Semi-annual reporting guidance
Reporting period: July 1, 2020 – December 31, 2020

Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

**SAR 6.0**

*Reporting Period:*

*July 1, 2020 – December 31, 2020*

*DY4 Q3-Q4*

*Updated Template Release Date: December 28, 2020*
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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Achievement values

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

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

*Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period July 1 – December 31, 2020*

<table>
<thead>
<tr>
<th>Number of Projects in ACH Portfolio</th>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NC</th>
<th>NS</th>
<th>OCH</th>
<th>SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of scale &amp; sustain Transformation activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Description of continuous quality improvement methods to refine/revise Transformation activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrate facilitation of ongoing supports for continuation and expansion</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrate sustainability of Transformation activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
### Semi-annual reporting requirements (July 1 – December 31, 2020)

<table>
<thead>
<tr>
<th>Section</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ACH organizational updates</strong></td>
<td>1-8</td>
<td>Attestations</td>
</tr>
<tr>
<td></td>
<td>9-11</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Key staff position changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Budget/funds flow update</td>
</tr>
<tr>
<td><strong>Section 2. Project implementation status update</strong></td>
<td>12-13</td>
<td>Attachments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Implementation work plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Partnering provider roster</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quality improvement strategy update</td>
</tr>
<tr>
<td></td>
<td>15-17</td>
<td>Narrative responses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- General implementation update</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Regional integrated managed care</td>
</tr>
</tbody>
</table>
There is no set template for the semi annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA’s webpage. See instructions for how to format the report below.

**File format**

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

- **Main Report or Full PDF:** ACH Name.SAR6 Report.2.01.21
- **Implementation work plan:** ACH Name.SAR6 Implementation work plan.2.01.21
- **Partnering provider roster:** ACH Name.SAR6 provider roster.2.01.21
- **P4R metrics:** ACH Name.SAR6 P4R metrics.2.01.21

*Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s [Medicaid Transformation resources webpage](https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents).*

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### Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than February 1, 2021 at 3:00 p.m. PST.**

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

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

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 6 – February 1, 2021.”

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The folder path in the ACH’s directory is:


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

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

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2020 – December 31, 2020.

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period July 1 – December 31, 2020 to ACHs</td>
<td>IA</td>
<td>August 2020</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>February 1, 2021</td>
</tr>
<tr>
<td>4.</td>
<td>If needed, issue information request to ACHs within 30 calendar days of report due date</td>
<td>IA</td>
<td>February 25 – March 2, 2021</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>February 26 – March 12, 2021</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>February 27 – March 29, 2021</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>April 2021</td>
</tr>
</tbody>
</table>

**Contact information**

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

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

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>Greater Columbia Accountable Community of Health (GCACH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary contact name</strong></td>
<td>Carol Moser, Executive Director</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>(509) 851-7601</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:cmoser@gcach.org">cmoser@gcach.org</a></td>
</tr>
<tr>
<td><strong>Secondary contact name</strong></td>
<td>Wes Luckey, Deputy Director</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>(509) 851-7784</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:wluckey@gcach.org">wluckey@gcach.org</a></td>
</tr>
</tbody>
</table>
### Section 1. ACH organizational updates

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

#### Attestations

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

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
| **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:  
  - 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](https://wahca.box.com/s/nfesialdec5m1ve6aobhiouw5zeneoh26) or a similar format) that addresses internal controls, including financial audits.² | X   |    |

*(Please see Attachment 1 on page 52)*

| **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 | X   |    |

² https://wahca.box.com/s/nfesialdec5m1ve6aobhiouw5zeneoh26
If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

**Documentation**

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

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

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

*If applicable, include current organizational chart.*

**GCACH Response:**

The previous Director of Finance and Contracts took leave of the GCACH in the second half of 2020. This position is currently posted online and will be refilled. Both the Finance and Contracts Coordinator and the Community and Tribal Engagement Specialist positions, which were vacant, were refilled during the reporting period with new hires to the GCACH.

**Attachment:**

GCACH Organizational Chart *(Please see Attachment 2 on page 59)*

10. **Budget/funds flow.**

   a) **Financial Executor Portal activity for the reporting period.** The Independent Assessor will receive an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. **No action is required by the ACH for this item.**

   b) The ACH is asked to provide additional context to add clarity about the portal activity payments made outside the portal.

   - For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.³

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

GCACH drew down funding from the WA FE Portal in the amount of $17,500 on 11/3/2020 for the Benton-Franklin masking campaign targeted for Spanish-speaking community members.

GCACH also used-up the remaining funding, approximately $4,200, drawn down from the WA FE Portal on 6/30/2020, to supplement the care packages project for Assisted Living Facility residents.

Attachment:

SAR 6 Payment Reconciliation (Please see Attachment 3 on page 60)

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

GCACH Response: There were no non-COVID-19 related WA FEP withdrawals and subsequent payments during the reporting time period.

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

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

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

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

iii. Description of use should be specific but concise.

<table>
<thead>
<tr>
<th>Use of incentives to assist in the transition to integrated managed care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of Use</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Integration Incentives include:</td>
</tr>
<tr>
<td>1. Behavioral Health Internships</td>
</tr>
</tbody>
</table>

4 The HCA issued non-COVID reconciliation spreadsheet can be found at the following link: https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx.
<table>
<thead>
<tr>
<th>Project Description</th>
<th>2020</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Collaboratives/Opioid Summit</td>
<td>$33,344</td>
<td>$50,000</td>
</tr>
<tr>
<td>Opioid Resource Networks</td>
<td>$600,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Project Incentives (Bi-Directional Integration)</td>
<td>$2,601,997</td>
<td>$777,237</td>
</tr>
<tr>
<td>Practice Transformation Staff</td>
<td>$834,889</td>
<td>$415,000</td>
</tr>
<tr>
<td>Telehealth Assistance</td>
<td>$276,660</td>
<td></td>
</tr>
</tbody>
</table>

**GCACH Response:**

Definition: Integrated managed care (IMC) coordinates physical health, mental health, and substance use disorder treatment services to help provide whole-person care under one health plan.

Financial support for IMC is directly related to the clinical integration success of Project 2A: Integration of physical and behavioral health.

Greater Columbia has expended over $14 million since 2018 to support providers in its healthcare delivery system to transition to integrated managed care as defined above. As shown in the table, funds were used to support the region’s 79 sites to:

- Transition successfully to integrated managed care in January 2019 (17 behavioral health agencies, formerly part of the BHO)
- Provide funding for infrastructure investments in electronic health record systems, staffing, physical improvements, and workforce
- Provide incentives to participating providers for behavioral health integration
- Provide behavioral health internships for 54 interns
- Support four opioid resource networks
- Fund telehealth investments
- Sponsor and lead learning collaboratives on VBP contracting, trauma-informed care, self-care, HIPPA and interoperability regulations, shared-decision making and more
- Host a two-day regional opioid summit with CMEs, June 20-21, 2019
- Employ practice transformation staff, including three Practice Transformation Navigators, a Director of Practice Transformation, an Opioid Project Manager, and administrative support

**Bi-directional Integration through Whole-Person Care**

GCACH’s overall strategy for the Medicaid Transformation project (MTP) is to transform 95% of partnering clinics by having them adopt the Patient-Centered Medical Home (PCMH) model of care. The PCMH model is a strategic way to strengthen primary care through a planned approach to care, workforce realignment and bi-directional integration of physical and behavioral health. PCMH models of care are team-based, which supports whole-person care.
through bi-directional integration, transitional care, chronic disease and prevention and the opioid crisis projects, the four project areas chosen by GCACH.

The current state assessment (CSA) that GCACH performed in 2018 identified organizational challenges to bi-directional integration, with the most widely indicated issues being sustainable funding, workforce, and physical space, followed by information technology. The CSA also assessed challenges to providers relative to bi-directional integration. The greatest challenges or needs were managing individuals with chronic disease, depression and anxiety; and patient needs relating to the social determinants of health.

Given these results, GCACH has been facilitating behavioral health integration by providing personal technical assistance and incentives to 79 sites using the Greater Columbia Cares Model (GCCM). Providers are trained on evidence-based models that promote bi-directional integration, management of chronic disease and use of population health tools.

Provider contracts include a revenue sharing model that incents provider to adopt a model of integration whether for behavioral health or primary care; participation in Learning Collaboratives; use of ONC certified information technology; use of the prescription drug monitoring program (PDMP) electronic database; use of population health management tools such as risk stratification, empanelment, and the emergency department information exchange database; and participating in annual MeHAF and PCMH assessments.

GCACH supports two Opioid Resource Networks (ORN). 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). ORNs contracting with the GCACH have provided a bridge between behavioral health and primary care providers, which may not have medication-assisted treatment (MAT) waivered providers or the capacity to take on a large base of patients that have opioid use disorder. Primary care may refer into their local ORN for treatment and wraparound services.

**Behavioral Health Internship**

During 2019, the workforce committee developed a policy that addresses one of the root causes of the maldistribution of behavioral health workers; a lack of resources by the BH organizations to offer clinical experience and preceptors who could supervise interns pursuing a clinical career in behavioral health. The policy was approved by the GCACH Board of Directors at their November 21, 2019 Board meeting, and an application for the funding was approved at their December 19th, 2019 meeting.
Section 2. Project implementation status update

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

Attachments

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

12. Implementation work plan

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

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

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

GCACH Response:

No response for this SAR

13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation. To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH. ACHs should maintain the roster provided by HCA at the time of the SAR4 release for the remaining semi-annual reporting periods.

Instructions:

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

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

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

*Submit updated partnering provider roster.*

**GCACH Response**
**Attachment:**

GCACH.SAR6 provider roster.2.01.21

**Documentation**

The ACH should provide documentation that addresses the following:

14. **Quality improvement strategy update**

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

**GCACH Response**
**Attachment:**

GCACH Quality Improvement Plan *(Please see Attachment 4 on page 61)*

**Narrative responses**

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

15. **COVID-19**

a) Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have changed (i.e.,

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6 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section
which projects remain on track, which projects or areas of focus have expanded, which capacity building efforts have emerged, etc.).

**GCACH Response**

**Changes to Practice Transformation Reporting Dates**

To accommodate COVID-19-related disruptions to the workflows of provider organizations participating in Practice Transformation, the GCACH modified its milestone deliverable reporting dates for Cohorts 1, 2 and 3 *(as shown in Figure 1)*. Reporting deadlines were moved back to allow providers additional time to upload milestone reporting deliverables into the provider reporting portal:

Provider organizations reporting in the second half of 2020 were still expected to meet all the requirements for Milestone reporting outlined in the Greater Columbia Cares Model (GCCM) practice transformation toolkit. As with second quarter, provider incentive payments were expedited to organizations.

Reporting timelines and deliverables for the two Opioid Resource Networks (ORNs), which are tied to MTP Project 3A, continued with the contracted deliverable reporting schedule outlined in their contracts. The Benton-Franklin-Walla Walla ORN had its first deliverables in July. The Board also approved in September a contract extension and year 2 funding with Palouse River Counseling as the ORN Network Manager in Whitman County.

