



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

Healthier Washington Medicaid Transformation Accountable Communities of Health Semi-annual Reporting Guidance

SAR 4.0

Reporting Period:

July 1, 2019 – December 31, 2019

Template Release Date: August 7, 2019

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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington 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).

Reporting requirements

The semi-annual report for this period (July 1, 2019 to December 31, 2019) includes four sections as outlined in the table below.

Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)		
Section	Item num	Sub-section components
Section 1. ACH organizational updates	1-8	Attestations
	9-13	Attachments/documentation <ul style="list-style-type: none"> - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	14-16	Attachments/documentation <ul style="list-style-type: none"> - Implementation work plan - Partnering provider roster - Quality improvement strategy update
	17-19	Narrative responses <ul style="list-style-type: none"> - General implementation update - Regional integrated managed care implementation update
	20	Attestations
Section 3. Value-based payment	21-23	Narrative responses
Section 4. Pay-for-Reporting (P4R) metrics	24	Documentation

There is no set template for the semiannual report. ACHs have flexibility in how to put together the report, as long as all required elements are 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.

Achievement values

Throughout the transformation, each ACH can earn achievement values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).
2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).
3. Reporting on Value Based Payment (VBP) milestones (Pay-for-Reporting, or P4R).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. 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 payment period.

For DY 3, 75% of Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of July 1 through December 31, 2019 determines achievement for half of the available P4R-associated Project Incentives.

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 Project for Project Incentives, Period July 1, 2019 – December 31, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23
North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Pierce County ACH	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

Table 2 provides the AVs associated with VBP Incentives for this annual reporting period.

Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
Potential AVs	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2020 at 3:00p.m. PST.**

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

ACHs must submit their 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 4 – January 31, 2020.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → *Semi-Annual Report 4 – January 31, 2020.*

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

File format

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word, Microsoft Excel, and/or a searchable PDF format. Below are examples of the file naming conventions ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR4 Report. 1.31.20
- *Attachments:* ACH Name.SAR4 Attachment X. 1.31.20

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

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, 2019 – December 31, 2019.

ACH semi-annual report 4 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2019 to ACHs	IA	August 2019
2.	Submit semi-annual report	ACHs	January 31, 2020
3.	Conduct assessment of reports	IA	Feb 1-25, 2020
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2020
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2020
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2020
7.	Issue findings to HCA for approval	IA	April 2020

Contact information

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

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

Include in the semi-annual report the contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's semi-annual report. If secondary contacts should be included in communications, also include their information.

ACH name:	Greater Columbia Accountable Community of Health
Primary contact name	Carol Moser, Executive Director
Phone number	(509) 851-7601
E-mail address	cmoser@gcach.org
Secondary contact name	Wes Luckey, Deputy Director
Phone number	(509) 851-7784
E-mail address	wluckey@gcach.org

Section 1. ACH organizational updates

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

Attestations

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

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

² <https://wahca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26>

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

Attachments

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

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

If applicable, attach or insert current organizational chart.

GCACH Response

See attached files:

GCACH.SAR4 Attachment 9-1. 1.31.20.pdf

10. Budget/funds flow.

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

GCACH Response

No action required

Documentation

The ACH should provide documentation that addresses the following:

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

GCACH Response

Yakama Nation LHIN Agreement: The Greater Columbia Accountable Community of Health (GCACH) and Yakama Nation entered into an Agreement similar to the contracts that GCACH has formed with its six Local Health Improvement Networks (LHINs). This agreement, as with the other LHIN agreements, is meant to foster collaboration at the community level and to support work that supports completion of GCACH project areas. Under this agreement, the Yakama Nation would meet the schedule of deliverables in Table 1. In return for these deliverables, the GCACH will provide the Yakama Nation with financial incentives.

Milestones	Payment
Submit a budget for 2019-2020 1st Quarter Milestone: Participation in GCACH Leadership Council, Board, or Learning Collaborative meetings/activities. Designation of Yakama Nation Liaison to GCACH Presentation about Yakama Nation, Culture, Programs Participation by appropriate representation in Yakama Nation Health Commons meeting/activities	\$10,000
Completion date by April 30, 2020	
2nd Quarter Milestone: Participation in GCACH Board, Leadership Council or Learning Collaborative meetings Participation by appropriate representation in Yakama Nation Health Commons meeting/activities	\$5,000
Completion date by July 31, 2020	
3rd Quarter Milestone: Participation in GCACH Board, Leadership Council or Learning Collaborative meetings Participation by appropriate representation in Yakama Nation Health Commons meeting/activities	\$10,000
Completion date Oct 31, 2020	
4th Quarter Milestone: Participation in GCACH Board, Leadership Council, or Learning Collaborative meetings 2019-2020 Report on use of \$30,000 Participation by appropriate representation in Yakama Nation Health Commons meeting/activities	\$5,000
Completion date January 31, 2021	

Table 1; Yakama LHIN Milestones, 2020

Cultural Competency Training: On September 26, 2019, the Yakama Nation hosted GCACH staff and directors from its Board, as well as staff from the tribal behavioral health services department, for a Cultural Competency Training. The training was conducted by Arlen Washines, Deputy Director for the Yakama Nation Department of Human Services, and Emily Washines, an author and poet. Arlen and Emily described that there are 29 tribal programs employing 350 people on the Yakama Reservation. They also described how modern culture is transforming traditional tribal practices around things like corporal punishment for children and traditional role models for men and women. Historical trauma inflicted on the tribe – such as through the Wounded Knee Massacre,

Trail of Tears relocation and Indian boarding schools – have carried down to this day. These and other historical incidents served to remove the tribal traditions and ways of traditional Indian life. Few now speak the traditional language, and without the native language, there is no culture, no traditions and no tribe. Tribal children are now beginning to learn these customs and traditions. To effectively collaborate with the tribe, Mr. Washines stated that the GCACH simply needs to communicate and ask, as well as follow tribal protocol.

Practice Transformation: The Yakama Nation has agreed in principle with the idea of working together toward an arrangement whereby the GCACH supports the tribe in the area of Practice Transformation. This would be similar to the GCACH’s other Practice Transformation (PT) efforts, where an agreement is signed, technical assistance is provided by Greater Columbia’s PT Navigators, and the tribe receives financial incentives based upon achievement of the Milestones outlined in the GCACH’s Practice Transformation Reporting Toolkit. So far discussions around this idea have included agreement from Katherine Saluskin, Yakama Nation Behavioral Health Program Director; Arlen Washines, Deputy Director of the Yakama Nation Department of Human Services; Michelle Womack, Clinical Director of the Yakama Indian Health Services clinic; and Christina Peters, Tribal Community Health Provider Project Director for the Northwest Portland Area Indian Health Board. This may take place either between the Indian Health Services Clinic in Toppenish and the Yakama Nation Behavioral Health Program or between the small tribal clinic in White Swan and the Yakama’s behavioral health program. We are still working through the process of clarifying who has decision-making authority to approve this work so it can move forward.

See attached files:

GCACH.SAR4 Attachment 11-1. 1.31.20.pdf

12. Design Funds.

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

GCACH Response

See attached files:

GCACH.SAR4 Attachment 12-1. 1.31.20.xlsx

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

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

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected

GCACH Response

The Excel workbook listed below has four tabs:

- Tab 1 is a high level over view of all the incentives dollars that were paid to providers as well as a planned use of funds for the Behavioral Health Internships;
- Tab 2 details how the providers spent their Phase 1 incenting funding;
- Tab 3 details how the Milestones that the providers completed to earn their funding;
- Tab 4 show how the Opioid Resource Networks earned their funding.

All of the funds are earned through executed contracts.

See attached files:

GCACH.SAR4 Attachment 13-1. 1.31.20.xlsx

Section 2. Project implementation status update

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

Attachments

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

14. Implementation work plan

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

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.³

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

³ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan. Semi-annual reporting guidance
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work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.

- c) If the ACH has made substantial changes to the work plan format since the last submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

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

GCACH Response

Please see workbook listed below.

See attached files:

GCACH.SAR4 Attachment 14-1. 1.31.20.xlsx

15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.⁴ To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

- a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.
- b) By **October 15**, HCA will provide ACHs a clean version of the ACH's partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.
 - i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.
- c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
 - i. Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an "X" in the appropriate project column(s).

⁴ 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).

- ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.
- d) Update partnering provider site information as needed over each reporting period.

Submit updated partnering provider roster.

GCACH Response

To the baseline provider roster sent by HCA in October, we have added our Cohorts 2 and 3 organizations, our participating Opioid Resource Network organizations and one EMS agency to the existing list, as all of these organizations were added to our programmatic work in the second half of 2019. This adds an additional 51 sites to the baseline list. As well, some of the organizations listed in the HCA baseline list have sites that have been listed twice.

See attached files:

GCACH.SAR4 Attachment 15-1. 1.31.20.xlsx

Documentation

The ACH should provide documentation that addresses the following:

16. Quality improvement strategy update

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

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

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

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

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

Attach or insert quality improvement strategy update.

GCACH Response

See attached files:

GCACH.SAR4 Attachment 16-1. 1.31.20.docx

GCACH.SAR4 Attachment 16-2. 1.31.20.xlsx

Narrative responses

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

17. General implementation update

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

GCACH Response

Patient Centered Interactions: The GCACH Practice Transformation process is based on eight Change Concepts, which are used to assess and guide practices through the Patient-Centered Medical Home transformation process. Change concepts are general ideas used to stimulate specific, actionable steps that lead to improvement and were derived from reviews of medical literature and discussions with leaders in primary care and quality improvement. In addition to primary care practices, many of these concepts and their associated improvement workflows are applicable to a wide array of organizations that provide either hands-on or hand-off patient care. The *Patient-Centered Interactions* change concept, which is embedded in the GCACH Practice Transformation Toolkit and facilitated through the technical assistance provided by GCACH Practice Transformation Navigators, allows organizations to integrate culturally competent self-management supports and the use of decision aids for preference-sensitive conditions into usual care. The GCACH Toolkit also provides links to resources

for defining and implementing culturally-sensitive care (ctrl-click [here](#) and [here](#)). This has helped partnering providers recognize, when appropriate, the client's healing beliefs and practices and explore ways to incorporate these into the treatment plan. It also helps negotiate a treatment plan that weaves the client's cultural norms and lifeways into treatment goals, objectives, and steps. This process was previously incorporated into transformation efforts for all contracted Cohort 1 organizations beginning in January 2019 and all contracted Cohort 2 organizations (behavioral health) which began Practice Transformation in July 2019.

