversight of CPAA and CHOICE programs
Christine Haywood	Director of Internal Resources	Oversight of HR, IT, Data, Facilities, Finance.
Ivan Rodriguez	Data and IT Manager, Technical Officer, and Privacy Officer	Provides oversight of data analytics and IT, as well as maintains security of protected health information.
<b><i>Marisa Berner</i></b>	Prevention Coordinator	Assists with substance Use response.
Sheena Johnson	Community-Based Care Coordinator	Assists the Community based care coordination program manager.
<b><i>Amanda Paschall</i></b>	Community-Based Care Coordination Manager	Manages the community-based care coordination program.
Kwabi Amoah-Forson	Chronic Disease, Transitional Care, and Reproductive and Maternal Health Manager	Manages the Chronic Disease, Transitional Care, and Maternal/Child Health programs.
<b><i>Lawrence Kinnamen</i></b>	Community Wellness Manager (Program Director continues to manage BH since he managed it prior to his promotion as Director, currently training Carlos Mejia Rodriguez)	Manages COVID vaccine uptake and Health Equity partners.
Connie Sowa	Executive Assistant and Communications Manager	Provides administrative support for the CEO and BOD. Communication duties
Joshua Plaster (termed August, left vacant until yr. 6 approved)	Program Support Coordinator	Provides administrative support for programs.
<b><i>Jonathan Mwewa</i></b>	Finance Manager	Provides fiscal and administrative support.
Robert Radakovich	Fiscal and Contracting Specialist	Provides fiscal and administrative support to Finance Manager.

Randolph Thomas	Facilities and IT Specialist	Provides data analytics and IT support.
Carlos Mejia Rodriguez	Community Outreach and Navigator Program Manager	Collaborates and coordinates with Tribes, outreach efforts, and local forums. Health Equity work and COVID-19 vaccine uptake for BIPOC communities. Training for BH program
Patrick Suther	Community-Based Care Coordinator	Assists the Pathways program manager.
<b>Zach Lynch</b>	Substance Use Response and Youth Marijuana Prevention Program Manager. Promoted from SUD coordinator position.	Manages the Youth Marijuana Prevention and Education program and the Opioid Response Program.

CPAA enhanced their staffing by replacing 5 staff during this reporting period. Staff left their positions due to retirement, internal promotion, and company separation. Two of these three open positions were filled with internal staff promotions. Outreach coordinator, general support coordinator and Community Based Care Coordination (CBCC) coordinator positions were not filled pending year 6 determination and assessment of needs. General coordinator and CBCC coordinator positions will be filled in 2022 now that year 6 has been confirmed along with continuing needs.



## 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.

Semi-annual reporting guidance

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

Please see the payment reconciliation spreadsheet for the reporting period clarifying portal activity payments made outside the portal.

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

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

Use of incentives to assist in the transition to integrated managed care		
Description of Use	Expenditures (\$)	
	Actual	Projected
Managed Care Contracting from a Position of Strength: Hosted an IMC training event with Adam Falcone, held on April 18, 2019.	\$12,000	\$15,000
Hosted MCO-BHA Forum on May 8, 2019.	\$1,950	\$1,500
Provide EHR enhancement funding to support partners transitioning to IMC.	\$330,000	\$330,000
Provided interpreter Services for the IMC Provider Readiness Workgroup.	\$1532	\$2000
Executed on-going contract with XPIO Health to provide technical assistance for up to 12 behavioral health agencies.	\$190,671.62	\$202,000
Provided UW- Caseload tracker support for 5 partners to support Collaborative Care programs	\$31,200.00	\$35,000

<sup>3</sup> The HCA issued reconciliation workbook can be found at the following link: <https://www.hca.wa.gov/assets/program/payment-reconciliation-form-sar-8.xlsx>

Contracted with the AIMS Center for BHA training series/Technical assistance	\$38,266.00	\$60,000
Contracted for psychiatric consultation services for partners implementing the Collaborative Care Model- Dr. Bhat	69,912.50	\$76,000

## 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

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. Updates to the ACH’s implementation plan were made optional for SARs 5.0, 6.0, and 7.0.

- The ACH must submit an **updated implementation plan** reflecting current status and *progress made since the last submitted update*.