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**Figure 1: GCACH schedule of reporting deadlines for uploading practice transformation Milestone deliverables**
Benton Franklin Masking Communications Campaign

In mid-June, the Benton-Franklin Health District (BFHD) contacted GCACH to lead a community task force to organize a masking communications campaign targeting the Spanish-speaking population in Benton and Franklin counties. At the time, Franklin County had the second highest COVID-19 case rate in the state (as shown in Figure 2).

![Figure 2; COVID-19 case rates as of June 2, 2020 (WA DOH)](image)

As elsewhere, the Hispanic population, which makes up around a third of the bi-county population had been particularly hard hit by the pandemic. BFHD knew that GCACH had offered assistance in the past to mitigate the effects of the pandemic and perceived an alignment between the GCACH’s mission of addressing health disparities and a messaging campaign for Spanish-speaking populations. GCACH approached its Board of Directors on June 18th to seek support for a masking campaign in Benton, Franklin, and possibly Yakima Counties and with a budget of $25,000. Once the campaign was approved and introduced, Tri-Cities Community Health (an FQHC) donated an additional $5,000 towards the campaign.

GCACH began the project by conducting outreach and then convening with Hispanic community leaders from Benton and Franklin counties on July 1st, asking for their help in shaping a message that would resonate with this target group. Representatives from the Tri-Cities Hispanic Chamber of Commerce, Pasco School District, Lourdes Health, Tri-Cities Community Health, Visit Tri-Cities, Kadlec, Benton-Franklin Community Health Alliance, Grace Clinic, Yakima Valley Community Foundation, Community Health Plan of Washington, Benton-Franklin Community Action Agency, City of Pasco, Boys & Girls Club of Benton and Franklin Counties, Downtown Pasco Development Authority, League of United Latin American Citizens, Heritage University, Amber Lives Well, Mission Support Alliance, United Farm Workers, Benton-Franklin Health District, Franklin County, Tierra Vida, and Franklin County PUD provided input on a theme, the messaging, and the outline of television and radio advertisements.

The final campaign featured community leaders (luchadores) wearing colorful lucha libre masks. Lucha libre, meaning “freestyle wrestling” or literally translated as “free fight,” is the term used in Mexico for professional wrestling. Community leaders began their advertising testimony
using the line, “I fight for (e.g., my mother) and that’s why I put on the mask.” *(as shown in Figure 3).*

*Figure 3; Sal Martinez, Mayor, City of Pasco, in a GCACH lucha libre masking commercial*

Two different thirty-second television spots aired on Telemundo and Univision, while two different thirty-second radio spots aired on KZHR, Exitos, La Raza, and La Reyna, throughout the month of August. The campaign launched on August 3, 2020, and the $17,500 budget supported a media mix of television, radio and social media advertisements. To assess the campaign’s impact, GCACH tracked the following outcome measures:

- # of masks distributed including lucha libre masks
- # of COVID-19 cases reported during the campaign period *(as shown in Figure 4)*
- # social media, tv and radio spots aired
- Community masking compliance rates within the overall population
- COVID-19 positivity rates
- COVID-19 death rates

*Figure 4; Benton-Franklin Number of COVID-19 tests with results: July 1, 2020 through August 31, 2020 (WA DOH)*
Yakima Masking Campaign for Spanish Speakers

The Yakima campaign for Spanish speaking individuals ran from mid-September through mid-October, and was funded from GCACH Operations/Design funds. The $11,824 campaign (as shown in Figure 5) featured a mix of radio and television advertising on popular outlets and in social media. Over the course of the one-month campaign period, there were 292 radio spots, 158 television advertisements and 30 social media postings. The Hispanic television and radio stations were matched dollar-for-dollar GCACH campaign funding, thereby increasing the reach and frequency of the advertising. Also, twelve local individuals provided testimonials for two different television and radio advertisements and were featured wearing masks while citing their scripts (as shown in Figure 6).

**Masking Communications Campaign Budget**

<table>
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<th>Item</th>
<th>Budget</th>
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<th>Description</th>
<th>Actuals Yakima Campaign</th>
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<td></td>
<td>$11,824</td>
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Total: $25,000 | $17,509 | $11,824

*Figure 5; Masking Communications Campaign Budget*

*Figure 6; Portions of the television campaign*
**Care Packages for Assisted Living Facility (ALF) Residents**

Building off the Skilled Nursing Facility Packages project (reported in SAR 5), GCACH embarked on its first community fund-raising event in collaboration with Numerica Credit Union in Benton County on August 5 and 6. GCACH partnered with Numerica to host a radiothon and telethon called #ShineThrough for Seniors. The event received an overwhelming local response and raised $14,092 in donations, which were used to purchase care packages for residents of twenty-one Assisted Living Facilities located in Benton and Franklin counties. Activities Directors of the ALFs were able to choose from a variety of themed care packages that best fit their residents. Themed care package options included a Tic Tac Toe package, a technology package, a bingo package, a 1950s diner package, and a Hawaiian package. GCACH also provided a $200 gift card to each of the facilities to be used for the ALF staff’s enjoyment and as a thank you for all their hard work during the pandemic. The amount spent on this initiative totaled $19,639, with GCACH providing the balance of funds through a transfer of $4,178 from the previous Skilled Nursing Facility Initiative plus a direct contribution of $1,369.

**Marketing of a Community COVID-19 Testing Site**

In August, the Health Commons Project, based in Western Washington, teamed up with the Washington State Department of Health to quickly stand up community COVID-19 testing sites in Benton, Franklin and Yakima Counties. As they have been partners for previous GCACH work, the Health Commons Project contacted Greater Columbia Accountable Community of Health (GCACH) to see if they would be interested in supporting the development of a testing site, in collaboration with the Benton-Franklin Health District (BFHD), Columbia Safety and the City of Pasco/Pasco Fire Department. GCACH agreed and took the lead on the test site’s customer outreach and marketing. With a history of successful masking marketing campaigns, including to vulnerable populations, GCACH was well-positioned to market another important resource to the bi-county population during the pandemic; the CBC-West COVID-19 testing site in Pasco.

GCACH returned to its trusted community partners to help message the COVID-19 test site and came to agreement on messaging; “be a lifesaver” for the English messaging and “save a life” for the Spanish messaging. Radio, television, digital and social media advertisements went live the week of October 12, 2020. Advertisements using English and Hispanic spokesmen featured firefighters from the Pasco Fire Department as lifesavers in the community. Community partners for the COVID-19 test site included Pasco Fire Department, Columbia Safety, BFHD, the Washington State Department of Health, the Health Commons Project, and UW Laboratory Medicine.

The community marketing turned out to be an overwhelming success. Cases tested per day eventually surpassed the 500-case capacity (as shown in Figure 7) and the site had to expand from five days of operation to seven. Even though the other existing testing site in the Benton-Franklin region, operated by the National Guard, had been in place for nearly six months prior, the GCACH-marketed site quickly grew to three times the volume of the National Guard site. In a
two-week time period in January 2021, the National Guard site collected test samples from 807 people. In the same time period, the CBC-West site, promoted by GCACH marketing, collected 8,699 samples.

Yakima Masking Communications Campaign Round 2

At its November meeting, the GCACH Board moved for the organization to lead an additional communications effort in Yakima County to wear masks/face coverings and social distance, targeting all community members (both Spanish-speaking and English speaking) and using $25,000 drawn from the 2020 Community Health Fund budget. Similar to the other campaigns, the Yakima county campaign will feature well known community members in its advertisements. The campaign is expected to launch the beginning of January and run through the first week of February.

Mask/PPE Distribution

GCACH continued its efforts in distributing personal protective equipment (PPE) in collaboration with the Health Care Authority (who provided the PPE) and the United Way of Benton and Franklin Counties (who helped store and distribute). By mid-November, GCACH received news that the Health Care Authority (HCA), through the FEMA Cares Act along with public assistance dollars, would be filling requests for Personal Protective Equipment (PPE) to all ACHs across the state. The PPE materials available included gowns, respirator masks, child-sized masks, coveralls, safety goggles, face shields, PAPR kits, and more. GCACH reached out to its seven Local Health Improvement Networks (LHINs) to obtain their orders for PPE for their regions. The LHINs include Benton Franklin Community Health Alliance, Blue Mountain Region Community Health Plan, Kittitas County Health Network, Southeast Washington Alliance Health Partnership,
Whitman County Health Network, Yakima County Health Care Coalition, and Yakama Nation. GCACH gave the LHINs two weeks to collect PPE orders from organizations within their service areas. On December 9th, GCACH received a large order of 22 pallets with a total of 196,013 items of PPE materials. These items were delivered and initially stored at the United Way office. The LHINs were able to pick up their orders of PPE materials between the weeks of December 16-30, 2020. Thanks to the work and help of each LHIN, the ACH was able to serve up to 40 organizations in the Greater Columbia Region.

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

GCACH Response

Through GCACH funding, technical assistance and resources, GCACH supported provider practices to find new ways to deal with the challenges brought on by COVID-19 patient populations:

- **Serenity Point Counseling (SPC)** is a substance use disorder (SUD) treatment provider located in Walla Walla. Previously one of their primary sources of patients were referrals from the local court system: Patients with SUD, identified through arrest and trial, were sent to SPC for treatment. However, the pandemic closed-down in-person trials there, reducing the ability of counselors to meet with patients. In addition, some trials were re-directed to the Tri-Cities, an hour to the west. This drop in business put the counseling agency in financial jeopardy and reduced capacity of SUD providers in Walla Walla. Because of its relationship with Providence St. Mary Medical Center – Walla Walla, the only hospital system and a large medical practice in Walla Walla, and SPC, the GCACH helped forge a collaborative relationship between the SUD practice and the health system. From this arrangement, patients with SUD are now referred from Providence to SPC. Likewise, patients with SUD but no primary care are referred back to Providence to be placed in a patient-centered medical home practice. The GCACH Practice Transformation team has helped support the sustainability of SPC.

- **Providence St. Mary Medical Center’s - Walla Walla** has also changed its approach to caring for COVID-19 patients. The need to focus on high needs, high utilizing patients existed before the pandemic, but the challenges stemming from pandemic refocused the direction of the health system. GCACH practice transformation incentive funding led to the development of the system’s Population Health Management department (PHM) prior to the pandemic. The capabilities developed through their PHM allowed
them to partner with the Walla Walla County Department of Community Health and travel to particular employers such as Tyson Foods, which saw a large outbreak and accompanying deaths, to test employees on site. This testing helped stem the flow of infections and reduced the amount of time the production plant was offline. The PHM also started to employ community health workers who became involved with care coordination and wraparound services for quarantined COVID-19 patients and provided them with oxygen saturation monitors to track patient’s progress. Providence acknowledges that without the GCACH, they would not have developed the population health team in the way they did. The PHM team is integrated with the hospital, its emergency room and its urgent care center, and all of this has led to a more coordinated pandemic response.