Barth Clinic: This small SUD treatment provider is located in Yakima; whose county population is nearly 50% Hispanic. Barth treats patients of various ethnicities. The GCACH supported the clinic in implementing shared decision-making tools that supported the patient's beliefs and values. The GCACH Practice Transformation Navigators and Barth came together to determine first a list of clinical conditions that would be the focus of this process. Next, education was provided on how such decision aids are used and how to identify the patients that are in need of the decision aids. The decision aids also had to be in a language and reading level that was suitable for the patient. Barth made it a point that the decision aids for each condition included a sufficient number of treatment options, so that patients would be able to make a reasonably educated decision that would best fit their lifestyle and culture. As well, the clinic previously had written satisfaction surveys that were conducted in only English and, accordingly, had very low response rates. GCACH worked with Barth to develop a process where patients completed surveys in their preferred language. These processes have been integrated into the clinic's overall quality improvement activities. They have done several Plan-Do-Study-Act cycles to refine the process of how to capture the patient's voice through surveys and for identifying patients that are in need of decision aids.

Kittitas Valley Healthcare (KVH): This is a public hospital district in Kittitas County. GCACH practice transformation efforts have worked in tandem with their Lean process improvement work. At the beginning of 2019, the GCACH's Practice Transformation Navigators worked with KVH during their planning process of integrating Chronic Care Management (CCM) visits for chronically ill patients. During the reporting period, they were supported to be able to implement these CCM visits effectively and in a culturally competent manner. During the initial face-to-face patient visit with the nurse, any material now presented to or discussed with the patient is made available in either English and Spanish. Moreover, the written material is now presented at a reading level that patients will more easily understand. Follow up CCM visits can occur in person or over the phone, and during these visits the nurses take the time to truly build a relationship with the patients while focusing on their chronic diseases. Due to the culturally competent care model that was developed through the partnership between the GCACH and KVH, one patient effectively lowered their HbA1c level from 10 to 8.7 in three months due to better communication methods and materials.

Providence St. Mary Medical Center: This community hospital in Walla Walla has been implementing new culturally competent workflows as a result of the technical

assistance provided by GCACH. During the reporting period, the team at Providence noticed a higher rate of readmissions, specifically for Congestive Heart Failure (CHF). It was found through focus groups that this was because of a lack of understanding of discharge instructions by the patient and/or caregiver. The team then created Zone Magnets based on chronic conditions that detailed next steps for the patient based on their symptoms. These tools are written in English and Spanish and at an elementary reading level. This pilot project is a direct result of GCACH's requirement in Milestone 5 to focus on plan all-cause readmission rates.

Gaps: Relative to gaps for partnering providers following evidence-based guidelines, we anticipate an eventual partnership with the Yakama Nation around practice transformation. The GCACH respects the sovereignty of the Nation and its pursuit of traditional practices in the treatment and healing of its members. We also realize that some of the healing practices the Yakama relies upon may not align with evidence-based research. As well, in the treatment of individuals with substance use disorder, the tribe seems to endorse an abstinence only approach over medication-assisted treatment (MAT). We hope to demonstrate to the tribe the value of MAT therapy and perhaps work with the tribe into forming an agreement where traditional practices are offered alongside more modern practices or where modern approaches and treatments are offered as at least an option.

See attached files:

GCACH.SAR4 Attachment 17-1. 1.31.20.pdf

GCACH.SAR4 Attachment 17-2. 1.31.20.pdf

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

GCACH Response

ONC Certified EHRs: Beginning in 2019, all eligible professionals and hospitals were required to use certified electronic health record technology (CEHRT) to meet the requirements of the [CMS' Promoting Interoperability Program](#), which provides incentive payments as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. This requirement will benefit health care providers and patients by using the most up-to-date standards and functions to better support interoperable exchange of health information and improve clinical workflows. GCACH base population health funding (\$140,000) has supported the adoption of ONC Certified EHRs that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality

improvement processes. Some of the organizations switching to ONC certified EHRs include the following:

- Serenity Point and Somerset Counseling
- Sundown M Ranch
- Quality Behavioral Health
- First Step Community Counseling Services
- Blue Mountain Counseling
- Lutheran Community Services
- Ideal Balance Counseling switched to the same EHR as its parent company, Ideal Option, allowing for full interoperability

Switching to an ONC Certified EHR serves Medicaid Transformation Domain 1 objectives and better situates organizations for current and future interoperability requirements.

KCHN Health Commons: The GCACH previously partnered with Quad+Aim Partners, an IT consultancy, to create a community level health information exchange in collaboration with the Kittitas County Health Network in Ellensburg. This system is built off a lightweight EHR produced by Strata Health Solutions and hosted through Amazon Web Services. It was constructed at the request of the community and paid through DSRIP funding from the GCACH. The system is custom tailored to address the needs of a small group of community members, with the focus being on individuals with co-occurring behavioral health issues. A cross-sector group of community organizations – primary and behavioral healthcare, social service, EMS and others – comes together to identify these high-risk individuals and a local Community Paramedic reaches out to them individually in their homes. After the patient agrees to participate in the program and completes a 42 CFR Part 2 compliant consent, the patient is then entered into the local Health Commons system. The intake process gathers health, demographic, pharmacy and social need information from the patient. An oversight group – the A-Team – then constructs a personalized care plan for the patient. The Community Paramedic then meets with the patient again to discuss the care plan. The A-Team through the Health Commons system then sends, manages, and tracks eReferrals that travel between local community care partners. The GCACH made the commitment to initially stand-up the system and will provide funding through 2021, when the KCHN will then assume full responsibility for funding the system.

Yakama Nation: GCACH has a Memorandum of Understanding with the Yakama Nation Behavioral Health Services and their Circle of Care Program in the amount of \$150,000 to use for upgrades to their internet, and to work with the consulting firm, Quad+Aim Partners to establish a Health Commons that will act as a communications and information exchange between the applicable Yakama Nation programs to implement

the Family Reunification workflow project. Established under the Yakama Nation's child welfare program, Nak Nu We Sha, social workers coordinate foster care for Indian children living on the reservation or coordinate with the state on case management off-reservation. Quad+Aim will also be providing IT hardware and HIPAA training in addition to creating a localized HIE system for the tribe. Quad+Aim has been working with a social worker in the Yakama Nation's Behavioral Health department throughout the reporting period and hardware will be purchased in early 2020.

Collective Medical: Collective Medical is the largest real-time IT care collaboration network in the United States. The technology unifies a patient's entire care team—including hospitals, primary and specialty care, post-acute care facilities, behavioral health providers, community service organizations, and health plans—to collaborate and expand patient care. This technology, which is in every Washington hospital, is also accessible to any Medicaid provider. The GCACH sees the ambulatory version of this technology – Collective Ambulatory – as an essential component and tool for managing and coordinating patient care transitioning from post-hospitalization and post-ED discharge. In its Practice Transformation Toolkit, the GCACH requires participating providers to attest to implementing Collective Medical technology, direct secure messaging (interoperable communication), and OneHealthPort, the state's sanctioned HIE.

GCACH Practice Transformation Navigators have worked with several Cohort 2 sites to implement Collective Medical into their patient workflows. Merit Resource Services has implemented it and been able to follow-up with patients after their discharge from local emergency departments. Because of the GCACH, Merit also signed up with OneHealthPort for the state's Clinical Data Repository. Catholic Charities also implemented this tool and follows up with all patients that have more than six ED visits within the most recent twelve months, have a behavioral health diagnosis, or have a trauma-related issue. This has resulted in positive patient results and satisfaction among the clinical staff. The GCACH has also worked with Collective Medical to allow for implementation in Kennewick Fire Department for their Community Paramedicine program. This will allow KFD to better manage their patients that have frequent EMS calls, and link them to the appropriate community services.

Patient Portals: Many of the GCACH sites have the capabilities for implementing an electronic patient portal that allows for communication with the patient and family members but not all have activated it. With the support of the GCACH Navigators, Kittitas Valley Healthcare implemented a patient portal optimization team to develop this feature. Since its start, the portal has had 4,000 patients register in it. KVH is still in the process of creating protocols for the release of labs and direct patient scheduling. This work is a direct reflection of the requirement of Milestone 3 of the GCACH Practice Transformation Toolkit: 24/7 Access by Patients & Enhanced Access.

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

GCACH Response

Kennewick Fire Department (KFD) ImageTrend Pilot Project: The GCACH is supporting a pilot project with KFD and their new Community Paramedicine program. A Community Paramedic (CP) is an advanced paramedic that works to increase access to primary and preventive care and decrease use of emergency departments, which in turn decreases health care costs. CPs also help coordinate access to needed community-based services to manage social needs, such as nutrition, transportation, employment and more. ImageTrend is an electronic Patient Care Reporting system (ePCR), similar to an EHR. Most of the fire districts in the Benton and Franklin counties use ImageTrend as their base ePCR. The company also offers a special module to support CP programs. GCACH is subsidizing the costs of this CP module for KFD in return for conducting a study that demonstrates the program's ability to reduce EMS calls and transports, reduce ED utilization and increase access to community-based services. The study began in October 2019 and should complete in 2020. While KFD is not a GCACH Practice Transformation organization, their work supports Milestone 6 - Care Coordination Across the Medical Neighborhood of the Practice Transformation Toolkit.