Thank you for asking, please see updated implementation workplan.

#### 13. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.<sup>4</sup> 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 pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project

<sup>4</sup> Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are 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).

column(s) with Y/N.

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

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

Thank you for asking, please see the updated partnering provider roster.

## 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.<sup>5</sup>

CPAA attempts to get a good pulse on the status of all MTP projects by means of the reporting template, called change plans. We described what this tool is, and how it is used in greater detail on our previous Semi-Annual report. Change plans are comprised of milestones and track level of implementation on a quarterly basis.

Besides the change plan, we also provide our partners with narrative questions, carefully selected to capture crosscutting aspects of MTP that may not be captured by the former. We have sought responses on matters such as sustainability plans, partnerships, workforce challenges and COVID-19. During the third quarter of 2021, we invited partners to share new activities and interventions they have had to undertake due to the global pandemic as well as a success story. We also sought to know, in their view, key accomplishments that their projects had achieved in the past five years of MTP work, provide an assessment of CPAA support, and signal their interest to continue in this work for Year 6.

For the 4<sup>th</sup> quarter 2021, the narrative questions underscored the importance of some key metrics, namely: All cause emergency department visits and follow up after hospitalization for mental illness and/or emergency department visit for mental health and/or or alcohol and other drug abuse or dependence. We also advocated for health equity lenses and sought to understand how COVID-19 could affect the work of our partners in 2022. Another question focused on the problem of workforce development. Against the context of high staff turnover and difficulty in attracting and retaining health professionals across the board, we asked partners to share measures and strategies taken to boost workforce development.

---

<sup>5</sup> Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section

In preparation for a potential Year 6, we asked partners to indicate their interest in continuing to engage in this work. While many partners expressed satisfaction and appreciation for an opportunity to participate in this important work, most of them said they stood ready to continue in their work, in partnership with CPAA. Some observed that it would be helpful for the ACH to share best practices and success stories in different project areas. One partner remarked that the oversight process put in place by CPAA had allowed them to work toward clear and achievable goals and assess progress at regular intervals which was helpful in keeping momentum toward long term goals. Also, several partners stated that their projects were sustainable.

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

- MTP Partner meeting and orientation for new staff members.
- Collaborative partner calls focused on peer-to-peer learning and peer-to-peer training.
- Integrated Managed Care (IMC) Provider Readiness Workgroup and dedicated webpage to support transition to IMCs.
- Virtual site visits with MTP Implementation Partners.
- Solicit and incorporate partner feedback on reporting, meetings, and shared learnings.
- Continues to broadly share partner success stories and highlight lessons learned.
- Continues to host and facilitate cohort calls to address specific interventions (e.g., pediatric call, behavioral health integration call, MOUD provider group).
- Bi-monthly CPAA council meetings reported out on progress on the compilation of CPAA’s 2020 Local Forum health priorities in relation to CPAA’s 2017 Regional Health Improvement Plan (Appendix B-CPAA Council Meeting Agenda Example).
- 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. (Appendix C- Community of Practice Meeting Agenda Examples)

### Regional Framework for Supporting Partnering Providers

<b>Quality Improvement Processes</b>	
<b>QI Area for Improvement</b>	<b>QI Activities</b>