Washington 211 (WA211) Partnership

Earlier in 2020, GCACH partnered with WA211 and provided $40,000 to support the development of a more user-friendly, public-facing search application for community resources listed on the www.WA211.org website. Besides phone dialing 211, clients may also identify local resources by using their new search app. GCACH spent considerable time researching online community referral platforms and resource directories (e.g., One Degree, Unite Us, Now Pow) to develop a matrix of optimal features. It also compared different databases to determine that WA211 had in its database the optimal mix of community resources. GCACH shared this research and the features list with WA211, and their technology vendor utilized it in the site’s redesign. Version 1 of the search app had a soft launch on August 3, 2020. Future versions of the search app will add the ability to save “favorites” and have advanced search functionality. A link will also be added to the search page to collect user feedback on their experience with the tool, identify issues and collect suggestions for additional improvements. GCACH is seeking to expand its relationship with WA211 to potentially partner around a community-based care coordination platform.

Data Analytics Support to Pasco Fire Department

As part of its work with Pasco Fire Department (PFD), which provided site management for the COVID-19 community testing site at CBC-West (as shown in Figure 8), the GCACH provided data analytics technical support to the PFD analyst who was processing statistics around clients visiting the test site. Client information (non-Protected Health Information) was analyzed by the GCACH and consultation was provided to PFD on how to analyze and model the data into a dashboard. Elements of the dashboard have been used by Pasco Fire Department and the City of Pasco to monitor site operations and track the site’s progress in testing clients.
GCACH Leadership Council/Learning Collaborative meetings for September and October

Similar to some previous meetings in 2020, the GCACH Leadership Council meetings for September and October focused on COVID-19 related issues and topics. These presentations were geared to support providers, stakeholders and community members, and give them tools to cope with the pandemic.

- **September Meeting:** The GCACH received a presentation from Dr. Kira Mauseth, a clinical psychologist and co-lead of the Behavioral Health Strike Team at Washington State Department of Health, who reviewed the current and potential behavioral health impacts of COVID-19 on large populations. Research has shown that natural disasters follow a predictable pattern in terms of the psychological response or fallout from those populations experiencing the event (as shown in Figure 9). This includes the COVID-19 pandemic, and with it roughly 3 million Washingtonians are expected to experience depression and anxiety symptoms as part of the fallout to this event.

![Figure 8; Image of CBC West testing site captured from newscast](image-url)
Increased rates of substance use disorder and domestic violence are also likely responses. People have also been experiencing problems concentrating, remembering things, tracking tasks and focusing. Knowing this information can normalize the shared experience across an affected population, which by itself can help people build resilience. Healthcare providers are affected by psychological stress (over 70%), and it is critical to prepare providers for this potential, otherwise there may be increased rates of burnout and resulting shortage in capacity. To reduce this from happening, Dr. Mauseth introduced mechanisms to increase resilience (as demonstrated in Figure 10).

Her September presentation had such an impact that it led GCACH to the adoption of the 2021 Cope, Calm, Care model to promote community resilience (as shown in Figure 11).
At the September meeting, the group also received a presentation from Paul Nagle-McNaughton, Senior Director at Comprehensive Healthcare, who reviewed how to recognize and respond to behavioral health concerns that might arise in our communities from “cumulative stress and ambiguous losses.” This includes experiencing one stressor after another stressor.

Common reactions to stress were also discussed, including intrusive reactions, avoidance, physical arousal, grief, and depression. This can lead to a variety of impacts including social isolation, economic impacts, suicide and more. To address these, key groups within the community might receive a variety of “first-aid” trainings: Suicide Awareness for Everyone, Mental Health First Aid, and Health Support Teams.

- **October Meeting:** At this meeting, presentations were provided by GCACH’s funded Local Health Improvement Networks (LHINs) and the associated Third-Party Administrators (TPAs) who administer GCACH’s Community Health Fund. The Benton-Franklin Community Health Alliance discussed how they had hosted webinars for parents on Surviving the “COVID Winter.” The Yakima Valley Community Foundation TPA shared a presentation on their COVID-19 relief funds, which relied on partnerships with United Way of Central Washington and the Latino Community Health Fund. Yakima Neighborhood Health Services LHIN discussed how their housing services identified and isolated quarantined clients. The Whitman County Health Network (LHIN) discussed their ReadyCare Respiratory Center.

**GCACH Learning Collaborative: Allison Massari**

- Allison Massari, inspirational healthcare keynote speaker, presented at the August Learning Collaborative on The Art of Person-Centered Care. This dynamic and poignant
program illuminated the value that healthcare providers have upon a patient who is suffering, and she offered real solutions to the struggle of how to keep the patient first despite limited patient time and other practical constraints. By weaving her remarkable journey with potent life-lessons and her own artwork, Ms. Massari highlighted the integral nature of patient-centered care and worked to reignite audience members’ passion for why they went into healthcare in the first place. She explained, "The power of what you do goes far beyond the technical part of your job. You are healing the places medicine cannot touch. In fact, YOU are the medicine."

c) Describe how your ACH included Tribes/IHCPs in your COVID-19 response activities.

**GCACH Response:**

The GCACH asked Katherine Saluskin, MSW, Yakama Nation Behavioral Health Program Director, to participate in the October HCA Medicaid Transformation Learning Symposium. During that program event, she shared the beneficial experience that her department and the Yakama Nation has experienced working with the GCACH and the work the tribe has been doing to confront the pandemic. The tribal population has been particularly hard-hit by COVID-19. Out of a tribal population of about 15,000, the tribe had reported 1,138 tribal members testing positive, four being hospitalized and 39 dying as of Dec. 14. This means that the Yakama Nation has a COVID-19 death rate of five times that of Washington State overall. COVID-19 vaccines were starting to be distributed to tribal workers on Dec. 17, starting with healthcare workers and extending to essential workers at tribal institutions.

In December, GCACH worked with the Yakama Nation to compile their request of Personal Protective Equipment (PPE), based on the arrangement ACHs have with HCA to request PPE. GCACH was able to deliver face masks, face shields, gowns and more needed PPE to the Yakama Nation as they dealt with the disproportionate impact of the COVID-19 pandemic.

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

**GCACH Response:**

Below is a summary of activities tied to the practice transformation process:

- Reporting deadlines were changed for July and October to allow sites more time to complete reporting requirements. See section 15.a. above.

- Tri Cities Community Health-Pasco School District site was unable to continue services since students were not in school. This GCACH site designation was allowed to transfer to Tri Cities Community Health’s clinic in Richland (a Primary Care Site) to enable to the organization to continue to participate in Practice Transformation.

- Practice Transformation Navigators continued to have virtual meetings with partnering
providers to comply with COVID-19 restrictions on in-person meetings.

- Partnering providers who had conducted an in-person Patient and Family Advisory Committees (PFAC) to provide feedback on patient care, an option under the Greater Columbia Cares Model (GCCM) toolkit, were not able to meet due to COVID-19 restrictions. Practice Transformation Navigators allowed some flexibility in how providers pivoted to gather feedback form patients in the absence of PFAC’s.

- Cohorts 2 and 3 received no contract changes. However, the GCCM Practice Transformation toolkit, which describes practice transformation activities for these organizations, received a moderate refresh and new measures were added. Now providers are required to review their paneled patients against the monthly patient rosters that are provided by the MCOs.

- Provider quarterly reporting continued to occur through uploads to the GCACH provider reporting portal.

- Feedback that was provided by providers led the GCACH to maintain the pre-existing reporting milestones, so no contract adjustments were made and no special reporting was required relative to the COVID-19 pandemic.

- No new provider types or organizations were engaged that had not previously been engaged prior to the reporting period.

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

**GCACH Response:**

**Risk:** Widespread, increased demand for telehealth services and associated lack of broadband access by under-served populations and geographic service areas.

**Mitigation Strategy:** The Internet’s importance is really no longer in question. Once used mainly for entertainment and some commerce, it is essential now a public good that serves healthcare, education, business and much more. Since the onset of the pandemic, the increased need for telehealth services for behavioral health and medical care has continued to expand throughout the GCACH. The GCACH has provided funding for provider organizations to add infrastructure and ramp-up telehealth use within their practices, which has benefit Medicaid beneficiaries and other payer classes of patients. But more remains to be done here, particularly for small providers in rural areas. Compounding this problem is the limited capacity and affordability of high-speed broadband in rural areas for both businesses and consumers. A recent Washington broadband survey by the state’s Department of Commerce highlights the shortage areas in the Greater Columbia region (as shown in Figure 12).
This need is being particularly felt in southeast Washington, where satellite Internet is expensive and unreliable. Addressing this overall issue might be out of the scope and funding of the GCACH, but the ACH sought to address it indirectly. It promoted through its newsletter and elsewhere that residents complete the State’s Broadband Survey. The ACH has also made presentations to the legislators, county commissioners and federal senators that serve its populations. In these presentations, one of the major “asks” was for increased funding and support of broadband capacity within the rural areas of Washington. The GCACH also continues to advocate for adequate reimbursement for providers that utilize telehealth services within their practices.

**Risk:** Hispanic populations disproportionately infected by COVID-19

**Mitigation Strategy:** GCACH has the highest percentage and number of Hispanics (33% and 243,000 residents) of any ACH in the state. And Hispanic populations in Franklin county, Yakima county and elsewhere throughout the GCACH continue to be disproportionately affected by the COVID-19 pandemic (*as shown in Figure 13*). The most recent data indicates that, while Hispanics make up about 13% of Washington’s population, they represent a third of all COVID-19 cases. In Franklin and Yakima counties, Hispanics make up about half of these populations but represent a much higher percentage of overall infections. In part, this accounts for the high case counts in both of these two counties.
The reasons for this disproportionate spread are complex, but for GCACH, it seemed evident in the data that we received on a daily basis; the workers and residents of skilled nursing facilities, food processing, and in agricultural jobs kept popping up as hotspots. There is a definite relationship between essential jobs requiring close proximity of workers, and spread of the virus. There is also a definite demographic to those types of jobs, income paid, and ethnicity. Partnering healthcare provider organizations have informed the GCACH that the Hispanic population is also sometimes inconsistent in its use of precautionary measures (e.g., use of face masks, physical distancing) to prevent spread of the virus.

The GCACH had partnered with the Benton-Franklin Health District (BFHD) to promote widespread community campaigns that promoted masking and testing for the virus, which targeted vulnerable populations, including Hispanics. These campaigns were very successful. Masking use increased and use of the promoted COVID-19 test site was more than ten-fold that of a similar test site being operated by the National Guard in Benton county but which was not promoted. In spite of this, the BFHD, for now, has declined to support future campaigns overseen by the GCACH that support masking or testing. The reasons are unclear, but the ACH hopes to work together with local health jurisdictions in future campaigns.

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

**GCACH Response:**

Garden Village, located in Yakima county, has been participating in practice transformation since January 2020. They provide patients and their families with a holistic approach to long-term, skilled nursing healthcare, in an interactive and innovative environment. The organization offers programs designed to serve populations whose needs cannot be met in a traditional nursing home, including residents with complex psychiatric and behavioral issues that have resulted in multiple failed placements at other facilities. Since beginning practice transformation, Garden
Village has gone from using paper patient records to using an Office of the National Coordinator of Information Technology (ONC) Certified Electronic Medical Record. Despite some initial ‘bumps’ and barriers to implementation, the new EMR is now up and running. This transformation was facilitated by GCACH financial incentives and technical assistance.