Barth Clinic: Barth is a small SUD treatment provider in Yakima and a GCACH Practice Transformation organization. It was assisted by GCACH in contracting with Consistent Care, a care management company based in Washington and having an office in Yakima. Consistent Care performs complex case management on high-risk patients and refers these patients to wrap around services within the local community. As part of their risk stratification work in meeting Milestone 2A.2.a, Barth identified high risk patients in its practice that would benefit from community-based services. As part of its contract, Barth referred these patients to Consistent Care, who assisted them getting the resources they needed in a timely manner.

Health Commons: As described above (item 17.a.i.2), the KCHN Health Commons is a localized HIE that integrates medical, behavioral and social service organizations in the management of a small population of high-risk individuals with co-occurring behavioral health conditions. One of the social service agencies linked into the KCHN Health Commons is Aging and Long-Term Care (ALTC) in Ellensburg. ALTC provides both direct and contracted services to seniors and vulnerable adults with disabilities. As part of the Health Commons patient's customized care plan, the patient may be referred by the A-Team to ALTC for social service needs.

Benton-Franklin Counties Housing Continuum of Care Task Force: The Executive Director of GCACH worked with the Benton-Franklin Housing Continuum of Care Task Force to modify their screening tool to better prioritize clients, and ensure that the chronically homeless were identified and received services. The new screening tool was adopted on October 30, 2019, and will be used to refer individuals into existing housing programs.

Partnership with Catholic Charities Spokane Diocese: GCACH and Catholic Charities Diocese of Spokane have been partnering since the spring of 2019 to bring a permanent supportive housing project to Pasco. The project would prioritize the most chronically ill individuals, and place them in a housing development that offers supportive services on the bottom floor and fifty-two units of housing in a four-story building managed by Catholic Charities. Services offered by the community would include behavioral health, case management, transportation, legal, and support programs. Catholic Charities was awarded \$2 million in Washington State Housing Trust Fund dollars in December, and is working with the city of Pasco to approve its Special Use Permit and land sale. GCACH is helping with distributing information about the project to the adjacent property owners and downtown business leaders. They are also working with Catholic Charities and Tierra Vida, a nearby apartment complex, to host a community forum about the project. Several partnerships for back-stop funding for this project have developed because of this effort; Kadlec Regional Medical Center, Shalom Ecumenical, and GCACH. Kadlec is hoping to place patients transitioning out of the hospital that are at high risk for readmission due to multiple health conditions into the facility. Shalom needs housing for disabled adults with a mental health condition. The Tri-Cities lacks permanent supportive housing facilities in general, so Benton-Franklin Human Services has been very supportive of this project as well.

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

GCACH Response

Quality Improvement (QI) Strategy: As has been described above (17.a.i.1), the GCACH Practice Transformation (PT) process is based on eight Change Concepts, which are used to assess and guide practices through the Patient-Centered Medical Home transformation process. The *Quality Improvement (QI) Strategy* change concept, which is embedded in the GCACH Practice Transformation Toolkit and facilitated through the technical assistance provided by GCACH Practice Transformation Navigators, is an approach to change and provides a framework and tools for planning, organizing, monitoring, sustaining and scaling based upon data. Within each organization, a QI team is sponsored by leadership and focuses on the organization's strategic priorities.

QI teams may use a Rapid-Cycle Improvement (PDSA), Lean Process Improvement or another style of process improvement, that will allow the organization to adapt to change based upon data. The findings and outcomes from this process are then conveyed to the practice organization to keep everyone on track.

At a high level, the GCACH QI Plan proceeds as follows. The GCACH PT *Quality Improvement (QI) Strategy* change concept lays the foundation and drives the development of a QI team within each PT organization that focuses on the organization's priorities. To support this process, the GCACH provides Practice Transformation resources, such as the PT Toolkit, Learning Collaboratives, acknowledgement of exemplar organizations that act as resources, technical assistance provided by Navigators, and the development of Practice Transformation Implementation Workplans (change plans) for each organization. Milestone 5 of the Practice Transformation Toolkit focuses on and lays the foundation for the QI processes within each PT organization. Each organization is required to identify and measure quality and utilization measures (Clinical Quality Measures or CQMs) that are important to them and their patients. CQMs are used as guides to test changes to their practice. Milestone 5 also requires each organization to develop a QI team to support completion of PT Milestones. To supporting the completion of this Milestone, incentive payments are made available to the organization for \$15,000, which supports infrastructure and team development costs around the QI process.

CSI Solutions is an IT vendor that offers Software as a Service (SaaS) solutions, including data reporting and knowledge management systems that facilitate collaboration and health care improvement initiatives. Several ACHs have successfully contracted with them for consulting and to develop an online site for electronic document management, organization collaboration and reporting. Through CSI, the GCACH has developed a landing page for its Practice Transformation organizations, and included in this site is a Reporting Portal where these organizations upload their quarterly performance across all of the PT Milestone deliverables outlined in the Practice Transformation Toolkit. A sample screenshot of the Reporting Portal for Milestone 5A2., Clinical Quality Metrics is displayed in Figure 1.

Milestone 5 also provides an additional incentive payment of nearly \$27,000 for the reporting process. After the quarterly uploads are completed, the data uploaded into the CSI Reporting Portal shown in Figure 1 is then reviewed by the Practice Transformation team and each organization is scored for completing each of the PT Milestones. This scoring process is then summarized into a report for the GCACH Practice Transformation Workgroup, who meets quarterly and reviews organizational performance, discusses roadblocks and obstacles for completing Milestones, and provides feedback to the GCACH for overall improvements into the PT process. Information gathered from the review of outcomes is then synthesized and fed back to the individual PT organizations by way of the PT Navigators. For more detail behind this approach, please see the GCACH Quality Improvement Plan document.

5A.2 Clinical Quality Metrics

1 For this milestone, your practice is required to provide practitioner or care team reports on at least three measures at least quarterly to support improvement in care. In this past quarter, for which quality measures did your practitioner(s) or care team(s) focus their quality improvement activities? Select all that apply. Please provide practitioner or care team reports to your Practice Transformation Navigator

- Antidepressant Medication Management - Acute Phase of Treatment
- Antidepressant Medication Management - Continuation Phase of Treatment
- Child and Adolescents' Access to PCPs - 12-23 Months
- Child and Adolescents' Access to PCPs - 2-6 Years
- Child and Adolescents' Access to PCPs - 7-11 Years
- Child and Adolescents' Access to PCPs - 12-19 Years
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Depression Screening and Follow-up for Adolescents and Adults
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence - 7 Days
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence - 30 Days
- Follow-up After Discharge from ED for Mental Health - 7 Days
- Follow-up After Discharge from ED for Mental Health - 30 Days
- Follow-up After Hospitalization for Mental Illness - 7 Days
- Follow-up After Hospitalization for Mental Illness - 30 Days
- Inpatient Hospital Utilization (includes psychiatric)
- Medication Management for People with Asthma (5 - 64 Years)
- Mental Health Treatment Penetration (Broad Version)
- Outpatient Emergency Department Visits per 1,000 Member Months - 0-17 years
- Outpatient Emergency Department Visits per 1,000 Member Months - 18+ years
- Patients on High-Dose Chronic Opioid Therapy by Varying Thresholds
- Patients with Concurrent Sedatives Prescriptions
- Percent Homeless (Narrow Definition)
- Plan All-Cause Readmission Rate (30 Days)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Figure 1; Milestone 5A2., CQM

Lourdes Health Network: This health system, which includes a Critical Access Hospital, primary and specialty care, and behavioral health, is located in Benton and Franklin counties. They are the earliest GCACH organization to undergo Practice Transformation and have become strong advocates of the process. At the beginning, Lourdes was not

able to provide documented self-management support and shared decision making tools to their patients. This was reflected in their quarterly reporting. Through the technical assistance provided by the PT Navigators and Milestones incentives provided by the GCACH, they have redeveloped their whole approach to quality improvement and implemented processes to address the issues above. They have also been better able to track and report the patients that have received these services. GCACH also supported their transition to a new EHR.

Community Health Association of Spokane (CHAS): This Federally Qualified Health Center has several sites in eastern Washington, including a dental clinic located in the GCACH region in Asotin County. To meet PT Milestone 4 – Patient Experience, CHAS submitted their patient survey return rates every quarter to the GCACH. CHAS and GCACH have used the data from these surveys to conduct Quality Improvement activities to successfully increase their survey return rate.

See attached files:

GCACH.SAR4 Attachment 17-3. 1.31.20.docx

GCACH.SAR4 Attachment 17-4. 1.31.20.docx

GCACH.SAR4 Attachment 17-5. 1.31.20.xlsx

GCACH.SAR4 Attachment 17-6. 1.31.20.xlsx

GCACH.SAR4 Attachment 17-7. 1.31.20.xlsx

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

GCACH Response

Through our contractual arrangements with GCACH providers who participate in Practice Transformation activities to complete Medicaid Transformation project and program objectives, the GCACH distributes significant financial incentives to organizations. This is done with the understanding that Practice Transformation is more than just project management. It is a change management approach to accomplishing the Patient-Centered Medical Home that requires infrastructural investments, capacity building, realignment of work flows and processes and, most importantly, a cultural shift on the part of management, clinicians and staff in how care is delivered to populations. All of this is time, labor and resource intensive.