<p><b>Structured Quality Improvement Activities and Partnering Provider Support Provided by CPAA</b></p>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Develop menu of project metrics that align with HCA metrics to monitor evidence-based practices and monitor outcomes</li> <li>• Test new quality improvement methods with partnering providers</li> <li>• Continue to embed ongoing learning opportunities, best practices, implementation successes and challenges, and collaboration throughout the region into Learning Collaboratives, local community forums, and CPAA Council meeting</li> <li>• Host regular webinars, CPAA Council meetings, and Learning Collaboratives</li> <li>• Conduct MTP Implementation Partner site visits</li> <li>• Set minimum metric completion standard to earn funds</li> </ul>
<p><b>Methods and Frequency of Tracking Partner QI Progress</b></p>	<ul style="list-style-type: none"> <li>• MTP Implementation Partners report on Change Plan milestones quarterly – Excel milestone report and Word narrative report submitted to CPAA</li> <li>• MTP Implementation Partners report on metrics semi-annually - Excel milestone report and Word narrative report submitted to CPAA</li> <li>• Conduct MTP Implementation Partner site visits</li> <li>• Monitor qualitative and quantitative data for intervention(s) to evaluate success of organizations' implementation of selected evidence-based interventions</li> <li>• CPAA issues quarterly performance emails to individual MTP partners</li> <li>• TA partners (Xpio Health, AIMS Center) provide quarterly reports to target efforts and advise progress</li> </ul>
<p><b>Process of Communicating and Implementing Adjustments to Optimize MTP Approaches</b></p>	<ul style="list-style-type: none"> <li>• Provide targeted technical assistance for partners to address quality concerns as indicated in Quarterly Reports; this TA could come from appropriate program manager(s) and/or external consultants as needed</li> <li>• Use submitted reports to identify partnering providers who need additional technical assistance to expand/improve their project(s)</li> <li>• Solicit advice from clinical experts and provider champions</li> <li>• Develop partner performance improvement plans as needed</li> </ul>
<p><b>Technical Assistance Provided or Facilitated by CPAA</b></p>	<ul style="list-style-type: none"> <li>• Use performance improvement plans, as needed, to monitor project progress</li> <li>• Identify regional champions who implemented a successful program and who are interested in training other organizations</li> <li>• Develop a peer-to-peer training model that works for regional champions and partnering providers</li> </ul>

	<ul style="list-style-type: none"> <li>• Contract with AIMS Center for partners participating in Bi- Directional Care Integration</li> <li>• Contract with Xpio Health for behavioral health partners transitioning to Integrated Managed Care</li> <li>• CPAA contracts with CCS for partners participating in Community-Based Care Coordination (Pathways)</li> </ul>
--	---

**Narrative responses**

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

**15. COVID-19**

a) Provide an update on COVID-19 response and recovery activities. Please describe ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., project management, communication and engagement, coordination of funding, etc.).

In the light of the COVID-19 pandemic, CPAA has taken a number of steps and measures to support partners. We have, out of necessity, adjusted the way in which we interact with partners and the community. Some of these measures include:

- CPAA Council meetings, site visits and trainings remained online due to physical distancing guidelines.
- Suicide prevention trainings (QPR) continued virtually with 8 sessions scheduled July through December. 182 participants were certified. (Appendix D-QPR Suicide Prevention Training Flyers)
- CPAA integrated COVID-19 work with MTP programs and platforms such as Local Forum, Community CarePort platforms, and Substance Use Disorder programs. Naloxone was distributed at COVID-19 outreach events.
- Through the WA Care Connect WA program, CPAA provided \$647,563.87 in financial relief through the Household Assistance Request process for 1,089 household bills from July through December. CPAA also provided 766 grocery orders at a cost of \$164,681.88 through the WA Care Connect program July through December.
- CPAA distributed the following from July through December:
  - 352 Food Kits from Kroger/Safeway
  - 490 Care Kits from Walgreens
  - 32,700 PPE from FEMA
  - 401 cell phones distributed to FCS providers for client use
- In July, CPAA began working directly with MTP partners and public health departments across the seven counties to organize vaccine clinics, and conduct focus group discussions to combat COVID misinformation, vaccine hesitancy and resistance. (Appendix E-COVID Educational Flyer Examples).
- CPAA partnered with two COVID-19 vaccine administrators: Birdseye Medical and Medical Teams International to provide available vaccines at outreach events.

- The following outcomes were achieved in August through December. (Appendix F-Vaccine Clinic Flyer Examples)
  - 36 vaccination clinics conducted
  - 1,488 adults and youth vaccinated
  - 691 (47% of 1,488) were from black, indigenous, and people-of-color communities.
  