In response to the coronavirus pandemic, Garden Village has incorporated some other significant changes. Newly admitted patients are now isolated for 14 days to ensure the absence of COVID-19 symptoms and infection, and then tested weekly thereafter. A negative air flow (laminar) room has also been constructed to ensure that any patient who tests positive for COVID-19 is appropriately isolated and cared for within the Garden Village facility. Risk stratification of patients, an essential milestone in the Greater Columbia Cares Model process, has been updated to incorporate the diagnosis of COVID-19. Patients who test positive are included in this highest risk stratum and receive appropriate care management. The PHQ-9 screening tool for depression is also utilized to monitor patients’ self-assessed physical and mental well-being. Increased isolation has negatively impacted the patients at Garden Village, therefore all patients are assessed for marked changes in their scores. All patients at Garden Village also receive integrated care that addresses both physical and mental health. The team at Garden Village continues to progress in their efforts at practice transformation despite the new challenges associated with the pandemic. Adding nursing facilities into the Greater Columbia Cares model was a radical departure from the affected concept of the traditional patient centered medical home as it was first devised. The success of Garden Village shows that this innovation can work to bring about evidence-based care into new practice types.

16. Scale and sustain update

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

**GCACH Response:**

With the advice of an external financial analyst, GCACH P4P and P4R incentive performance rates were conservatively estimated for 2021 through 2023. Pay-for-performance incentives were originally projected to be 25% for DY3 through DY5. DY3 has since been adjusted through recent analysis performed by the GCACH (as shown in Figure 14).
Project Incentives | Potential Revenue | 2018 | 2019 | Projected Revenue by Calendar Year | 2020 | 2021 | 2022 | 2023 | Total |
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
Project Incentives - Project Plan | $14,424,340 | $14,424,340 | $0 | $0 | $0 | $0 | $0 | $14,424,340 |
Project Incentives - P4R | $43,258,160 | $11,530,000 | $17,260,780 | $9,135,280 | $4,368,300 | $968,800 | $0 | $43,258,160 |
Project Incentives - P4R (DY6) | $13,114,490 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
Project Incentives - P4R | $16,412,020 | $0 | $0 | $0 | $2,101,286 | $1,702,250 | $1,445,625 | $5,249,161 |
Behavioral Health Incentives | $10,183,916 | $4,073,566 | $6,110,350 | $0 | $0 | $0 | $0 | $10,183,916 |
VBP Incentives - P4R | $700,000 | $0 | $300,000 | $250,000 | $150,000 | $0 | $0 | $0 |
VBP Incentives - P4P | $1,500,000 | $0 | $0 | $100,000 | $250,000 | $450,000 | $700,000 | $1,500,000 |
Total Revenue | $99,592,926 | $38,027,906 | $23,671,130 | $9,485,280 | $6,869,586 | $3,116,050 | $2,145,625 | $75,315,577 |

Figure 14: Estimate Incentive Performance Rates

Applying these percentage allocation factors to potential P4R and P4P financial incentives, GCACH has estimated project incentive payments for 2021 to 2023 (as shown in Figure 15).

These potential incentive payments for GCACH were then allocated to planned projects and activities, which produces the following budget for 2021 through 2023 (as shown in Figure 16).
Note that this budget does not assume a funded DY6 so does not include DY6 incentive funding. Even with this budget there are projected to be sufficient funds to extend the Greater Columbia Cares Model (GCCM) implementation and practice transformation activities out until 2023 (as shown in Figure 17).

Practice transformation activities have been intentionally extended into these outyears because, historically, successful organizational performance improvement efforts typically take hold only after three to five years of implementation. These additional years of implementation will ensure that the GCCM has been fully implemented within all of its provider practices.

However, given these large revenue projections and the possibility of additional funds for a DY6, the GCACH Budget & Funds Flow Committee and Board plan to re-evaluate payments for the next three years. They will also be considering additional new project areas, including the implementation of a community-based care coordination infrastructure and platform, and the addition of a fourth provider cohort relating to community paramedicine.

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

**GCACH Response:**

The majority of these funds will be distributed to practice transformation provider organizations and their sites. The distribution of these provider sites by type is (as shown in Figure 18).

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Figure 17; Cash Flow Balances for DSRIP Funds (excluding design and other funding sources)

<table>
<thead>
<tr>
<th>Type</th>
<th>2018</th>
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<th>2020</th>
<th>2021</th>
<th>2022</th>
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<td>18</td>
</tr>
</tbody>
</table>

Figure 18; Distribution of Practice Transformation Provider Types
Additional project funds have been directed to six regional cross-sector collaboratives (Local Health Improvement Networks), two opioid resource networks, multiple community-based organizations addressing the social determinants (Community Health Fund), a program to increase capacity of community health workers and a community resilience campaign directed at mitigating the effects of the COVID-19 pandemic. These funds may also support the development of a fourth Cohort tied to community paramedicine and the infrastructure tied to the development of community-based care coordination platform. There is also considerable tribal investments in their Community Health Aid Program (CHAPS).

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

**GCACH Response:**

The GCACH has budgeted $4.2 million for project management and administrative expenses to oversee and manage this work for 2021 through 2023. GCACH has typically paid salaries through DSRIP funding, with the assumption that programs would not exist without staff support and oversight. Moving forward, the additional year 6 DSRIP money, if approved and allocated by HCA, will propel the program for 2023 and 2024.

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

**GCACH Response:**

GCACH has and will be paying practice transformation providers based on the achievement of Milestones in the Greater Columbia Cares Model (GCCM), which is linked to a budget based on earned VBP, P4P and P4R incentive funds. All practice transformation providers are in at least Performance Year 2 of the GCCM implementation schedule. By 2022 and 2023, provider organizations will be in either Performance Year 3, 4 or 5. The specific revenue sharing models, which uses a distribution of earned P4P and P4R incentives, has not yet been developed for outyears beyond Performance Year 3. The GCCM revenue sharing schedule for Performance Years 2 and 3 is *(as shown in Figure 19).*
a) If applicable, describe how any other P4R or P4P funds (already earned or to be earned before the end of the DSRIP period) have been obligated for ACH or provider payments post-2021.

**GCACH Response:**

The revenue sharing models for Performance Years 4 and 5 of the Greater Columbia Cares Model have not yet been devised. These models will either repeat the revenue sharing model of Performance Year 3 or will use a fraction of the funding of that particular model. The act funding for these out years has yet to be determined by the Budget & Funds Flow committee and Board of Directors.

b) Assessment of DSRIP sustainability:

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

**GCACH Response:**

Activities to support GCACH sustainability started in earnest in 2020 after hiring Chelsea Chapman who is a former consultant and skilled in strategic and sustainability planning. Chelsea had worked for a company called NewEdge who used a process call Opportunity
Thinking to lay the foundation for a sustainability plan (as shown in Figure 20). Opportunity Thinking is grounded in understanding the needs of the market, the conditions that make it the right time, and the value propositions that can be delivered. She conducted workshops and consulted with outside stakeholders to identify core competencies, values, and key strengths of GCACH in early 2020.

![Opportunity Thinking Process](image)

**Figure 20; Opportunity Thinking process**

Building off the GCACH’s 2019 retreat, Chelsea developed a framework that was presented at the August 20, 2020 GCACH Board retreat that illustrated the organization’s core competencies, market analysis and funds flow. Core competencies capture the knowledge, skills, and attitudes that an organizations possesses, and helps them align opportunity with their skillset. Through this process the following GCACH core competencies were validated by the Board:

- Consultant for integrated primary care systems
- Connector for local, state, and government entities
- Champion for health equity and social determinants of health

The purpose of the retreat was to gain approval to develop a business and financial plan for beyond 2021, which was approved. The plan will be comprised of a marketing plan, financial plan, and management/operations plan. Key phases of this work involve an environmental scan and meeting with stakeholders (healthcare providers, community-based organizations, etc.) to inform and guide the strategic direction of GCACH.

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

**GCACH Response:**

Washington’s nine Accountable Communities of Health (ACHs) have worked together to identify areas of collaboration, coordination and alignment since 2018. Discussions around sustainability have been featured at Learning Symposiums, State of Reform, joint meetings with Managed Care Organizations and the Health Care Authority (HCA), one-on-one meetings with HCA Director Sue Birch, Medicaid Director MaryAnne Lindeblad, and with HCA senior policy leadership.

Work began in earnest when the ACHs hired Artemis Consulting in the Spring of 2019 to facilitate strategy development, alignment and decision making around financing strategies including ACH sustainability.

By February of 2020, a shared framework for sustainability of the ACHs was developed with the recommendations that ACHs develop a clear and consistent message that articulates the ACH value proposition, and develop communication materials that articulate and demonstrate this value. A website domain name was purchased in April 2020, https://washingtonch.org/, and policy papers on Care Coordination, Community Information Exchange, and Equity and Social Determinants of Health were posted.

ACH Leaders have also been working with HCA on a Social Investment Fund model concept that holds the potential to play a key role in ACH sustainability. In December the ACHs finalized a two-page document crafted for legislators that could be utilized for messaging the value of ACHs in the transformation ecosystem, and sent a joint letter to Sue Birch, Director of the Health Care Authority to express the GCACH’s commitment to working in partnership on the extension of the Medicaid Transformation Project.

Another activity implemented for GCACH sustainability was a program of outreach to elected leaders representing the nine-county region. Between February and December, GCACH staff met with State Senators Brown, Warnick, King, and Schoesler and Representatives Ybarra, Dent, Corry, Jenkin, Rude, Klippert, Bohynke, and Dye. GCACH staff also met with Congressional staff for Senators Murray and Cantwell and Congressman Newhouse. GCACH made presentations to these individuals to explain the work of GCACH and its importance to their constituents.

As an internal measure, GCACH created a Sustainability workstream in 2020 to ensure progress was being made toward sustainability. A second Board retreat was held in August, and the Board approved moving forward with a business plan to identify market opportunities that leverage the assets of GCACH and build upon its core competencies. The plan will include a 3-year implementation plan to leverage the most viable market opportunities to support a sustainable future for GCACH, and should be completed by July 2021.
iii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation and/or scaling of specific DSRIP project toolkit evidence-based models and/or pilots (e.g. Community Based Care Coordination, CoCM). If you have not supported related activities and/or conversations during the reporting period, please explain why.

**GCACH Response:**

GCACH hopes to have greater clarity with respect to the Medicaid Transformation Project (MTP) extension by June. During the summer of 2020, GCACH became aware that HCA was asking for an MTP extension from CMS due to COVID-19. Because of this disruption, a true analysis of the effectiveness of the MTP could not be demonstrated, leading the HCA to ask for an extension. CMS approval is contingent on receiving authorization from the Washington State Legislature to continue the MTP which will probably not be known until late Spring.