Our funding model to PT organizations begins with base population health funding in the sum of \$140,000 per organization, which is provided initially upon signing the Practice Transformation contract. This funding is meant to support population health infrastructure, such as the addition of software that allows for the development of patient registries, the production of clinical quality reporting, the risk stratification of patient populations, pre-visit planning prior to visits and more. Some organizations hired health information technology staff. This fund may also support upgrades to existing clinical software, such as EHRs, where things such as hidden templates or other features are turned on, or the addition of interoperability software, such as direct secure messaging, which allows providers to share clinical data across systems and organizations. Many behavioral health organizations chose to upgrade their EHR systems to become ONC certified. All this work, which varies from one organization to the next, sets or establishes the necessary baseline to begin the Practice Transformation process. For 2019, the total payout for base population health funding amounted to \$2,870,000 that was distributed to forty-five clinics and hospitals.

In addition, Milestone 2B.1 of the GCACH PT Toolkit provides guidance to organizations for performing bi-directional of behavioral health. The Toolkit lays out strategies for organizations to accomplish this objective, including choosing a behavioral health integration model, choosing evidence-based instruments to assess and monitor care, selecting the methodology for identifying patients needing bi-directional care, and more. Each of the organization's sites is provided Milestone incentives of nearly \$15,000 for completing this work. Milestone payments made in 2019 to providers for bi-directional integration was \$328,410, however this is a bi-annual payment and does not reflect fourth quarter awards for Cohort 1, and second quarter awards for Cohort 2.

Integrated Managed Care (IMC) funding helped with IT infrastructure to support the four different payment reporting portals for the four Managed Care Organizations (MCOs) operating in the region, reporting analytics, templates to gather required information, and quality improvement staff. Other purchases included signature pads, computers and storage hardware. Each organization was rewarded different sums of funding from Phase I integrated managed care (IMC) funding based upon and aligned with the original funding methodology of the Behavioral Health Organization (BHO) serving the GCACH region. This methodology was originally introduced by the BHO and approved by the GCACH Board of Directors. See attached 2018 Reconciled Budgets document. Phase II IMC funding was primarily allocated to Cohort 2 based on the PCMH revenue sharing model, which is achieved through PT Milestone deliverables.

See attached files:

GCACH.SAR4 Attachment 17-8. 1.31.20.xlsx

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

- a. Schedule of initial implementation for each Pathway.

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Adult education		
Employment		
Health insurance		
Housing		
Medical home		
Medical referral		
Medication assessment		
Medication management		
Smoking cessation		
Social service referral		
Behavioral referral		
Developmental screening		
Developmental referral		
Education		
Family planning		
Immunization referral		
Lead screening		
Pregnancy		
Postpartum		

- b. Partnering provider roles and responsibilities to support Pathways implementation.
- c. Inventory of Care Coordination Agencies (CCAs) and the number of referrals initiated to date.

CCA Name	Total # of Referrals to CCA for any Pathway

- d. Systems the HUB lead entity is using to track and evaluate performance. Provide a list of the related measures.
- e. Success in hiring staff, a listing of open positions and efforts to fill those. Describe barriers or gaps that exist in retaining staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.
- f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.

- g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.
- h. Include two examples of checklists or related documents developed for care coordinators.

GCACH Response

NOT APPLICABLE

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

GCACH Response

On August 1st and 2nd, 2019, the GCACH held a Transitional Care and Disease Management Learning Collaborative at Pacific Northwest University in Yakima. Two of the presentations during the summit focused on palliative care. One was given by Gregg VandeKieft, MD, MA, FAAFP, FAAHPM, a Hospice / Palliative Care specialist with Providence St. Joseph Health Southwest Washington. The other was a panel presentation hosted by Kevin Martin, MD, a family physician and Chief Medical Officer for Kittitas Valley Healthcare, and included Deborah Watson, RN, MBA, Clinical Project Manager for Pullman Regional Hospital; Brenda Swenson, RN, Director of Hospice Outreach for Chaplaincy Health Care; and a representative from Compass Care, the palliative care and hospice program at Virginia Mason Memorial Hospital in Yakima. During both discussions, the POLST form was discussed, including its content and its usefulness in planning advance directives for individuals with severe and chronic illness.

The GCACH has worked to provide information to its participating provider organizations and stakeholders about the usefulness of the POLST tool. At its November 21 Leadership Council meeting, Dr. Wayne Kohan, Medical Director for Chaplaincy Hospice Care, provided the audience with a presentation on the POLST tool, which provided background on the tool and its implementation in Washington State. He also discussed the different sections of the tool, including medical interventions, the use of antibiotics and medically assisted nutrition. Dr. Kohan also provided a thorough review of cardiopulmonary resuscitation along with supporting research around survival statistics. The POLST tool itself was distributed to the audience and included in the Leadership Council meeting packet.

Discussion and education about the contents and use of the POLST form in sessions such as these has proven useful in educating our Practice Transformation organizations and

our community partners and stakeholders. One challenge for implementing the POLST tool that was identified through the discussion was that it is still primarily being directed by medical providers toward only those patients with advanced illness. This points to the opportunity for wider use of the tool by individuals with lower or no medical acuity. At the very least, adults should have in place some form of advanced directives.

See attached files:

GCACH.SAR4 Attachment 17-9. 1.31.20.pptx

4. Project 3A: Provide two examples of the following:

Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recover supports.

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

GCACH Response

The GCACH has monitored the 2016 Washington State Interagency Opioid Working Plan, 2017 Washington State Interagency Opioid Working Plan and the 2018 Washington State Opioid Response Plan. The GCACH's Opioid Resource Network Project Manager has been monitoring changes across these documents as new Plans appear, and these changes have informed and updated the GCACH's Project 3A project implementation plan during the completion of its Semi-Annual Report submissions.

Some of the project work performed by or in collaboration with the GCACH and informed by the state's opioid response plan is as follows:

Prevention of opioid misuse and abuse

- Working with community through schools to promote and implement strategies to prevent misuse of opioids and other substances: GCACH Practice Transformation organizations also have programs that reach into school districts throughout the region. For example, Merit Resource Services is providing education and resources to middle schools and high schools on the prevention of opioid use disorder (OUD). One of their counselors also goes into the schools to provide counseling services where needed. Tri-City's New Horizons High School offers the SPARK program, which trains students on becoming peer counselors. The student population at this alternative high school is considered high risk due to their prior experience with SUD. Lutheran Community Services offers the Wraparound with Intensive Services (WISe) program, which is a wraparound services program for youth. Whitman County Health Network is offering the Strengthening Families program.

GCACH also promoted the best use of opioid prescribing practices among its participating health care providers. GCACH's 62 current practice sites in Cohorts 1 and 2 accomplished Milestone 2B.3.a Medication Management, and these sites received technical assistance from the GCACH that offered guidance around medication management, Washington's Prescription Monitoring Program, The Six Building Blocks program, American Medical Directors Association guidelines and the CDC's opioid prescribing guidelines, information about the Bree Collaborative's Addiction and Dependence Treatment recommendations, resources about WA State TelePain and implementing different collaborative care models (i.e., AIMS, Bree Collaborative, Co-location and other models).

- Increase the use of the Prescription Drug Monitoring Program (PMP) to encourage safe prescribing practices. GCACH's Practice Transformation Toolkit Milestone 2.b.3 Medication Management includes a reporting requirement around use of the PMP. All practice sites receive technical assistance around this subject.
- Educate the public about the risks of opioid use, including overdose. GCACH has provided providers with information on the HCA's program, *It Starts with One*. GCACH has also provided the Yakama Nation with information from The One Tribal opioid campaign. Following the GCACH's Opioid Use Disorder summit held in June, it has provided information to providers on HCA's media campaign on opioid use and abuse.
- Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse. GCACH's Sponsorship Fund provided funding to the Walla Walla County Department of Community Health's National Night Out on August 6, 2019 in conjunction with Walla Walla Area Crime Watch. The theme of the event was "Starts With One," based on an opioid prevention campaign created by HCA. The \$5,000 grant provided by GCACH helped with the purchase of N.N.O. T-shirts and the distribution of 90 medication lock boxes to community members to safely secure their prescription drugs. An estimated 3,000 people attended the event, which featured 54 local vendors including law enforcement, emergency management, community health, schools, and private businesses.

Identify and Treat Opioid Use Disorder

- GCACH Practice Transformation Navigators have worked with providers on prescribing guidelines for opioids, on key clinical support features for prescribing opioids, and on linkages to behavioral health care and Medication Assisted Treatment for people with opioid use disorders. Each Practice Transformation provider must show how they have been able to increase their

practices' capacity to implement the use of MAT for their patients who have been diagnosed with OUD. Providers are required to have MAT training, identify a MAT referral source, or be a participant of their local Opioid Resource Network (ORN). GCACH Opioid Resource Networks (ORNs) identify patients needing intensive case management services, then link patients with physicians or healthcare providers, MAT providers and other community-based services.

Reduce morbidity and mortality in those with opioid use disorder

- GCACH has contracted with four Network Managers for the creation of Opioid Resource Networks (ORN) in Benton, Franklin, Walla Walla, Kittitas, Whitman, Asotin, Columbia and Garfield counties. The ORNs work directly with the syringe service programs with education for their clients on treatment, to provide infectious disease screening services, overdose education and naloxone, and engage clients in health and support services, including housing.
- GCACH ORNs have successfully linked with EMS, social service providers, syringe services programs, jails, courts, housing, recovery supports, and other community providers to identify clients most at-risk from OUD overdose and who would benefit from MAT.
- GCACH has supported Kennewick Fire Department's EMS in utilizing the PMP with some of the high-risk patients they have identified through high-volume 911 calls.

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

GCACH Response

GCACH has contracted with Network Managers to create four Opioid Resource Networks (ORN) across its service area. The ORNs cover Benton, Franklin and Walla Walla counties combined, Kittitas county, Whitman county, and Asotin, Columbia and Garfield counties combined. The purpose of the ORN is to coordinate a systemic response to the complex issues of opioid addiction among the Medicaid and low-income populations, focusing specifically on Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorder (OUD). GCACH understands that people with OUD seek services in a variety of places. Some people request treatment from primary care providers, while others request through traditional Substance Use

Disorder (SUD) treatment agencies. Other persons with OUD present in jails, syringe services programs, emergency departments and homeless shelters. The ORN is very similar to the Hub and Spoke that is currently supported by Washington State and used in a variety of other settings. This model connects a network of community providers around a central hub, or Network Manager, that either offers or contracts with a MAT component to all patients seeking services for OUD.