- Beginning in August, we developed well-crafted and targeted COVID-19 social media messaging across our Facebook and Instagram platforms to educate, and advocate vaccine uptake. The following statistics were achieved July through December. (Appendix G-Social Media Post Examples)
  - 391 posts created and shared
  - Audience reach average of 17, 298 per month
  - Average number of impressions of 12,932 per month
  - Average number of clicks and shares of 707 per month
  
- In September, we launched the “The Equity Circle Podcast” – our latest tool for covering a range of health-related issues, including COVID-19 education, and whole-person person care through health equity lenses. From September through December, we released 24 podcasts and videos with an audience reach of 21,557 in our region. (Appendix H-Podcast and Video Link Examples)
  
- COVID recovery efforts have been augmented by two new grants that CHOICE, our backbone agency, recently received: \$100,000 from the CDC Foundation to accelerate COVID-19 vaccine and influenza uptake in communities of color. HRSA provided \$973,914 to strengthen CBO workforce in managing the pandemic, provide education materials, and equip our partners with funds to provide grassroots education within their communities to encourage vaccine uptake.
  
- HRSA funding allowed us to purchase a 14-seater, wheelchair-accessible van to help meet transportation needs for our rural, hard-to-reach communities. We deploy this van on blended MTP outreach activities, and in delivering care packages as needed for our CarePort program. (Appendix I-Van Pictures)
  
- b) 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.

The pandemic has worsened workforce challenges faced by our partners. Our regular and periodic check in with MTP partners has revealed a growing concern around staff turnover. Several partners have reported the departure of their most experienced and dependable program managers and coordinators, often to employers paying higher wages and more flexible terms of service. This attrition has created considerable negative impact on the effective oversight and management of projects. In some bi-directional care integration cases, staff turnover has affected third party partners leading to a delay or total abandonment of integration efforts.

There is noted delay in partners turning in quarterly reports, with at least four of them severely affected and falling behind, at least since Q2 of 2021.

CPAA has responded to workforce difficulties by offering partners, including their new hires, technical assistance, and one-on-one coaching around MTP work. We held two partner meetings where we recalled the purpose and spirit of the Medicaid Transformation project, reviewed our reporting requirements, and underscored various metrics that are pertinent to this work. One of these meetings was exclusively with our seven tribal government partners. We have also been flexible and accommodating to partner needs and requests around the preparation of reports.

We continue to highlight workforce challenges and share training opportunities that are available for our region, including passing along information from the Health Care Authority around various initiatives to expand and strengthen community health workers and peers. Internally, we have responded to this challenge by integrating our efforts, building crosscutting teams, and ending siloed approach to program work.

- c) Highlight one best practice or “bright spot” that emerged during this reporting period because of COVID-19 response and recovery efforts, if applicable.

Thank you for asking. We are happy to share a bright spot from one of our Community Based Care Coordination agencies:

*"This person was assigned to me as a care connect client back in August. She was unhoused and at the time we didn't have much we could offer other than our food boxes and care kits. Both these items help greatly, since she had COVID she was not able to get to food banks for her food. In conversation with her, she mentioned that she would like to work on finding a doctor since she has not had a PCP in many years. I shared with her the information about the Pathways program but offered to provide her a list of doctors that might be an option for her regardless.*

*She said that she would be interested in the Pathways program, not only to work on getting a PCP, but also to have someone that she could check in with regularly and be accountable to with some of the other changes she is trying to make. We are currently working on housing, establishing with a PCP, and recently completed the process to get her a more reliable phone. In the last few months, she has share some of her struggles with recreational substances and was feeling interested enough in scheduling with a doctor's office for primary care.*

*We were able to work with her insurance provider to identify offices that take her state insurance and one of the doctors on the list is someone she has seen in the past but quite a while ago. This is the doctor that we scheduled with for early January, the closest appointment they have available for a new patient."*

Please take into consideration that often the first step is the hardest step to take in any desired change process. This client has agreed to take the first step, and we have great hopes that she will open and close many more social determinants of health pathways with her designated Community Health Worker in the months to come, allowing her to realize more of her potential.

She has taken the first step, a step so much easier to accomplish with the help of a Community Health Worker at her side for support.

## **16. Scale and sustain update**

- a) In SAR 7.0, 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.

In the SAR 7.0, CPAA did not comment on any conversations regarding infrastructure sustainability, activities, and/or evidence-based models. However, we would like to share the following updates.