Planning for 2021, 2022, and 2023 as shown in the cash flow spreadsheet below demonstrates GCACH projections to fund MTP projects and activities at least through 2023 (as shown in Figure 21).
These activities include continued investment in transformation project areas, Tribal programs, regional campaigns, Local Health Improvement Networks, workforce, and the social determinants of health.

17. Regional integrated managed care implementation update

a) For 2020 adopters, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken, in partnership with providers and MCOs, to address these challenges?

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

GCACH Response

From the standpoint of integrated managed care implementation, the GCACH continues to foster collaboration between its contracted behavioral health agencies (BHAAs) and with the MCOs, Greater Columbia Behavioral Health (the Behavioral Health: Administrative Services Organization or BH-ASO) and HCA. This approach continues to be successful and has been carried out mostly through monthly scheduled provider meetings that include participation from all of these organizations. These meetings provide the behavioral health agencies (BHAs) a place to ask questions and discuss barriers to IMC implementation. GCACH has worked hard to keep lines of communication open between all parties. However, there are some ongoing
issues. Below are some of the recent major challenges that have arisen during the ongoing implementation process:

- **Supplemental Data Request from MCOs:** Officially, this process went live as of 10/1/2020, but there are still some issues being addressed, and the GCACH Navigators have been notified by BHAs of challenges around the manual data submission process. Beacon, the outside vendor contracted to support this work, has reportedly been less than supportive of providers in providing guidance or assistance. Issues also arose around the go-live timeframe. They BHAs continue to work through this, but this has been a financial issue as it has cost them money from having to have their EHRs updated with specific data entry templates and the associated labor cost. The MCOs are aware of these issues and are continuing to work on them.

- **MCO Claims Payments:** Claims being paid late by the MCO has been an issue since the inception of IMC. The GCACH has often acted as an intermediary between the BHAs and the MCOs, for some of these incidents, and has facilitated providers to work directly with their provider contacts within each of the MCOs. Payment delays have improved, which is progress, but some MCOs continue to perform better than others.

- **Service Encounter Reporting Instructions (SERI) Guide:** The SERI guide was released in December of 2020, and many changes have been made to the SERI guide, which is provided by HCA. There were initial challenges with simply getting the most up-to-date guide to the BHAs, as well as issues around the interpretation and use of the latest guide. Through HCA’s continued support and participation in the roll-out process, this has largely been resolved. Currently, all of the BHAs have and are following the correct guide.

- **MCO reimbursement:** The BHAs have stated that reimbursement rates for some procedures were not keeping pace with the underlying cost increases associated with managing patients who receive medicated assisted treatment (MAT) services. Slowly, this has improved between the MCOs and individual BHA Providers. Connecting the individual BHA with the right contact person in the MCO has helped facilitate resolution in many instances.

- **Challenges with submitting authorization or pre-authorization for services:** There have been general challenges with submitting authorizations or pre-authorizations for a variety of services, sometimes resulting in denials. This recurrent topic is being worked out through general discussions with the MCOs, BHA providers, and HCA but may continue to be an ongoing issue. The Provider meetings have created a useful venue for BHAs to discuss this with the MCOs.

GCACH continues to develop their relationship with the BH-ASO *(as shown in Figure 22).* GCACH received $10,182,566 in integrated managed care funding during 2018 and activities made presentation to the BH-ASO on July 2nd on how these funds were being used. The presentation highlighted the GCACH overall successes in behavioral health integration, practice transformation, telehealth, and the $850,000 Behavioral Health Internship fund. The presentation was well received.
c) For **all regions**, what steps has the ACH taken, or what steps does the ACH plan to take, to support coordination with local, regional and statewide partners to design and implement strategies to address gaps and barriers impacting the health system in response to integrated managed care implementation?

**GCACH Response**

- **Provider Meetings:** As described in the previous section above, the GCACH has continued to convene monthly provider meetings to discuss, address and many times, resolve issues affecting the local behavioral health agencies and their relationships with other organizations. These meetings have included regional and state partners, such as the MCOs and HCA, and occasionally vendor organizations, such as Beacon. This meeting venue continues to support a coordinated response across many delivery system players.

- **Ties with the Behavioral Health ASO:** The GCACH and the BH-ASO have strengthened their relationship in the last 6 months, inviting them to be participate in one of the learning sessions that focused on regional crisis response services. This helped with the knowledge gap in the ACH’s understanding of the nature and extent of crisis services in its service area and what the BH-ASO was doing to manage these services under its contract through HCA. The GCACH is now attending the ASO’s regularly scheduled meetings. Through these activities, the ACH has forged closer ties with this regional service provider.

- **Collective Medical:** The Collective Medical platform provides software for provider organizations and integrates hospital admission, discharge and transfer (ADT) data into provider workflows. Managing patients that have experienced high ED or inpatient use has been a priority for the GCACH practice transformation process, and the use of this platform for BH providers has been a result of IMC implementation. The Collective Medical platform has informed practices as to patients with high institutional utilization. The implementation
of this software has come about through the ACH’s relationship with the MCOs, who are subsidizing the related software costs. Implementation has also extended beyond primary care to include behavioral health and even EMS. Receiving support for all these organizations took some effort, but the MCOs now acknowledge the usefulness of providing this technology in these settings. The process of following-up on patients after they receive hospital services is also an essential component of the GCACH Practice Transformation Toolkit. Prior to all this, there were significant knowledge gaps on the part of the behavioral agencies about their clients presenting to the emergency departments for behavioral health issues.

- **Opioid Resource Networks**: The four Opioid Resource Networks (ORNs) contracting with the GCACH have provided a bridge between behavioral health and primary care providers, which may not have medication-assisted treatment (MAT) waived providers or the capacity to take on a large base of patients that have opioid use disorder. Primary care may refer into their local ORN for treatment and wraparound services.

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

**GCACH Response**

All the behavioral health providers contracted with GCACH are going through Practice Transformation. It is a requirement that all of its behavioral health agencies (BHA) integrate in some way either with primary care or with mental health or with substance use disorder agencies. This is done through the Greater Columbia Cares Model practice transformation process. The Practice Transformation Navigators work with each of the BHAs to provide technical assistance, training, and resources to ensure that bi-directional integration is completed.

**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.

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

If the ACH checked “No” in item above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.
Section 3. Value-based Payment

This section outlines questions specific to value-based payment (VBP) milestones in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 4, Q4.

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

Narrative responses

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

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

GCACH Response

To adequately respond to this question requires acknowledging an inconvenient truth: The Managed Care Organizations in the GCACH, and elsewhere, are reluctant to form value-based payment arrangements with small, rural providers. This was stated directly to the GCACH by one of the largest MCOs in Washington and, in part, explains the low VBP penetration by providers in the GCACH (as shown in Figure 23).

![Figure 23; 2019 Levels of VBP adoption by ACH](image)

The MCO’s reluctance could be explained by way of administrative efficiency; it’s easier to form contracts with a few large provider organizations covering thousands of lives than it is to contract with many more smaller provider practices that may serve tens or hundreds of Medicaid beneficiaries. It is also financially riskier for smaller practices to implement more robust and advanced risk-sharing payment models, where even one or two high-utilizing patients can place the provider at financial risk. However, it is also true, according to JD Fischer
with HCA, that there are some modest VBP contracting arrangements that small rural practices could still take on immediately. This remains the largest barrier to implementation of VBP.

The GCACH has served many roles in supporting the implementation of VBP. The Greater Columbia continues to support the completion of the annual Paying for Value Provider Survey and has also sponsored an annual convening focused on VBP (both described below). The GCACH has also openly and vehemently advocated to both HCA and the MCOs the need to support VBP contracting with these smaller practices and behavioral health agencies. Most importantly, the GCACH has developed the Greater Columbia Cares Model, likely the most comprehensive, evidence-based practice transformation model for preparing providers for successfully managing individuals with chronic conditions and for preparing providers for VBP contracting.

For provider practices themselves, there are additional barriers that impact them moving towards value-based care. One is providers’ low-level of knowledge about what value-based care looks like in practice, due to a lack of emphasis on VBP in the past. This is truer of very small rural providers, like Pomeroy Medical Clinic in Pomeroy, WA. With a small patient population and having issues with retention and recruitment of staff, and MCOs being reluctant in entering into VBP; the Pomeroy Medical Clinic has not focused much on VBP. Although, with the implementation of the GCCM and better understanding on the value of conducting population health management and education provided through learning collaboratives, headship council meetings and technical assistance from the Practice Transformation Navigator, their knowledge of VBP has increased.

Another barrier for providers is inadequate or poorly configured EHRs or no technology to track clinical quality measures. Throughout the Greater Columbia Region, many providers do not have the proper templates integrated into their EHRs, their staff are documenting and charting inconsistently within the EHR or they lack the proper population health management tools integrated with their EHR to account for things like HEDIS measures.

All of the provider-level barriers above have been identified by the GCACH Practice Transformation Navigators (PTNs), which continually meet with contracted providers, and are being documenting in their Practice Transformation Implementation Workplans for monitoring and review. The PTNs have also strategized with these practices on how to resolve issues. Another strategy that GCACH uses to identify provider barriers is by analyzing GCCM Milestone data uploaded by contracted practices on a quarterly cadence into the provider reporting portal. Once the uploaded data has been analyzed by the GCACH Practice Transformation team and barriers have been identified, targeted resources and technical assistance are provided.

For example, Kadlec Clinics in Kennewick and Pasco had inconsistent Milestone reporting in the reporting portal relative to the number of patients empaneled for their Primary Care Providers. Upon review of the empanelment statistics in the CSI Portal, it became obvious that the numbers reported were incorrect. Significant turnover of staff had impacted the application of a consistent method of defining and tracking empaneled patients within Kadlec Clinics. The
Practice Transformation Navigator worked closely with the leader of the Practice Transformation for Kadlec Clinics to provide education using the Safety Net Patient Centered Medical Home resources and tools. After discussing the electronic health record functionality and associated workflows for measuring empaneled patients, Kadlec Clinic was able to define a methodology, apply it consistently and be able to track the number of empaneled patients in their clinics.

Another example is First Step Community Counseling Services in Benton County. They did not have a reliable system to track patients that had recently been seen in the Emergency Room or been hospitalized. This type of follow-up in primary care would be a generally accepted practice but was previously not done by a behavioral health agency. Through its relationship with GCACH, the Collective Medical platform (an admission, discharge, transfer (ADT) notifications platform) has been implemented in this and other practice transformation practices to gain access to this important information so to prevent future utilization. After implementing Collective Medical, the leader of practice transformation at First Step commented, “As I reviewed the information we received from Collective Medical, I could see pieces of the patient’s story. An initial ED visit with a fracture and prescription of pain medication. Subsequent ED visits for pain and anxiety. It was remarkable to see this valuable information that could be used to better understand and care for patients.” Because of the sponsorship by the MCO’s for the Collective Medical Platform, this valuable resource is available to smaller rural partnering providers. It has provided an invaluable tool in managing care coordination.

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

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

**GCACH Response:**

Practice Transformation Navigators provide education and training around identified issues, and connect sites with other organizations to compare processes and workflows. Some issues are escalated to the Director of Practice Transformation to gain additional insights. Collaboration between practice transformation sites and the GCACH Practice Transformation team is a core principle of the Greater Columbia Cares Model.