Guiding Principles for the ORNs:

- The ORN must be a MAT Prescriber or have a collaborative agreement with a MAT Prescriber.
- The purpose of the ORN is to provide Case Management for high risk, high utilizers that have OUD.
- The ORN will develop and maintain strong relationships across counties with network provider organizations.
- The ORN must establish collaborative agreements with a network of Primary Care, Behavioral Health, SUD Providers, and other partners to create wrap-around services for individuals with OUD.
- The ORN will have monthly meetings with GCACH to report progress.
- The ORN must comply with the GCACH pay-for-reporting requirements relating to OUD.
- The ORN will serve as a bridge for one year to help transition PCMH organizations that are not ready to provide case management services to OUD patients.
- The ORN will offer education and training to providers to help them learn care management skills.

The Current GCACH ORNs:

1. Benton/Franklin/Walla Walla ORN – Network Managers: Consistent Care (CC) and Blue Mountain Heart-to-Heart (H2H)
 - CC has Walla Walla office and TC office with case managers and client advocates. They can provide MAT and wraparound services.
 - H2H has a Syringe Services Program (SSP) in Kennewick with an ARNP who can do rapid MAT inductions. H2H also has an SSP in Walla Walla that can perform rapid MAT inductions.
 - H2H is MAT certified and linked to Ideal Option, also a MAT provider.
 - In Benton and Franklin Counties, CC is partnering with Lynx Healthcare, which has a mid-level provider; with New Start Clinic, which has several sites; and with Hugh Thomas at Kadlec Regional Medical Center's ED. All

can do MAT induction.

- The first step for the ORN was to identify local partners (spokes), with whom they formed collaborative agreements that created partnerships but without payment mechanism. The partnership required the organizations to attend ORN meetings.
- ORN Partners include local MAT Providers, SUD providers, EMS and mental health providers.
- The ORN also wants to include wraparound services: Housing supports and Foundational Community Supports, homeless and day shelters, supplemental food providers (food banks), and others.
- Most of the patients entering into the ORN program have come from the SSPs. The ORN is now working to ID other referral sources. They started with a 1-800 number and fliers, but the phone number was changed to a 509-area code out of concerns that clients would not respond to a service they thought was out-of-area. They have posted flyers at food banks, laundromats, low-cost hotels, all of which have referred a handful of patients who have had other SUD issues, such as meth addiction.
- The ORN is working to educate primary care practices but reluctant to post fliers or put out materials because of the stigma tied to OUD. The ORN is now partnering with GCACH Practice Transformation Navigators, who they will accompany on visits to the clinics.
- Working with Fire Departments to ID overdoses in their emergency response calls and then reach out to these clients later on.
- Having a link to primary care providers is important too and training and waverling more MAT providers there.
- So far, they have had 119 inductions with 60 remaining in treatment for 30 and 90 days.

2. Whitman ORN – Network Manager: Palouse River Counseling (PRC)

- PRC has signed agreements with Pullman Regional Hospital and local primary care. They are working on agreements with EMS and Fire Districts for all small counties in Whitman.
- PRC is also collaborating with MAT therapy providers for referrals, education and care, with mental health and SUD providers and with clinicians to refer into MAT treatment.
- They are starting with bigger practices: 2 in Pullman and 1 in Colfax. So far, they have agreements with EDs in 2 hospitals and some agreements with

PCPs. One area they want to make connections is with dentists. In their area, PCPs have been working on opioid prevention for years.

- They are also working with Ideal Option, a MAT provider, for MAT treatment only.
- So far, they have 10 patients in their ORN Program. Five have been in the program for 30 days and the other 5 have been in for 90 days.

3. Asotin/Columbia/Garfield ORN – Network Managers: Blue Mountain Heart to Heart (H2H) and Tri-State Memorial Hospital (TSM)

- They are starting with the Asotin Syringe Services Program, but they would like to do more promotion by attending other agency meetings. Majority of program participants in are not engaged in primary care. They are reaching out to people who are not engaged in healthcare until they need ED care.
- They would like to include Lewiston and other parts of Idaho into this work, as this is just across the border. They would also like to add law enforcement, courts, jails, and addiction specialists. However, local stigma has driven patients to being ashamed of their drug behavior, making them afraid of telling medical providers of their actual habits.
- Clarkston has a MAT provider and infectious disease provider. Because of the small size of these communities, there are issues with client's inability to get to resources. The normalization of seeking a SUD provider for treatment could be a marketing strategy, and could help reduce stigma among providers and the community in general.
- Currently they have just 2 people induced in MAT who are from Columbia County.

4. Kittitas ORN – Network Manager: Kittitas Valley Healthcare (KVH)

- KVH has hired a doctor that specializes in Addiction Medicine, and they are in the on-boarding process right now. KVH is also hiring an RN to be dedicated to the ORN. They are also still in the on-boarding process for this RN.
- Currently, KVH has an MOU with the Kittitas County Health Network, the Local Health Improvement Network established through the GCACH. KVH is hoping to get referrals from this partnership once they have everything in place.
- The public Health Department in Kittitas and Ellensburg has Syringe Services Programs but have not yet reached out to them.

- They currently have 5 people enrolled in their MAT program, with 4 that are still in the treatment for 30 days and 2 in treatment over 90 days.
- c. Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH's planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

GCACH Response

The GCACH has already identified, through various reporting mechanisms, gaps in the capacity of primary care, behavioral health and oral health providers throughout its service area. Shortages also extend to providers offering recovery support services, such as peer counselors and community health workers. There are many reasons for shortages of these recovery support specialists but a leading cause has been a lack of reimbursement. Fortunately, as of July 1, 2019, peer support services are now included in both the mental health and substance use sections of the Medicaid State Plan. This allows appropriately licensed behavioral health agencies to provide peer support services for both mental health and substance use disorders and bill them as Medicaid reimbursable encounters. However, this administrative change does not include new reimbursement for community health workers (CHWs). We have heard from stakeholders within the GCACH about the need to increase the capacity of CHWs and peer counselors to support individuals in recovery for substance use disorder.

Behavioral Health Internship and Training Fund: To help counteract capacity issues across all behavioral workforce areas, the GCACH created an internship and training fund. The goal of this program is to support organizations willing to precept, supervise, or train professionals seeking careers in behavioral health or having a behavioral health component who need clinical experience in order to complete their educations and certification requirements. The program allocates \$490,000 from IMC Phase 2 funds to provider organizations across the GCACH. The competitive application process is overseen by the GCACH Workforce Committee and provides awards in amounts of from \$5,000 up to \$40,000 per year per award. Applicants may apply for up to three internships/preceptorships/trainees per year or a total not to exceed \$120,000. The Behavioral Health Internship and Training Fund is available to support many behavioral health disciplines, including peer support specialists and community health workers who support individuals in recovery. Because of the broad roll-out of this program, it is expected to increase capacity across the region

Benton Franklin Recovery Coalition (BFRC): The BFRC is the second largest member of the Washington Recovery Alliance, a statewide, grassroots organization comprised of individuals in recovery from addiction and mental health conditions,

families impacted by behavioral health conditions, and recovery community organizations driving change in two spheres related to behavioral health recovery: public policy and public understanding. The BFRC, itself, is an educational organization that connects community partners, advocates for changing practices, and promotes opportunities for recovery. They have a broad membership that includes medical providers, behavioral health providers, law enforcement, housing, city government, patients and families in recovery and more. The BFRC was formed in the summer of 2018, and the GCACH was one of the supporting organizations present at its inception. Since that time, the GCACH has been a member of the BFRC's Steering Committee and also provided financial support for its keynote fundraising event, the 5K Run for Recovery in September, 2019.

Board Representation: The GCACH Board has been privileged to have Ronni Batchelor as a Director and representative of the consumer sector. Ronni has successfully supported people through the process of creating changes in their circumstances; homelessness, addiction, mood disorders, disease states, and food insecurity. She has advocated for people caught up in the court system, behavioral health system, and medical system. She has navigated people into mental health and addiction services. In 2015, Ronni successfully assisted 26 homeless people through the arduous process of getting them housing. Currently, she works for Lourdes Health as a Peer Specialist Case Manager. Ronni is also an Emerging Advocate Program graduate with the Washington Low Income Housing Alliance (WLIHA), and has earned several certificates of educational units in health and mental health, including Trauma Informed Care, and Mental Health First Aid.