### **Priority Investment and Projects**

The CPAA Board of Directors made a priority investment decision to allocate the dedicated Wellness Funds on a three-year Blue Zones Activate initiative to help in our efforts in building a healthier future in the CPAA region. CPAA has partnered with CHOICE Regional Health Network on this project. The Blue Zones contract was fully executed in December 2021. As you may be aware, health and life expectancy have been on a continuous decline in America, and research shows that where people live has a bigger influence on their health than on their genetics. Blue Zones tackles this so-called “zip code effect” using scientifically proven lessons of longevity, health, and happiness gleaned from 20 years of research to boost the well-being of entire communities. Their innovative work in 60 communities around the country has sparked transformations that enhance the well-being of all residents, improve employee and student productivity, and boost economic vitality and development. Blue Zones focuses on the single largest determinant of our health: the place we live. The Blue Zones Life Radius approach is a systems-focused model to make healthy choices easier in all the places people spend the most time so that it is easier to move naturally, connect with others, eat wisely, and connect with one’s purpose. By focusing on the places where people live, work, learn, and play, Blue Zones has been able to move the needle in improving overall population health and happiness and reducing healthcare costs.

An additional heavy emphasis continues with a focus on behavioral health. In the midsts of a pandemic, addressing suicidality, while working up-stream with youth by providing evidenced based prevention education, is seen as a project that must continue. Braided funding will allow a continued workstream in this valuable area of prevention. Multiple QRP trainings have been deployed in our region and a budding partnership with Hope Squad, an evidenced based suicide prevention program for youth, has emerged.

### **Community/Partner Engagement**

CPAA will provide an amendment for most of our community partner contracts for continued or expanded MTP program work in the coming year. Working through a more robust and evolving equity lens, we seek to add more partners in our endeavor to address health disparity while we strive to improve health in our region. The majority of our current MTP partners have sustainability plans in place to carry forward their projects independently. However, CPAA is keenly aware that growth along with scaling successful pilot projects in the region will require

additional funding and are grateful for the financial assistance extension year 6 will bring to the region.

- d) As a result of MTP, please share your reflections on changes and improvements that have occurred and/or lessons learned over the past five years. Note, this is not expected to be a comprehensive inventory, but a summary of a page or less.

As a result of the MTP, many changes, improvements and lessons have been learned. The waiver period, although short in duration of only 5 years to adequately measure change, has proven to demonstrate the continual need for focusing on our overall health care system. Disparity in access to providers is still blatant within the Medicaid population.

### **Changes**

Much growth has taken place in the past 5 years between state agencies and ACHs. Relationships are being built and planning together is manifesting. We have established important multi-stakeholder platforms across the region where partners can engage regularly to discuss key healthcare priorities and share opportunities. We continue to receive positive feedback on the value of these platforms, especially our Local Forums that are in each of the seven counties.

### **Improvements**

One of the significant improvements noted in the CPAA region has been the ability to connect individuals and families in need of assistance to resources. Through our Community Based Care Coordination platform, named CarePort, we have connected thousands of clients to resources, including permanent housing. Washington State's coordinated entry system for housing has funds for approximately 25% of residents in need, with a placement rate of approximately 43% in that subset. Compared to CPAA's pilot program where the success rate for permanent housing, for the same subset, is 94%. Utilizing a process where a trained Community Health Worker or trusted peer builds a relationship with a client, while using an algorithm or pathway to guide assistance, a foundation of trust is built, and progress is measured while staying the course. The CPAA region is a leader in the state in permanent housing placement largely due to our CarePort HUB services of training, quality assurance and billing/invoice assistance. This process can, and as demonstrated, should be replicated statewide.

Another significant improvement has been seen when we get out of our own way and head space, or in other words, reduction of stigma. In our opioid workstream, much focus has been placed on harm reduction measures and anti-stigma efforts. When embraced by leaders, such as county commissioners, change can take place. Allowance of a needle exchange site not only provides clean needles, but it allows for a trusting relationship to be built over time where resources can be shared and accepted by clients that will enhance their health. This has been a struggle in Grays Harbor County.

One cannot rush a process of trust, but we can forge forward with anti-stigma campaigns, campaigns that aim to ensure everyone is treated with dignity. Although difficult to measure, acceptance has been promoted in our region. Acceptance of those that are different than one's self. Whether it is skin color, age, or recreational drug usage. We will continue to seek acceptance in our region and elimination of stigmas.