Navigators also provide technical assistance, offering explanations on the purpose and importance of empaneling patients to individual clinicians or teams, and how that leads to the identification of high-risk patients.

The Director of Practice Transformation provides education and assistance particularly when sites are looking into using modified billing codes to receive enhanced reimbursement for services not currently being billed.
The level of support varies from site to site and also depends on the types of clinical services being provided to clients. For large organizations, the level of support might not be as intensive as for a smaller provider. This is due to large organizations having the resources and staff to tackle identified barriers. For smaller practices including behavioral health providers, the level of support can vary based on the support given from their executive leaders. Smaller organizations may also have more intensive levels of support, especially for behavioral health providers, as some of the things that have or need to be implemented are things that might be new to them. For larger organizations it is sometimes more difficult to get approval for implementation of new processes because of layers of management review.

For example, Chaplaincy Behavioral Health, a small behavioral health provider in Benton County, was having difficulty assessing patients’ need for self-management. They were connected with an exemplar organization, Catholic Charities, to learn about the Patient Activation Measure assessment tool to accomplish this. Chaplaincy Behavioral Health has adopted this best practice and has incorporated the use of the Patient Activation Measure scores into their workflows. Chaplaincy Behavioral Health will be able to assess patients’ need for Self-Management Support, and demonstrate the impact by using the Patient Activation Measure and associated data reports.

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

a) Provide an example of the ACH’s efforts to support completion of the state’s 2020 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

**GCACH Response:**

The GCACH continues to support completion of the annual Paying for Value Survey by its provider organizations. Below are some of the tactics that we have recently deployed:

- On August 26, 2020, GCACH distributed a flyer through an e-mail blast, using its comprehensive list of over 1,500 organizations throughout the nine-county region *(as shown in Figure 24)*. The message encouraged organizations to complete the Paying for Value Provider survey and provided a $100 incentive to take the survey.
• GCACH Practice Transformation Navigators, which provide technical assistance to 79 practice sites, encouraged organizations to participate in the survey through personal emails and their ongoing communications with site personnel.

• GCACH placed an article in its June and July 2020 Newsletters urging provider organizations to complete the Paying for Value Provider survey. The newsletter article also offered the $100 incentive for completing the survey.

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:**

**November Leadership Council meetings devoted to sharing VBP survey results**

HCA has been presenting the results of the Value Based Purchasing (VBP) survey at the November GCACH Leadership Council meetings since 2018. The survey is conducted during the month of August, allowing the Health Care Authority time to gather the results and do report outs to the ACHs in late fall. The presentation is typically given by HCA’s Senior Health Policy Analyst, J.D. Fischer. J.D. was joined by Mia Nafziger to present the survey findings at the November 19th 2020 meeting.

J.D. showed the chart below explaining that payments in the alternative payment category showed statewide VBP adoption at 69% according to the survey results. In 2020, the results of the survey indicate that the GCACH region had the second lowest VBP adoption rates compared to other ACHs (as shown in Figure 25).

![MCO VBP by Accountable Community of Health](image)

*Figure 25; VBP Adoption by ACH3*

Value-based purchasing (VBP) is a payment model that offers financial incentives to physicians, hospitals and other healthcare providers for meeting certain performance measures. The purpose of VBP is for providers to assume more accountability for the quality and cost of care, incentivizing higher-value care.

Providers contracted with GCACH are incented to reach milestones that are part of the Greater Columbia Cares Model which uses evidence-based practices adopted from the Patient-Centered Medical Home (PCMH) model of primary care delivery, and other evidence-based sources including the Comprehensive Primary Care Initiative, the Safety net Medical Home Curriculum, and Six Building Blocks. In PCMH practices, patients receive well-coordinated services and
enhanced access to a care team. Providers practicing in PCMHs use decision support tools, measure their performance, engage patients in their own care and conduct quality improvement activities to address patients’ need.

To this end, GCACH has been working with providers to ready them for VBP contracts as shown in the survey results. VBP assistance received the most votes for the type of technical support providers were wanting and receiving (as shown in Figure 26).

**Figure 26: Results on technical assistance from HCA 2019 Paying for Value survey (WA HCA)**

*In fact, providers in the GCACH region are ready for VBP arrangements, yet there seems to be a low adoption rate for the region.*

GCACH took the opportunity to use J.D.’s presentation findings to host provider and MCO panels at the November 19th Leadership Council meeting to get their feedback and reaction (as shown in Figure 27).

**Figure 27; GCACH Leadership Council Agenda for November 2020**

Healthcare providers offered these barriers to VBP:

- Lack of engagement or communications from the payors
- The reimbursement model is extremely variable across the state
• Long lag time for quality and claims data, it can be months
• Quality metrics are different across payors
• Rural areas are aggregated together which produce nonsensical reports that are not relevant or meaningful

The MCOs offered:
• It is not safe from a risk standpoint for smaller providers to take on any risk for such a small population because the incentive varies widely
• This is a partnership between provider and MCO and they must work together to align incentives and shared goals

ACH Transformation Alignment Call

The survey results were discussed at an ACH Transformation Alignment call in December. During this call, it was confirmed that the MCOs are being held at a different standard of VBP adoption rate than ACHs. Several ACHs raised the issue of inequity for smaller providers in rural areas.

Education to Legislators

GCACH has also used the survey results to educate legislators across the region. A major tenet of transforming the healthcare system relies on transforming the payment model. GCACH has educated and incented providers in anticipation that VBP contracts will follow, but the Managed Care Organizations and Health Care Authority have yet to respond through HCA contractual changes with the MCOs.
Section 4. Pay-for-Reporting (P4R) metrics

Documentation

22. P4R Metrics

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

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: How to read metric specification sheets.
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under “ACH pay for reporting metrics.”

Instructions:

a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).

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

Format:

a) ACHs submit P4R metric information using the reporting template provided by the state.

Optional: The ACH may submit P4R metric information.

GCACH Response

Attachment:

GCACH.SAR6 P4R metrics.2.01.21

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7 https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121
Organizational Self-Assessment of Internal Controls and Risks

ACH Name: Greater Columbia Accountable Community of Health

Date Prepared: January 29, 2021

Answer "Yes" if the activity in question is performed internally or externally (unless specified). Each "No" answer indicates a potential weakness of internal fiscal controls. All "No" answers require an explanation of mitigating controls or a note of planned changes. If the activity does not apply to your organization, answer N/A.

I. CONTROL ENVIRONMENT
A. Management’s Philosophy and Operating Style

<table>
<thead>
<tr>
<th>Yes</th>
<th>N/A</th>
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1. Are periodic (monthly, quarterly) reports on the status of actual to budgeted expenditures prepared and reviewed by top management?

2. Are unusual variances between budgeted revenues and expenditures and actual revenues and expenditures examined?

3. Is the internal control structure supervised and reviewed by management to determine if it is operating as intended?

B. Organizational Structure

<table>
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<tr>
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4. Is there a current organizational chart defining the lines of responsibility?

5. Have all staff been sufficiently trained to perform their assigned duties?

C. Assignment of Authority and Responsibility

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6. Are sufficient training opportunities to improve competency and update employees on Program, Fiscal and Personnel policies and procedures available?

7. Have managers been provided with clear goals and direction from the governing body or top management?

8. Is program information issued by the Health Care Authority distributed to appropriate staff?

II. HUMAN RESOURCES
A. Control Activities/Information and Communication

<table>
<thead>
<tr>
<th>Yes</th>
<th>N/A</th>
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1. Are personnel policies in writing?

2. Are personnel files maintained for all employees?
II. HUMAN RESOURCES (continued)
A. Control Activities/Information and Communication

Yes  N/A  No

3. Are payroll costs accurately charged to grants using time spent in each program?

4. Are accurate, up-to-date position descriptions available?

5. Do all supervisors and managers have at least a working knowledge of personnel policies and procedures?

6. Does each supervisor and manager have a copy or access to a copy of personnel policies and procedures?

7. Does management ensure compliance with the organization’s personnel policies and procedures manual concerning hiring, training, promoting, and compensating employees?

8. Are the following duties generally performed by different people?

   a. Processing personnel action forms and processing payroll?

   b. Supervising and timekeeping, payroll processing, disbursing, and making general ledger entries?

   c. Personnel and approving time reports?

   d. Personnel and payroll preparation?

   e. Recording the payroll in the general ledger and the payroll processing function?

9. Is access to payroll/personnel files limited to authorized individuals?

10. Are procedures in place to ensure that all keys, equipment, credit cards, cell phones, laptops, etc. are returned by the terminating employee?

11. Is information on employment applications verified and are references contacted?

III. ACCOUNTS PAYABLE
A. Control Activities/Information and Communication

Yes  N/A  No

1. Has the organization established procedures to ensure that all voided checks are properly accounted for and effectively cancelled?
III. ACCOUNTS PAYABLE (continued)
A. Control Activities/Information and Communication

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<th></th>
<th>Yes</th>
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2. Do invoice-processing procedures provide for:

- a. Obtaining copies of requisitions, purchase orders and receiving reports?

- b. Comparison of invoice quantities, prices, and terms with those indicated on the purchase order?

- c. Comparison of invoice quantities with those indicated on the receiving reports?

- d. As appropriate, checking accuracy of calculations?

- e. Alteration/destruction of extra copies of invoices to prevent duplicate payments?

- f. All file copies of invoices are stamped/marked paid to prevent duplicate payments?

3. Are payments made only on the basis of original invoices and to suppliers identified on supporting documentation?

4. Are the accounting and purchasing departments promptly notified of returned purchases and are such purchases correlated with vendor credit memos?

5. Are monthly reconciliations performed on the following:

- a. All petty cash accounts?

- b. All bank accounts?

6. Are the following duties generally performed by different people?

- a. Requisitioning, purchasing, and receiving functions and the invoice processing, accounts payable, and general ledger functions?

- b. Purchasing, requisitioning, and receiving?

- c. Invoice processing and making entries to the general ledger?

- d. Preparation of cash disbursements, approval of them, and making entries to the general ledger?

7. Is check signing limited to only authorized personnel?

8. Are disbursements approved for payment only by properly designated officials?
III. ACCOUNTS PAYABLE (continued)
A. Control Activities/Information and Communication

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<th>Yes</th>
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9. Is the individual responsible for approval or check signing furnished with invoices and supporting data to be reviewed prior to approval or check-signing?

10. Are unused checks adequately controlled and safeguarded?

11. Is it prohibited to sign blank checks in advance?

12. Is it prohibited to make checks out to the order of "cash"?

13. If facsimile or e-signatures are used, are the signature plates adequately controlled and separated physically from blank checks?

14. Are purchase orders pre-numbered and issued in sequence? (Not pre-numbered but issued in sequence)

15. Are changes to contracts or purchase orders subject to the same controls and approvals as the original agreement?

16. Are all records, checks and supporting documents retained according to the applicable record retention policy?

IV. COMPLIANCE SUPPLEMENT ELEMENTS
A. Cash Management
Control Activities/Information and Communication

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<th>Yes</th>
<th>N/A</th>
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1. Are requests for advance payment (A-19's) based on actual program needs?