5. Project 3C: Provide the following:
 - a. A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.
 - b. Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.
 - c. A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

GCACH Response

NOT APPLICABLE

6. Project 3D: Provide the following:

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

GCACH Response

The GCACH's Practice Transformation (PT) model is the foundation for all its work and seeks to implement components of the Patient-Centered Medical Home (PCMH) in all of its contracted Cohort organizations. PCMH incorporates and builds upon the components of the Chronic Care Model, as was confirmed to the GCACH by Mike Hindmarsh, President, Hindsight Healthcare Strategies and who worked alongside Ed Wagner and other colleagues at the MacColl Institute for Healthcare Innovation at Group Health Cooperative during the creation of the Chronic Care Model. During his visit with the GCACH, Mr. Hindmarsh also validated the training tools needed to implement the CCM and PCMH. These included the following:

1. AHRQ PCMH Resource Training Tools (<https://pcmh.ahrq.gov/>) There are 32 easy-to-read training modules tied to the AHRQ Primary Care Practice Facilitation Curriculum (<https://pcmh.ahrq.gov/page/primary-care-practice-facilitation-curriculum>). This forms the basis for the general role of the Navigators (e.g. how to schedule meetings)
2. Safety Net Medical Home Initiative (<http://www.safetynetmedicalhome.org/>). There are 11 comprehensive implementation guides relating to this part of the training, which cover the functional parts of the Navigator's work. Each guide has supporting trainings and materials:

These tools and resource are the foundation for the training of the GCACH Practice Transformation Navigators. To guide PT organization work, the GCACH developed its *Practice Transformation Implementation & Reporting Toolkit* which builds off the eight change concepts of the PCMH as shown in Figure 2:



Figure 2; Eight Change Concepts of the PCMH

The Toolkit itself is based on one of CMS’s Innovation Models: The Comprehensive Primary Care (CPC) initiative. This initiative supported the provision of a core set of five “Comprehensive” primary care functions (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood. The CPC initiative also provided resources to help practices work with patients to provide the following five comprehensive primary care functions:

- Access and Continuity: Because health care needs and emergencies are not restricted to office operating hours, primary care practices optimize continuity and timely, 24/7 access to care guided by the medical record. Practices track continuity of care by provider or panel.
- Planned Care for Chronic Conditions and Preventive Care: Participating primary care practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Providers develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently.
- Risk-Stratified Care Management: Patients with serious or multiple medical conditions need extra support to ensure they are getting the medical care and/or medications they need. Participating primary care practices empanel and risk stratify their whole practice population, and implement care management for these patients with high needs.
- Patients and Caregiver Engagement: Primary care practices engage patients

and their families in decision-making in all aspects of care, including improvements in the system of care. Practices integrate culturally competent self-management support and the use of decision aids for preference sensitive conditions into usual care.

- Coordination of Care Across the Medical Neighborhood: Primary care is the first point of contact for many patients, and takes the lead in coordinating care as the center of patients' experiences with medical care. Practices work closely with patients' other health care providers, coordinating and managing care transitions, referrals, and information exchange.

CMS guided development of the five CPC functions at each CPC practice through a framework of "Milestones." Participating practices reported their Milestone progress regularly through a web portal. CMS supported practices in attaining the CPC Milestones through regional learning networks and online collaboration opportunities. CMS also built up guides to drive practice change. The GCACH has incorporated all of these principles into its Practice Transformation program.

This is the optimal, evidence-based framework for preparing provider organizations to be successful under VBP payment models. To guide organizations in a robust, practical and structured way, and to maintain fidelity to the core concepts of the Patient-Centered Medical Home model, the GCACH created its GCACH Practice Transformation Toolkit (ctrl-click [here](#)) and an accompanying Practice Transformation Reporting Workbook (ctrl-click [here](#)). The Toolkit is based on one of the original CPC Implementation and Milestone Reporting Summary Guides (2014). Provider Practice Transformation contracts are linked to the Milestones laid out in the Toolkit and supported by a revenue sharing model or schedule of payments tied to completing individual Milestones.

Practice Transformation is a portfolio approach to all four of the Medicaid Transformation project areas selected by the GCACH, and is a comprehensive process that requires a long-term relationship with the participating provider. Year 1 is about standing up the program while Years 2 and 3 are about scaling and sustaining implemented changes. The process is more about top-to-bottom change management rather than simple program solutions or project management. The GCACH believes this will lead to more long-lasting and sustainable changes by the provider organization. Having the Practice Transformation Navigators be employed by the GCACH, rather than having this service consulted out with another organization, has also been a major reason for success. Having these individuals reside in-house allows GCACH to more easily learn from the successes and failures of its PT organizations and then apply this information towards quality improvement.

GCACH Toolkit Milestone 2B.2.8 relates to patient self-management supports and requires participating providers to select community-based resources that will be

made available to patients through formal referral to an agency or by distributing information to the patient about the community resource. Figure 3 is a sample of the related reporting measure contained in the CSI Reporting Portal:

8 What community-based resources do you make available to your patients for support for self-management and how do you link patients to this resource? Identify three to five community-based resources. List community-based resources you make available to your patients. For each community-based resource, indicate how the link between the patient and the resource is made. Select one per resource:

	Community-based resource	Link between patient and resource
Community-based resource 1	Consistent Care	Formal referral or prescr ▼
Community-based resource 2	Connections-Neighborhood Health	Formal referral or prescr ▼
Community-based resource 3	Oxford Housing	Information provided ▼
Community-based resource 4	AA/NA	Information provided ▼
Community-based resource 5	Comprehensive Healthcare	Formal referral or prescr ▼

Figure 3; Milestone 3, Community-Based Resources

Some examples of clinical and community-based strategies include the following:

- Catholic Charities of Yakima provides information to patients on Northwest Justice Project, Northwest Immigrants’ Rights Project, Neighborhood Connections and Wellness House
- Barth Clinic makes formal referrals to Consistent Care, Yakima Neighborhood Health Services, and provides information on Oxford Housing and AA/NA
- Palouse Medical makes formal referrals to Adult Protective & Child Protective Services, and provides information on Community Action Center, Pullman Regional Hospital Social Work Department, and Palliative Care services.

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

GCACH Response

Barth Clinic & Associates, a small, locally owned, outpatient SUD treatment facility in Yakima, is currently contracting with Consistent Care, an independent case management company. This contract allows Barth clinic to refer patients, who have been identified through an initial risk stratification as being at moderate or high risk of readmission, to receive intensive care management services by Consistent Care. Once the referral process has been initiated, education is provided to the patient about the services that Consistent Care will be providing. To better coordinate the health of the patient, a release of information document is signed by the patient. This allows Consistent Care to assess the patient's social needs and medical history to come up with a personalized plan on how to address this. Some of the services that Consistent Care offers their clients range from home visits by clinical staff to making referrals to housing, primary care, behavioral health or other needs that the patient might have. Consistent Care is in constant communication with Barth Clinic, providing updates on a regular basis on their patients' progress. This is a direct result of GCACH's requirement under Milestone 2B.2., which facilitates the Practice Transformation organization to identify the community-based resources the practice makes available to their patients.

Kennewick Fire Department (KFD) expanded its services in July 2019 by way of mobile community health with the addition of their Community Paramedicine program. This program expansion was aided by a partnership between KFD and the GCACH. With growth in the local population, KFD has seen a steady increase in the number of citizens using the community's 911 service and emergency departments in place of a primary care provider and other services more appropriate to their health care issues. Many of these patients have chronic disease that has gone unmanaged and which has contributed to their unnecessarily high use of community EMS services.

The goal of Community Paramedicine is to assist in coordination of the patient's care and connecting these individuals with the community services that can benefit them the most, and thus reduce their need for 911 calls and ED visits. The Community Paramedic is specifically geared towards identifying these individuals, making contact, building a rapport, identifying obstacles to care, assessing their total health needs, and then connecting them through a referral with the appropriate resources to get that care. Some of the local referral partners that address the patients chronic care and social service needs are Consistent Care, Aging and Long Term Care (ALTC), and Meals on Wheels.

The GCACH is providing first-year funding for software (ImageTrend) that will support the Community Paramedicine program. As part of a pilot study, the GCACH will also support an evaluation of the program's effectiveness at reducing 911 calls and ED transports. The study also hopes to monitor a reduction in overall ED utilization. The analysis will be carried out by the Institute for Public Policy & Economic Analysis at Eastern Washington University.

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

GCACH Response

Challenge/Risk: Workforce shortage in behavioral health workforce

Impact: Capacity issues with the behavioral health workforce impacts all GCACH project areas (2A, 2C, 3A and 3D) and Domain 1: Promoting a health workforce that supports comprehensive, coordinated and timely access to care. The primary concern is having adequate staff to facilitate bi-directional integration across the region. Provider organizations have struggled to recruit Licensed Independent Clinical Social Workers (LICSWs) and/or Peer Support Specialists. Moreover, many of these organizations have also tried to recruit behavioral health specialists in rural areas but don't have the resources to attract them.

Mitigation Strategy: To help mitigate capacity issues across all behavioral workforce areas, the GCACH created an internship and training fund. The goal of this program is to support organizations willing to precept, supervise, or train professionals seeking careers in behavioral health or having a behavioral health component who need clinical experience in order to complete their educations and certification requirements. The program allocates \$490,000 from IMC Phase 2 funds to provider organizations across the GCACH. The competitive application process is overseen by the GCACH Workforce Committee and provides awards in amounts of from \$5,000 up to \$40,000 per year per award. Applicants may apply for up to three internships/preceptorships/trainees per year or a total not to exceed \$120,000. The strategy behind this policy is that an organization is more likely to attract potential staff through internships and subsequently retain them because of their applied experience with the organization. This policy and fund was approved by the Board of Directors on November 16th, and the application for these funds will be open for a six-week timeframe beginning in January 2020, with awards mid-March. While the impact is not yet known, early response of interest is a good indicator this program is needed.

Challenge/Risk: Clinical staff not working at "the top of their license." Within GCACH Cohort 1 provider organizations, there have been challenges with staff being able working at the top of their license.

Impact: Each care team member works within a different scope of practice, so that a nurse practitioner can do more than an RN, an RN can do more than a CNA, and so on. The idea of operating at the top of your license means practicing to the full extent of your education and training, instead of spending time doing something that could be effectively done by someone else. Under the Patient-Centered Medical Home (PCMH) model, nursing (RN, MA, CNA) staff must be able to practice to their full potential for the practice to operate at full patient capacity.

This also affects staff satisfaction and practitioner “burnout.” This affects all GCACH MT project areas.

Mitigation Strategy: Many of the GCACH practice sites are working to implement Practice Transformation Milestone requirements, such as shared-decision making, self-management support, and medication management, all of which influence chronic disease prevention and control. In order to do this, staff need to have the ability to work at the top of their license. This has required a culture change in addition to a change in workflows for many practice sites. GCACH has helped to mitigate this by providing best practices that have been gleaned from other Practice Transformation organizations within the Greater Columbia region. Also, the Practice Transformation team works with the sites to help conduct process improvement efforts.