## **Lessons learned**

Standardization is powerful, but only if individualism is allowed. Our state is a blend of urban and rural communities, each with their own special needs and preferences. We are not a one size fits all state. By allowing the ACH regions to achieve the same goal, with different strategies, breeds success. The ACHs are a powerful resource to the state, and if allowed to be a part of the planning process, we can achieve more together.

Our region faces some significant challenges and barriers to care that the present MTP work may not truly address. The CPAA region is a rural territory whose proximity to Seattle, King County and the I-5 Corridor has served to push healthcare workers out more than attract them. Inadequate resources means both providers and counties are not able to attract talent, pay competitive wages and retain workers they really need. Lack of adequate housing and ancillary services such as an urban transport system, quality schools, colleges and institutions of higher learning are often mentioned among key barriers to workforce development.

Also, low population spread out in a large rural territory is a barrier to attracting providers. It would appear there is no critical mass in Wahkiakum (pop. 4,000); and Pacific County (pop. 20,000). Telehealth remains an impossible proposition due to lack of broadband and internet connectivity across large swathes of the territory.

CPAA continues to convene meetings with partners for the purposes of gaining a better understanding of these challenges and exploring possible sustainable solutions. We have also received funding, including from Cambia Health Solutions, that we seek to leverage to bridge this gap in Wahkiakum and Pacific. Despite our efforts, it's clear: providing quality housing as homes for potential new hires, or erecting telecommunication towers and laying broadband cables for connectivity is way beyond the capacity of the ACH, CBOs and individual counties. We are hopeful that the Federal and State government could help address these challenges as a matter of priority. In our assessment, such investment would be worthwhile for they will help unlock the region, attract new populations, providers and boost access to quality, affordable and reliable care.

## **17. Regional integrated managed care implementation and stabilization update**

- a) For **all regions**, briefly describe any challenges the region continues to experience due to the implementation or stabilization phase 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?

As mentioned above, 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 non-competitive 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 training 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 a behavioral health mobile clinic in Pacific and Wahkiakum Counties. However, those communities voiced concern about bringing up a new program when they are unable to staff existing programs.

Having heard these concerns, CPAA has shifted focus to providing behavioral health support in the form of Hope Squad in schools through an additional grant to reduce the behavioral health staffing burden by thwarting off potential crisis up-stream. Hope Squad is a peer-to-peer suicide prevention program. It is designed to reduce youth suicide through education, training, and peer intervention.

- 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 and/or the stabilization phase of integration post 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 children's behavioral health meeting in May, we are consulting with partners regarding concrete steps to take.
- We continue to facilitate monthly integrated managed care (IMC) workgroup calls.
- CPAA has held several meetings around behavioral health needs in Wahkiakum and Pacific counties with the view of supporting a pilot mobile clinic, initiation of Hope Squad, or supporting additional co-location initiatives. Analysis of feedback is in process to assist in decision making.
- We are gravely concerned by unacceptably high incidents of suicide and suicidality among young people and are exploring standing-up a Hope Squad program in schools.

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. We have since held two meetings where the HCA and Comagine shared findings 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?

The pandemic has worsened the workforce situation and potentially affected the way (some of) our partners implement, oversee, and report on their projects. At the Children's Behavioral Health meeting last May, we learned that not only were primary care facilities including

pediatric clinics providing physical health but were providing mental and behavioral health services as well. This scenario was brought out by necessity. The pandemic exacerbated anxiety, panic as well as suicidality among young people yet it was not possible for them to schedule visits to behavioral health therapists. Since then, these partners have become important players in administering COVID-19 vaccines and addressing hesitancy and reluctance concerns raised by parents and individuals.

As previously reported, there are concerns that primary care providers are not adequately compensated for the behavioral health therapy work, 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.

To address some of these problems, CPAA has partnered with the Southwest Washington, and the North Sound ACHs in a pilot program that seeks to support the provision of remote behavioral health supervision. The process may allow individuals and facilities seeking supervision hours get access to hard-to-find supervisors, especially in rural areas. Increasing the number of credentialed behavioral health providers will assist with the staffing shortage.