2. Are the following duties generally performed by different people?
   a. Preparing the request for payment from HCA (A-19)?
   b. Reviewing and approving the request for advance payment from HCA (A-19)?

B. Equipment and Real Property Management
Control Activities/Information and Communication

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<thead>
<tr>
<th>Yes</th>
<th>N/A</th>
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4. Are all disposals of property approved by a designated person with proper authority?

5. Has organization management chosen and documented the threshold level for capitalization in an internal policy/procedure book?

Page 4 of 7
### IV. COMPLIANCE SUPPLEMENT ELEMENTS (continued)

#### B. Equipment and Real Property Management

**Control Activities/Information and Communication**

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6. Is someone assigned custodial responsibility by location for all assets?
7. Is access to the perpetual fixed asset records limited to authorized individuals?
8. Is there adequate physical security surrounding the fixed asset items?
9. Is there adequate insurance coverage of the fixed asset items?
10. Is insurance coverage independently reviewed periodically?
11. Is a fixed asset inventory taken annually?
12. Are missing items investigated and reasons for them documented?

#### C. Procurement and Suspension and Debarment

Non-Federal entities are prohibited from contracting with or making sub awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of $100,000 and all non-procurement transactions. [Http://www.sam.gov/](http://www.sam.gov/) This website is provided by the General Services Administration (GSA) for the purpose of disseminating information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits.

**Control Activities/Information and Communication**

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<th>Yes</th>
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</table>

1. Is there established segregation of duties between employees responsible for contracting; accounts payable and cash disbursing.
2. Is the contractor’s performance included in the terms, conditions, and specifications of the contract monitored and documented?
3. Do supervisors review procurement and contracting decisions for compliance with Federal procurement policies?
4. Are procedures established to verify that vendors providing goods and services under the award have not been suspended or debarred by the Federal government?
### C. Procurement and Suspension and Debarment

**Control Activities/Information and Communication**

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

5. Are there written policies for the procurement and contracts establishing:

- [ ] a. Contract files
- [ ] b. Methods of procurement
- [ ] c. Contractor rejection or selection
- [ ] d. Basis of contract price
- [ ] e. Verification of full and open competition
- [ ] f. Requirements for cost or price analysis
- [ ] g. Obtaining and reacting to suspension and debarment certifications
- [ ] h. Other applicable requirements for Federal procurement
- [ ] i. Conflict of interest

6. Is there written policy addressing suspension and debarments of contractors?

7. Are there proper channels for communicating suspected procurement and contracting improprieties?

8. Does management perform periodic review of procurement and contracting activities to determine whether policies and procedures are being followed?

### D. Reporting

**Control Activities/Information and Communication**

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<th>Yes</th>
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1. Are personnel responsible for submitting required reporting information adequately trained?

2. Does management review required reports before submitting?

### E. Single Audit

**Control Activities/Information and Communication**

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<th>Yes</th>
<th>N/A</th>
<th>No</th>
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</thead>
</table>

1. Was the organization audited by an objective accounting firm this past fiscal year?

2. Did appropriate organization staff review the findings of the previous years' audit as preparation for the current year audit?
E. Single Audit (continued)
Control Activities/Information and Communication

<table>
<thead>
<tr>
<th>Yes</th>
<th>N/A</th>
<th>No</th>
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3. Have all audit findings and questioned costs from previous years been appropriately resolved?

V. CERTIFICATION

I hereby certify that the information presented in this self-assessment of internal controls and risk is true, accurate, and complete, to the best of my knowledge.

Organization Name

Greater Columbia Accountable Community of Health

Authorized Official Signature  

Date 1/29/2021
Greater Columbia ACH Organizational Chart
12/31/2020

Board of Directors

Executive Director
(Carol Moser)

Deputy Director
(Wes Luckey)

Director of Finance and Contracts
(vacant)

Director of Practice Transformation
(Sam Werdel)

Marketing Manager
(Lauren Noble)

Opioid Resource Network Project Manager
(Diane Halo)

Finance and Contracts Coordinator
(Sula Savchuk)

Practice Transformation Navigator
(Martin Sanchez)

Community and Tribal Engagement Specialist
(Brissa Perez)

Administrative Assistant
(Chelsea Chapman)

Practice Transformation Navigator
(Laurel Avila)

Practice Transformation Navigator
(Brittany FoxStading)
<table>
<thead>
<tr>
<th>Transaction #</th>
<th>Amount withdrawn ($)</th>
<th>Date funds drawn</th>
<th>FE Use category used to draw down the funds</th>
<th>Expenditure detail</th>
<th>Amount paid ($)</th>
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<tr>
<td>8611</td>
<td>$17,500.00</td>
<td>11/3/2020</td>
<td>Health Systems and Community Capacity Building</td>
<td>Sinclair Broadcast</td>
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<td>Spotted Fox</td>
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<td>Diamante Media</td>
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<td>Telemundo</td>
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<td>Sonja Photography</td>
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<td>Travel Expenses</td>
<td>$92.60</td>
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<td>Downtown Pasco Development Ass’n</td>
<td>$4,000.00</td>
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<td>7440</td>
<td>$23,340</td>
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<td>Health Systems and Community Capacity Building</td>
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<td></td>
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<td>Bonaventure of the Tri-Cities</td>
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<td>Brookdale Canyon Lakes</td>
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<td>Brookdale Meadow Springs</td>
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<td>Brookdale Richland</td>
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<td>Brookdale Torbett</td>
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<td></td>
<td>Callaway Gardens Alzheimers Special Care Center</td>
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<td>Creekstone Care Homes LLC</td>
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<td>Fieldstone Grandridge Independent and Assisted Living</td>
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<td>Fieldstone Memory Care of Kennewick</td>
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<td>Parkview Estates</td>
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<td>Rosetta Assisted Living, Fisher</td>
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<td>Rosetta Assisted Living, Hoxie</td>
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<td>Rosetta Assisted Living Olympia</td>
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<td>Rosetta Pasco</td>
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<td></td>
<td></td>
<td></td>
<td>Royal Columbia Retirement Inn</td>
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<td>Ruan’s Garden</td>
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<td>Sun Terrance Prosser</td>
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<td>Three Rivers Place Senior Living</td>
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<td></td>
<td></td>
<td>Tri-Cities Retirement Inn</td>
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**Budget**: $17,508.61  
**Total**: $4,200.00

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).
QUALITY IMPROVEMENT PLAN
JANUARY 2020

ATTACHMENT 4
Greater Columbia Accountable Community of Health  
(Medicaid Transformation project areas 2A, 2C, 3A, 3D)  
Quality Improvement Plan

Develop continuous quality improvement strategies, measures, and targets to support the selected approaches

Greater Columbia Accountable Community of Health (GCACH) is using the transformative model of care called the Patient-Centered Medical Home (PCMH) as its framework for quality improvement (QI). Based on the principles of the Chronic Care Model, the PCMH model uses evidence-based guidelines, applies population health management tools, and demonstrates the use of “best practices” to consistently and reliably meet the needs of patients while being accountable for the quality and value of care provided. The PCMH model delivers whole-person care that is team-based and coordinated, based on data, and measured continuously for quality improvement. The PCMH model incorporates evidence-based practices identified in the Healthier Washington Medicaid Transformation Project Toolkit and from the four MTP project areas that GCACH has chosen:

- Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation
- Project 2C: Transitional Care
- Project 3A: Addressing the Opioid Use Public Health Crisis
- Project 3D: Chronic Disease Prevention and Control

Providers that contract with GCACH receive hands-on technical assistance by Practice Transformation Navigators (PTNs). The Director of Practice Transformation has put together an extensive training program using the Agency for Healthcare Research and Quality’s (AHRQ) Primary Care Practice Facilitation Curriculum and the Safety Net Medical Home Initiative PCMH implementation guides. The curriculum is continuously supplemented with the latest resources and evidence-based tools.

PTNs guide clinics through PCMH transformation through assessments, training on population health management tools like registries, risk stratification, and decision tools. They identify barriers, provide resources, assist in implementation and troubleshoot issues.

However, the formation of a QI team is a requirement and Milestone of each partnering provider clinic or hospital. Improvement work invariably involves work across multiple systems and disciplines within a practice. The QI team is the group of individuals within a practice charged with driving quality improvement efforts. One of the first tasks to complete with the QI team is to identify opportunities for the improvement work and associated performance metrics, and it is recommended that the team is comprised of a cross-sector workgroup (clinicians, IT, senior leadership, finance, etc.) from within the organization. As of 12/31/2019, the sixty-two clinic sites contracted with GCACH for Practice Transformation represent over nine-hundred QI team members and providers that serve over seven hundred thousand patients (all-payers) in Greater Columbia ACH’s service area.

PTNs make site visits to each participating clinic at least once a month, and meet with the QI team to review progress, discuss barriers or challenges, and to make adjustments to their workplans. PTNs
also communicate regularly with each QI team to answer questions and to send resources and tools that will help them through the various Milestones.

The PCMH model entails numerous changes to the clinic’s business model, from claims and billing processes, to workflows and scheduling systems, to EHR configurations and organizational culture. PTNs provide resources and guidance to help each clinic, hospital, and practice be successful throughout the Practice Transformation journey, working with the QI teams, or specific departments within the organization. The Practice Transformation Implementation Workplan (PTIW) is a change plan for each site and a living document that that integrates the PCMH-A and/or MeHAF assessment results incorporated into a Plan Do Study Act (PDSA) cycle and guides the improvement process. The PTIW is reviewed on a quarterly basis, and is one of the incented Milestones that is reported on.

The PCMH model incorporates regional Learning Collaboratives that bring together the QI teams from hospitals and clinics that are seeking improvement in a focused topic area. Learning Collaborative sessions vary from two hours to two days, depending on content, interest level to providers, and project area. Learning Collaborative sessions occur on a monthly cadence. The sessions often use representatives from exemplar organizations from within the PCMH Cohorts, and other subject matter experts who share best practices, lessons learned, and success stories. Learning through this process has helped Practice Transformation organizations in their implementation of PCMH Change Concepts: please see Figure 1.

Feedback from the providers has indicated that they would rather learn from their peers than bring in subject matter experts from outside the region. How to change the culture of an organization, how to integrate behavioral health and primary care, and how to effectively use nurse case managers for transitional care are examples of site visits for peer learning within the GCACH region.

Participation in the Learning Collaboratives is also a Milestone requirement of Practice Transformation organizations who contract with GCACH. Providers must attest that they have participated in at least four Learning Collaborative sessions during the year to meet that Milestone.
PCMH success stories are also shared in the monthly Community Newsletter that is distributed to over 1,100 individuals associated with GCACH, and reviewed monthly by the GCACH Board of Directors.