Challenge/Risk: Sub-optimal billing practices by Practice Transformation organizations

Impact: Practices that do not optimize reimbursement for billed services are not maximizing potential revenue for their businesses. This could lead to a failing business, very stressed-out providers, and clients without providers.

Mitigation Strategy: Some Cohort 1 and 2 Practice Transformation organizations have demonstrated issues with their billing workflows. These organizations have historically been using billing codes and/or work procedures that do not produce optimal reimbursement. GCACH has worked with many of these organizations to identify these sub-optimal workflows and partnered with them to provide education on the use of billing codes and procedures that will allow for full and appropriate reimbursement for the services they provide. Demonstrating how to optimize the value for the services provided is key to understanding how VBP contracting works to their advantage. GCACH works with providers to ensure they understand the connection between value-based care and VBP contracts.

Challenge/Risk: Practice Transformation organizations not using ONC certified EHRs

Impact: Medical providers must use ONC-certified EHR systems to receive Medicaid and Medicare incentive payments. Furthermore, this certification allows providers and patients to feel more confident in the way health information is stored and used.

Mitigation Strategy: ONC certification leaves providers with some assurance that the technology they use for record keeping and billing is secure, trustworthy and functional. Many of the Cohort 2 organizations, which are behavioral health agencies, were initially not using ONC EHRs. However, the GCACH requires ONC certification in its Practice Transformation Milestones. Practice Transformation organizations used GCACH funds to upgrade their EHR, and PT Navigators gave support through this process. Organizations transitioning their EHRs included:

- Serenity Point and Somerset Counseling

- Sundown M Ranch
- Quality Behavioral Health
- First Step Community Counseling Services
- Blue Mountain Counseling
- Lutheran Community Services
- Ideal Balance Counseling switched to the same EHR as its parent company, Ideal Option, allowing for full interoperability

Challenge/Risk: Connecting provider organizations to community-based organizations providing services that impact the social determinants of health.

Impact: The move to value-based payment models by health insurance and government payers has driven healthcare organizations to seek ways to address their patients’ social and economic needs. Providers increasingly refer patients to local community-based social service organizations that can assist with non-medical needs.

Mitigation Strategy: To know where to refer patients for non-medical needs, health care organizations have traditionally relied on informal approaches such as hard-copy or electronic lists (e.g. MS Excel) of local service providers or the experiential knowledge of social or community health workers. Many have found these informal approaches inadequate and inefficient. Washington 2-1-1 (WIN 211) is a statewide service organization that helps connect people to social services. One of their principal features is a consumer resource directory (CRD), accessible through the Internet and their call-center. This is an invaluable resource for consumers – particularly low income – who rely on social resources (e.g. supportive housing or shelters). Anecdotal comments from service professionals and consumers within the Greater Columbia region have pointed to opportunities for improvements in WIN 211’s CRD. This includes the need for a more coherent website and a context driven database. The GCACH has been collaborating with WIN 211 for some time to implement changes to their consumer resource directory. A proposal was developed during the reporting period that outlines suggested changes to their website and funding was allocated to help with this redevelopment process.

See attached files:

GCACH.SAR4 Attachment 17-10. 1.31.20.docx

18. Pre- and post-project implementation example

- a) Highlight a success story during the reporting period that was made possible due to Semi-annual reporting guidance
Reporting period: July 1, 2019 – December 31, 2019

DSRIP investments, including how DSRIP removed the barrier to implementation and lessons learned that the ACH has used to make modifications moving forward

GCACH Response

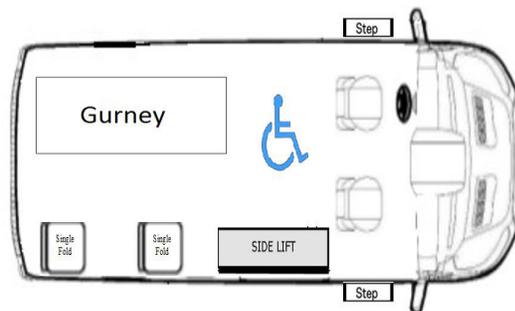
Columbia County Health System (CCHS) is Public Hospital District with a Critical Access Hospital. Their primary service areas include Dayton, Waitsburg, Starbuck, and surrounding areas. Through its Community Health Fund, the GCACH provided CCHS with \$23,750. Here is the story that their CEO, Shane McGuire, wrote to the GCACH about how they utilized these funds. Figure 4 is a picture of their DSRIP investment.

“When we hired our community health workers, Paul and Mike, to help with some challenges we were having with no call/no show patients, we really didn’t fully understand the problem we were asking them to help us fix. What we discovered was that reliable transportation was the single largest hurdle and barrier to care affecting these patients. The solution was to use our 2005 van with 223,126 miles on it to assist in meeting these patients’ needs, but this was not going to be sustainable given the age and mileage of the van especially when considering the distances we were driving. In addition to the more local appointments in Walla Walla and our own clinics, our team routinely take patients to specialists’ visits in the Tri-Cities, Spokane, and even Seattle.

Along with the reliability issues we were facing, we were also transporting patients with wounds that were much more comfortable traveling on a gurney rather than in a chair or wheel chair. The money received from the Greater Columbia Accountable Communities of Health, Community Health Fund has made it possible for us to order a new, modern and flexible van that can accommodate vehicle chair, wheel chair and gurney patients. The van is also a mid-sized vehicle making it easier to maneuver as well as maintain a comfortable environment in the winter and summer months. We expect to make roughly 1,800 transports in the first year, and we anticipate the new van’s arrival sometime in August!”



Figure 4; CCHC Transport Van



19. Regional integrated managed care implementation update

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

GCACH Response

More than a year after integrated managed care implementation, the GCACH has been asked by its contracted behavioral health (BH) providers to continue to facilitate meetings between them, the HCA, and the four MCOs to address ongoing issues. Some of the challenges that still exist include the following:

- MCO's inconsistent processing and accuracy of claims payments
- The need for substance use disorder Peer Recovery Support workers and local training
- Preparing their EHRs to interface with the new behavioral health data element requirements that must be submitted to the MCO's
- Constant changes to the SERI guide, which causes confusion to the providers on which version is the most recent
- Challenges around submitting the supplemental Native data to the MCOs and the related cost to implement it in their new EHRs

Another major challenge for behavioral health providers are problems relating to reimbursement for Residential Treatment. GCACH has facilitated two meetings on this subject to address:

- Clarity around who completes residential pre-authorizations
- Clarity around referring to an out-patient (OP) facility or a residential provider
- Lack of consistent guidelines statewide for pre-authorizations
- Clarity around who schedules an interpreter for Residential treatment, whether the OP or residential provider
- Issues around Molina's use of criteria other than ASAM for SUD residential utilization and continued stay reviews

GCACH will continue to facilitate meetings for the HCA, MCOs and BH Providers, and advocate to have their questions and concerns answered. Additionally, the Executive Director interfaces with the HCA to bring these issues forward to look for statewide solutions and advocate for changes in policy.

- b) For **2020 adopters**, briefly describe progress made during the reporting period on the

development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.

GCACH Response

NOT APPLICABLE

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

GCACH Response

NOT APPLICABLE

Attestations

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

	Yes	No
<p>20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:</p> <ul style="list-style-type: none"> • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • 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. 	X	

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

Section 3. Value-based Payment

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

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

Narrative responses

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

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

GCACH Response

Section 17.a.i.1. above describes the GCACH's Practice Transformation (PT) model, its background and its related change concepts. As described, this model is the foundation for all GCACH's work and seeks to implement the components of the Patient-Centered Medical Home (PCMH) in all of its contracted Cohort organizations. To support completion of the Milestones laid out in the GCACH Practice Transformation Toolkit, the GCACH has a staff of in-house experts: The Practice Transformation Director and Navigators. These individuals currently support 62 practice sites across the nine GCACH counties and provide technical assistance across a number of areas. Most importantly, they help guide the participating provider to complete the PT Milestones and on a quarterly basis, report data into the CSI Healthcare Community where data is uploaded into a reporting portal (ctrl-click [here](#)). Data across all practice sites is aggregated and reviewed by the GCACH staff. This information is then summarized and reviewed by the GCACH clinical advisory group, the Practice Transformation Workgroup, who review organizational performance, obstacles and challenges, and make recommendations for improvement to the overall program. The review of data uploaded into the reporting portal also aids the GCACH in recognizing providers struggling to implement practice transformation and helps staff focus time and attention to those in most need. This can come through additional technical assistance or referral to outside resources. It also helps the GCACH know what type of Learning Collaboratives to develop to aid provider performance.

An example of this is a Federally Qualified Health Center in the GCACH service area. It had a very successful start to Practice Transformation, and their leadership that was in place at the beginning of this project saw the benefits and the importance of transforming their organization so that they can be ready for when value-based care comes into play in 2021. Their quality director assembled a quality improvement (QI) team that was responsible for

reviewing/implementing new processes and procedures into their daily workflows and also conducting Plan Do Study Act (PDSA's) cycles. The QI team that was assembled included staff from pharmacy, office staff, data analytics/IT, behavioral health, dental care and specialty medical care. The QI team was very engaged in Practice Transformation and started looking into standard operating procedures (SOPs) and workflows that were currently in place that were identified as needing process improvement.

Through this work some of the SOPs were updated as well as some of the workflows for the front desk staff throughout the organization. The QI team also identified that their current electronic health record (EHR) was not adequately set-up and needed optimization so that it was adequate for their current workflows. The optimization of the EHR allowed them to electronically bill for services, as they were previously not billing electronically. Another area GCACH helped to improve was their provider schedules. It was identified that their scheduling system had too many events and categories options available, causing confusion among schedulers and making it difficult to run reports to identify their 'third next available appointment', a routine measure of patient access. Through weekly QI meetings, the GCACH developed a parking lot of over 90 task items needing process improvement. These parking lot items were being assigned to staff and were being completed in a timely manner, as leadership set time aside for the QI team to work on these items.