## Attestations

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

	Yes	No
<p><b>18. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation.</b> ACH support or engagement may include, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Identification of partnering provider candidates for key informant interviews.</li> <li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li> <li>• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</li> </ul>	<p>X</p> <p>X</p> <p>X</p>	

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

## Section 3. Value-based Payment

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 5, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2021).*

## **Narrative responses**

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

- a) Providers reported the following top three barriers in the 2020 Paying for Value survey: “misaligned incentives and/or contract requirements,” “lack of timely cost data to assist with financial management,” and “Lack of interoperable data systems.” Describe whether these align with your region’s experience or if you are experiencing other more impactful barriers regarding implementation of value-based care. Also, describe methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

CPAA convenes and facilitates monthly meetings of Integrated Managed Care, bringing together BHOs, BH-ASO’s, MCOs (Molina, United, Amerigroup and Coordinated Care) and the Health Care Authority to discuss a range of issues around integrated care. Other than legislative updates, there are always opportunities to seek clarification around VBP, including different features and updates. Indeed, the lack of timely cost data to assist with financial management,” and “Lack of inter-operable data systems” remain a challenge. Ahead of each meeting, CPAA encourages BHOs to send in their questions in advance for forward transmission to the HCA for thorough and researched response. We strive to work with the HCA to bring speakers and resource persons to these meetings, and pledge to offer technical assistance to partners needing it.

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

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

We continue to invite partners seeking technical assistance to speak out and reach out. We are also keen in organizing and facilitating meetings for mutual learning and sharing of experience. The score of intensity of support to date has not been distinguished in terms of the size of the providers.

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

- a) Provide an example of the ACH’s efforts to support completion of the state’s 2021 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

CPAA has financially incentivized the region’s providers for completion of the VBP survey. This past year, there was an increased incentive awarded if the organization had previously participated in the survey and positive progress was determined. Organizations were able to earn \$500, or \$1000 for survey completion commitment with demonstrated progress.

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

CPAA is keen on evidence-based interventions and has found data and information gathered from state-issued provider Paying for Value Surveys very informative and useful. This data helps indicate performance of the CPAA region, and is leveraged to identify areas and partners needing further support and attention. Special meetings are held by CPAA senior leadership and managers to consider these findings at length, and to share their implications with partners. Our data manager attends state meetings on behalf of the agency and is able to share with the team any updates and findings pertinent to our region, partners and ACH.

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

### Documentation

#### 22. P4R Metrics

The reporting requirements for the P4R Metrics updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. ACHs may use discretion, and will not be penalized, surrounding the timing and volume of P4R metric data collection during the COVID-19 pandemic. For example, an ACH may choose to delay data collection, make participation optional, or target participation. The submission of P4R Metrics are considered optional for this reporting period but are encouraged. However, it is requested if an ACH continues P4R data collection, including the MeHAF assessments, that the ACH submit a completed P4R report. These reports are helpful in providing utilization numbers and provider engagement totals throughout the state.

#### *MeHAF guidance:*

- The state continues to develop future integration assessment surveys and processes to improve on the reporting of behavioral and physical health integration. Until a new assessment is officially implemented it is recommended ACHs avoid engaging new providers in MeHAF assessment.

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.<sup>6</sup> 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:*

---

<sup>6</sup> <https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121>

- 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).

An aggregate number of sites that responded to the P4R metric questions.

Project 3A PCS

- o Provider use of guidelines for prescribing opioids for pain: 8
- o Key clinical decision support features for opioid prescribing guidelines: 8
- o Linkage to behavioral care and MAT for people with opioid use disorders: 8
- o Linkage to behavioral care and MAT for people with opioid use disorders: 8
- o Emergency department has protocols in place to initiate MAT or offer take home naloxone: 2

Project 3A CBO

- o Does the CBO site have protocols in place to refer people with opioid use disorders to providers of medication-assisted treatment? 5
- o Does the CBO site refer people with opioid use disorders for psychosocial care? 5
- o Does your site actively refer patients with opioid use disorder to a Hub & Spoke network where both medication and behavioral health treatments are available? If site indicates that they have more than one type of referral protocol, include the site in each category. 5
- o Did your CBO receive technical assistance to organize or expand a syringe exchange program, or to learn about locally available access to clean syringes? 5
- o Does your CBO provide referral information for clients interested in testing or treatment for Hepatitis C and HIV? If site indicates that they have more than one type of referral protocol, include the site in each category. 5

- b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the [reporting template](#).