A change in the leadership of the quality improvement department, and outside market forces have impacted their progress in practice transformation. The Executive Director and the Director of Practice Transformation have been working with upper management to find solutions. In conversations with the CEO, other issues have arisen that are out of GCACH's control, but greatly impact the organizations' ability to fully embrace PCMH at this time. While practice transformation may be the solution to some of the internal business challenges, GCACH understands that there are many issues facing business, such as market forces, union negotiations, accreditation standards, and more that compete for a CEO's attention. GCACH remains committed to assisting all organizations under contract, and has given extra time to complete milestones when possible.

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

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

GCACH Response

The GCACH believes that Practice Transformation, through completion of the Milestones deliverables laid out in the GCACH Toolkit, is the optimal strategy for moving providers toward success under value-based payment models. The Toolkit itself is a form of a VBP contract, where providers are paid based on the completion Milestones. When providers have sought additional information regarding the concept of value-based payment, the Practice Transformation team has provided educational materials and resources to suit the provider's need.

Low VBP Knowledge – The Health Center: The Health Center is a school-based clinic in Walla Walla, WA and serves students and staff at Lincoln High School, Blue Ridge Elementary, and the HeadStart/ECEAP Preschool. Practice transformation and value-based care were new topics when the GCACH began its relationship with this clinic. Education on VBP and technical assistance ensured their EHR was configured correctly to capture data that demonstrated the value of the care they were providing. Through an EHR assessment, it was identified that it was not set up to be able to create patient registries or track assessment scores. Once the registries were in place, the Health Center was better able to identify their high-needs patients and to provide the appropriate level of planned care. The PT Milestones that were required for the GCACH also helped with the implementation of strategies that is moving them along the path to success under VBP. Identifying their needs that would move them towards VBP happened during one of their monthly QI meetings. At that meeting, staff from the Health Center mentioned that they were not very familiar with concept of VBP. A plan was then developed that provided them with more information around this topic and the PT Navigator then delivered this information to the staff.

Small provider – Garfield Pomeroy Medical Clinic: Pomeroy Medical Clinic is a small Rural Health Clinic offering primary care to the community of Pomeroy and surrounding area. One of the needs identified to move the clinic towards VBP was more clinical staffing. Pomeroy is a very small rural community that has had recruiting issues relating to medical providers, medical assistants, administrative people and registered nurses. Due to the isolation and small size of the community, it has been difficult to recruit/retain staff. It is also difficult to collaborate with other organizations: The nearest town is about 30 miles away. The GCACH has helped the clinic understand what it really means for their staff to work to the top of their licensure, allowing individuals to become more productive and share greater responsibility of the overall clinical workload. Additionally, the action plan that was developed to tackle their issues, was to move to a better electronic health record that allows them to do quality and population health management reporting along with better billing. In spite of obstacles, the clinic is now better positioned for value-based payment models.

Behavioral Health Provider – Quality Behavioral Health: Quality Behavioral Health (QBH) is a behavioral health provider located in Clarkston, WA. Originally, QBH was reluctant to partner with GCACH and to go through Practice Transformation. Once they moved into Practice Transformation and realized its benefits, they built a closer relationship with the GCACH. QBH is currently participating in Practice Transformation with sites in Cohorts 1 and 2. However, they initially struggled to connect Practice Transformation with VBP. With the funding that GCACH

provided, QBH was able to bring in a medical provider, an RN, upgrade their EHR, and bring in a staff person responsible for directing Practice Transformation within their two participating sites. Through the course of their relationship with the GCACH, QBH has converted to fully integrated care that not only includes behavioral health and primary care but also adds dental care and tele-psychiatry. In some sense, they are becoming a full-service community health center in an area of the state where there are provider shortages, particularly for dental health for Medicaid adults. QBH now also understands the importance of transforming their practice into a Patient Centered Medical Home and how this will positively impact their VBP contracts in the future.

How Practice Transformation Milestones Link to VBP: The PT Toolkit is a mechanism for providers to be successful under VBP models. An example of this is Milestone 5A.2. Under this Milestone, practices are required to provide practitioner or care team reports on at least three clinical quality measures at least quarterly to support improvement in care. The measure list that providers may choose from is equivalent to the list of pay-for-performance measures the GCACH is subject to under the Medicaid Transformation project. The GCACH provides base population health funding of \$140,000 to each organization to support the adoption of ONC Certified EHRs that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes, including the production of clinical quality metrics (e.g. Comprehensive Diabetes Care). This helps provider performance under the models outlined in the Health Care Payment Learning & Action Network (LAN) Alternative Payment Model Framework (ctrl-click [here](#)).

Additional Supportive Activities: During the reporting period, GCACH has worked towards increasing provider knowledge and level of preparation for value-based purchasing. To help meet this end, the GCACH hosted a Learning Collaborative with [Adam Falcone](#) as the key note speaker. Mr. Falcone has considerable experience in consulting with healthcare organizations on how to form better provider contracts. During this particular event, he presented on contracting strategies for value-based purchasing. Additionally, GCACH hosted another Learning Collaborative in September that featured representatives from the four Medicaid MCOs as part of a panel discussion. Each MCO had the chance to answer questions from audience members and the ACH regarding value-based contracts, reimbursement, and required data. At the same September meeting, we had J.D. Fischer from the Health Care Authority give a presentation on the results of the most recent HCA value base payment survey.

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

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

offered, and if so, include a description of the incentives.

GCACH Response

During the reporting period, the GCACH put forth various efforts to support the completion of the 2019 Paying for Value Survey. Greater Columbia ACH posted a newsletter article in its Community Newsletter and in its monthly GCACH Report in both July and August on completing the provider Paying for Value Survey. This newsletter went (ctrl-click [here](#)) out to over 1,100 individuals. Additionally, GCACH offered a \$100 incentive to all provider organizations that completed the survey. This was a practice that achieved great results for the Sentinel Network survey, and created a healthy competition between all ACHs. Lastly, J.D. Fischer from Washington State Health Care Authority (HCA) presented on the importance and the results of the VBP survey at the September Leadership Council/Learning Collaborative meeting. Information on the survey was also posted on GCACH website.

See attached files:

GCACH.SAR4 Attachment 23-1. 1.31.20.pdf

- 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.

GCACH Response

At the September Leadership Council/Learning Collaborative meeting, the GCACH presented the Paying for Value Provider Survey results through a presentation made by J.D. Fischer, Manager at the Value-based Purchasing Policy Division of HCA. The presentation summarized the results of the most recent survey. Leadership Council participants had the ability to view the survey results and to ask questions of J.D. From that discussion, no major needs in technical assistance or support were identified outside what is already being provided through current GCACH Practice Transformation efforts.

See attached files:

GCACH.SAR4 Attachment 23-2. 1.31.20.pdf

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

Documentation

24.P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.⁵ Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster affiliated with Project 2A and 3A. ACHs will gather the responses and report an aggregate summary to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets](#).
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under “ACH pay for reporting metrics.”
- The value of the P4R metric information to HCA is to track progress by primary care, behavioral health and community-based organizations in implementing changes that advance clinical integration and strengthen statewide opioid response. Reporting may evolve over time to ask ACHs to generate reports or increase the participation among providers as needed to track progress on Projects 2a and 3a.

Instructions:

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

Format:

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

Submit P4R metric information.

GCACH Response

See attached files:

GCACH.SAR4 Attachment 24-1. 1.31.20.xlsx

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Update to:

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

Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual reporting guidance
Reporting period: January 1, 2019 – June 30, 2019
SAR 3.0

12. Design Funds.

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

GCACH Response:

From a conversation between Becky Kolln, GCACH Director of Finance and Contracts and Gabby Weik, MHA, HCA Senior Health Policy Analyst, we are resubmitting an updated 2016-2019 Budget versus Actuals file for SAR 3.0.

See attached files:

Section 1.C.12 Budget vs Actuals 2019.xlsx

GCACH.SAR3 Attachment 12-1. 1.31.20.msg

Greater Columbia (GCACH)

July 1, 2019- December 31, 2019

Source: Financial Executor Portal

Prepared by: Washington State Health Care Authority

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A	\$ -	\$ 1,838,773.00	\$ 1,838,773.00
Project 2C	\$ -	\$ 747,001.00	\$ 747,001.00
Project 3A	\$ -	\$ 229,847.00	\$ 229,847.00
Project 3D	\$ -	\$ 459,693.00	\$ 459,693.00
Integration	\$ -	\$ -	\$ -
VBP	\$ -	\$ -	\$ -
Total	\$ -	\$ 3,275,314.00	\$ 3,275,314.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	\$ 44,025.93	\$ 59,820.60	\$ 103,846.53

Table 3: distribution of funds for shared domain 1 partners

	Q3	Q4	Total
Shared domain 1	\$ -	\$ -	\$ -

Table 4: incentive funds distributed, by use category

	Q3	Q4	Total
Administration	\$ -	\$ -	\$ -
Community health fund	\$ -	\$ -	\$ -
Health systems and community capacity building	\$ 671,307.00	\$ 720,422.00	\$ 1,391,729.00
Integration incentives	\$ 1,060,000.00	\$ 1,201,423.25	\$ 2,261,423.25
Project management	\$ -	\$ -	\$ -

Provider engagement, participation, and implementation	\$ 621,301.00	\$ 682,549.00	\$ 1,303,850.00
Provider performance and quality incentives	\$ 723,815.00	\$ 326,062.00	\$ 1,049,877.00
reserve/contingency fund	\$ -	\$ -	\$ -
Total	\$ 3,076,423.00	\$ 2,930,456.25	\$ 6,006,879.25