Thank you for asking, please see attachment

**Format:**

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

Thank you for asking, please see attachment (same document as above)

## **Narrative responses:**

**23.** 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.

N/A

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

The 2021 Q4 MeHAF survey was sent out to all 24 2A partners, including tribes, in December. There were 20 responses, translating to 83.3% completion rate. Three of the four government tribal partners successfully completed the survey (Quinault, Skokomish, and Squaxin). Shoalwater Bay tribe is experiencing capacity issues. CPAA is working with them to bring their project back on track. Other non-responsive partners were Kaiser Permanente, Providence, and Wahkiakum Human and Health Services department. Like Shoalwater Bay, Wahkiakum is faced with the same capacity challenges. Kaiser Permanente appears to have experienced changes in staff roster, at least since the start of third quarter.

### **I. Integrated Services and Patient and Family-Centeredness**

All 20 partners responded to the twelve questions in this section and performance was as follows: Question 10, "Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications" received the highest average score of 8.85 which affirmed that they "follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert". The lowest score here was 7.

The lowest average scores (7) were reported for questions 3 (7.25), and 11 (7.20). As an ACH, treatment plan(s) for primary care and behavioral/mental health care (3) are on the upper end of "providers have separate plans but work in consultation; needs for specialty care are served separately". Also, on "tracking of vulnerable patient groups that require additional monitoring and intervention", the general experience for CPAA is largely "... patient lists exist, and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking".

Responses for all other questions in this section averaged 8.

### **II. Practice/Organization**

Out of all questions, the lowest score was 6, for questions 7 (6.35) and 9 (6.4). Average score for question 5 and 8 was 7.3 and 7.0 respectfully. The rest averaged 8. Focusing on the questions that scored low, here is what we can deduce.

On average, patient/family input to integration management (7) is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate.

Also, on funding sources/resources, there are “separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training”. (Appendix J – MeHAF Data Q4)

***Optional: The ACH may submit P4R metric information***

## Cascade

*October 1-December 31, 2021*

### Cumulative snapshot

Funds Earned	\$ 59,185,045.16
Funds Distributed	\$ 46,094,398.90
Funds available	\$ 13,090,646.26

**Table 1: Incentive Funds earned**

	Q3	Q4	Total
Project 2A	\$ -	\$ 262,244.00	\$ 262,244.00
Project 2B	\$ -	\$ 180,292.00	\$ 180,292.00
Project 2C	\$ -	\$ 106,536.00	\$ 106,536.00
Project 3A	\$ -	\$ -	\$ -
Project 3B	\$ -	\$ 32,780.00	\$ 32,780.00
Project 3D	\$ -	\$ 40,975.00	\$ 40,975.00
VBP	\$ -	\$ -	\$ -
Bonus pool/High Performance Pool	\$ -	\$ 65,561.00	\$ 65,561.00
<b>Total</b>	<b>\$ -</b>	<b>\$ 688,388.00</b>	<b>\$ 688,388.00</b>

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

	Q3	Q4	Total
Interest accrued	\$ -	\$ -	\$ -

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

	Q3	Q4	Total
Administration	\$ -	\$ -	\$ -
Community health fund	\$ 3,333.00	\$ 389,085.00	\$ 392,418.00
Health systems and community capacity building	\$ 71,779.99	\$ 6,989.50	\$ 78,769.49
Integration incentives	\$ -	\$ -	\$ -
Project management	\$ -	\$ -	\$ -
Provider engagement, participation, and implementation	\$ 661,161.00	\$ 104,522.00	\$ 765,683.00
Provider performance and quality incentives	\$ 338,447.00	\$ 604,563.00	\$ 943,010.00
reserve/contingency fund	\$ -	\$ 243,178.00	\$ 243,178.00
<b>Total</b>	<b>\$ 1,074,720.99</b>	<b>\$ 1,348,337.50</b>	<b>\$ 2,423,058.49</b>

*Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 26, 2022 to accompany the seventh Semi-Annual Report submission for the reporting period October 1 to December 31, 2021.*