Providers work from a guidebook called the Practice Transformation Reporting Workbook that is modeled after the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care's (CPC) Implementation and Milestone Reporting Summary Guide. The workbook has been customized to meet the needs of the Medicaid Transformation (MT) program and contains Milestones and reporting measures linked to the MT project areas, to PCMH/Practice Transformation concepts, and to statewide measures (MT Pay-for-Performance). These Milestones are evidence-based and critical to health care delivery transformation. However, the GCACH takes a very collaborative approach and is flexible with PT organizations doing the work. The workbook has been described “descriptive without being too prescriptive” and offers providers flexibility in designing their change programs, allowing them to choose the targets and measures that they want to track and report on within the project areas. In this manner, providers are introduced to a fairly rigorous form of value-based contracting, and their level of attainment and improvement are both rewarded. Patients are also treated more proactively through a planned model of care. Quality is built into the Milestones for which the providers are rewarded. Beginning in July 2019, the PT organizations will begin recording their progress in a web-based portal site (CSI Healthcare Communities portal) to track progress in completing PCMH Milestones. Through this reporting portal, PT organization will upload PT Milestone data on a quarterly basis.

Finally, the process is overseen, monitored and evaluated by the Practice Transformation Workgroup (PTW), a chartered committee selected by the GCACH Board of Directors and comprised of clinical providers and subject matter experts in quality improvement, population health management, complex case management, and workforce development. The PTW meets quarterly to review the results of each Cohort using the Practice Transformation Scoring Report. The Practice Transformation team presents an overview of the progress of each participating provider across the four project areas, indicates barriers to implementation in the prior reporting quarter, and highlights success stories from the PT organizations in their implementation work. The PTW offers guidance and adjustments to the process and this is integrated into changes in the overall Practice Transformation process.

SAR 4.0 UPDATE: Provider results are also reviewed by the Board of Directors, and beginning in 2020, CSI Solutions will be producing an aggregate report in the form of a dashboard to enable providers to visualize their progress, and compare their progress with other sites. Each site will be assigned an anonymous ID so their site identity will remain unknown. However, the data will aggregate all eighty-three sites across twelve measures. The twelve dashboard measures are those that will give GCACH staff the greatest insight into how sites progress using population health management tools, approach care coordination, and progress under the quality metrics they are gathering. The twelve dashboard measures are:

- Top Ten Clinical Quality Metrics
- Care Management for High Risk Patients
- Empanelment Rate
- Top Five Risk Stratification Methods
• Care Coordination Options
• Behavioral Health Integration Models
• Medication Management Services
• Follow-up within One Week of ED Discharge
• Follow-up within 72 Hours of Hospital Discharge
• High Referral Community Partners
• Identify Patients Needing Integrated Care
• Behavioral Health Integration Assessment Tools

**SAR 6.0 UPDATE:** While in-person Navigator visits were curtailed due to the COVID-19 pandemic, GCACH adjusted quickly to on-line Learning Collaboratives, Leadership Council meetings, and visits with Providers. Virtual visits had the advantage of being able to share screens with the provider organizations, helping them with reporting requirements, and bringing up resources that they could use to improve their services.

The following quality improvement steps were extracted from the Quality Improvement sections of the Project Area in the Implementation Plan, Semi-Annual Report 2.0 (SAR 2.0) and are common to all four MT project areas:

**Step 1:** Create an advisory committee of subject matter experts with C-suite representation from large, medium and small practices to guide the transformation project, review the process for PCMH transformation, study the results, and monitor the progress. Engage these leaders to understand, facilitate, and advocate transformation within their organizations, and to become disciples of the PCMH care model. Their responsibilities include:

- Reviewing regional data and helping identify the appropriate selection criteria for providers to receive PCMH technical assistance;
- Selecting providers to engage in the PCMH transformation process;
- Reviewing GCACH provider assessments and identifying regional strengths and weaknesses to better inform the selection of providers and application of change strategies;
- Monitoring PCMH provider performance and making any necessary adjustments in strategy or tactics.
- Reviewing and recommending changes to the Milestones for years two and three of the Transformation program.

**STATUS:** The Practice Transformation Workgroup (PTW) was chartered in January 2018, and met twice a month from February to October 2018. In April 2018, GCACH staff introduced the PCMH model as the framework that met many of the Medicaid Transformation objectives regarding value-based payments, chronic care management, bi-directional integration, care coordination, transitional care, and the social determinants of health. In 2019, the meetings moved to a quarterly cadence in order to review the quarterly reports from the participating Provider organizations.
**SAR 4 UPDATE:** GCACH has added two additional Cohorts since June 30, 2019. The second Cohort includes the seventeen behavioral health agencies that transitioned to integrated managed care (IMC) in 2018. Upon receipt of the second phase of IMC funding in April 2019, GCACH staff recommended to the Provider Readiness Group and the Budget and Funds Flow Committee that $4.2 million of the $6.1 million be distributed according to the same Practice Transformation revenue sharing model as Cohort 1. While it would not be expected of the behavioral health agencies to achieve all of the Milestones of Cohort 1 for Practice Transformation, it would honor the expectations of the Washington State Health Care Authority to support implementation of a fully integrated physical health and behavioral health managed care system. This recommendation was forwarded by these committees and approved by the Board of Directors.

While the behavioral health agencies were skeptical that Practice Transformation applied to their clinics, they have quickly embraced transformation concepts, and are eagerly making changes within their workflows and practices. Their earlier suspicions about the GCACH have also dissipated as well. GCACH has allowed more flexibility in their integration models, and are seeing innovative partnerships such as integrating mental health and behavioral health services, offering mental health services in a school setting, screening for behavioral health in a dental setting, and offering primary care in a SUD clinic. This has pushed integration approaches to new limits.

GCACH had more difficulty in assembling the third Cohort, in spite of the possible substantial financial incentives. While roughly the same process was used for sending out the Letter of Interest/Current State Assessment application and scoring them upon receipt, fewer providers responded. So the GCACH Board allowed for a “rolling start” through the end of November to allow time for GCACH staff to go back to specific providers to give them more information about the PCMH program. GCACH solicited independent primary care offices with medium to large Medicaid populations, and organizations referred to the GCACH by Practice Transformation organization CEOs during our mid-year check-ins. Most of the independent practices did not seem to understand the 1115 Waiver and were not ready for transformation within their clinics. However GCACH was able to attract a mix of palliative care agencies, skilled nursing facilities, and additional primary care clinics from larger health systems, again pushing the Practice Transformation process to new frontiers. There are twenty-one clinics in the third Cohort, and they are still finalizing contracts and determining practice sites. With the addition of the second and third Cohorts, GCACH will have eighty-three sites doing Practice Transformation using all or part of the PCMH framework.

**SAR 6 UPDATE:** Additionally, GCACH embarked on a major effort to inform the Legislators in our nine-county region of our PCMH efforts. While not directly involved with Greater Columbia ACH, their advocacy on the behalf of primary care is critical to sustaining these vital services and advancing needed policy changes at the state legislative level.

**Step 2:** Create a standardized method to assess the readiness and willingness of potential participating Providers to undertake Practice Transformation, and the PCMH model. Use the
following change concepts to assess Provider readiness: Leadership, Transparency, Collaboration, Adaptive, Value-Driven and Equity. Prioritize Provider list based on independent analysis of adherence to change concepts.

**STATUS:** The Current State Assessment (CSA) tool was initially used by Oregon Health Sciences University (OHSU) to score the provider organization applications in July 2018. OHSU scored the CSAs and made recommendations for high, medium, and low levels of readiness for Practice Transformation. The PTW used the OHSU recommendations and factored in geographic equity across the nine counties to finalize the list of PT organizations. The same process will be used to add future Cohorts to the PCMH program.

**SAR 4 UPDATE:** GCACH combined the Letter of Interest and Current State Assessment documents (LOI/CSA) in August 2019 to streamline the application process and remove redundant questions across both documents for the third Cohort. Scoring for the third Cohort was done by OHSU, and the third Cohort is provided the opportunity to earn incentive funding using the same revenue sharing model as Cohort 1.

**Step 3:** Develop Milestone reporting measures that align and reinforce the PCMH change concepts and project areas. Incorporate Milestones in Provider contracts. Contracts developed based on a revenue sharing model that rewards completion of the Milestones. Milestones are weighted, and based on work tasks that build capacity in the organization, develop and enhance population health management tools like risk stratification and decision-making tools, EDIE and PreManage, and track clinical quality measures chosen by PCMH organizations. Host a Learning Collaborative meeting to explain contract, revenue sharing model, and reporting Milestones. Incent attendance for Partnering Providers.

**STATUS:** All contracts with PCMH Cohorts include the revenue sharing model, deliverables, and Implementation Toolkit. The PCMH contract was thoroughly reviewed with all of the PCMH Cohort #1 providers on January 3, 2019 and attendance was required. All contracts were signed by April 14th. (See attached contract, and Practice Transformation Implementation & Reporting Toolkit for more detail.) Example of revenue sharing model for 2019 is shown in Figure 2.
GCACH developed a revenue sharing model that includes incentive funding for a three-year period. Technical assistance will be provided to each site during this timeframe with the expectation that sites will adapt to the Change Concepts and processes for each Milestone. Incentive funding decreases in a step-down fashion from Year One to Year Three, however. Please see Figure 3. Emphasis on the following Milestones in Year Two builds on the processes and evidenced-based practices introduced in Year One: Budgeting, Care Management, Bi-Directional...
Integration, QI Team, Reporting, PTIW, Attestations, Care Coordination, Training and Mentoring, Learning Collaboratives, and the PCMH-A and MeHAF assessments.

Additionally, some of the Year One Milestones will be mandatory in Year Two.

The following Milestones are mandatory or new Milestones in contract Year Two:

- Empanelment Status
- Review of Patient Rosters
- Increase target rate to risk stratify 85% of empaneled patients (up from 75% in Year One); provide care management to at least 95% of patients
- Screen for Social Determinants of Health
• Provide a concise narrative describing the approach methodology or tools used to stratify patients
• Record the total number of patients in each risk stratum and the number of patients within the stratum that received care management services
• Conduct a daily (in-person or electronic) team-based huddle
• Quantify the percentage of patients that have been assessed for behavioral health
• Sites will follow-up with patients after one no-show. Follow up can be completed via phone call or mailed letter
• Being trained in medication assisted treatment (MAT) having a MAT referral source will be required
• 10% of patients that have at least three high-risk conditions should receive self-management support
• Providers must identify measures that are tracking patients with three or more high-risk conditions
• Medication Reconciliation will be mandatory
• Engaging pharmacists will be mandatory (i.e. collaborated, integrated, contractual, tele-pharmacy)
• Collaborative Drug Therapy Management is mandatory for contracted or staffed pharmacists
• Clinic sites will report on third next available appointment for the following appointment types: Acute, Adult, Well-Child, and New Patient visits
• Clinics sites will determine what workforce or training is needed to provide patient-centered care (i.e., Community Health Worker, Behavioral Health Peer Specialist, ARNP, etc.)
• Each quarter, the sites will be expected to show an increase in the percentage of patients that received surveys
• Each quarter, the sites will be expected to show an increase in the percentage of patients that received shared decision-making tools
• QI teams must meet internally at least monthly
• Clinical Quality Measures (CQM) must be reviewed on a weekly or monthly cadence
• Practices will be required to create individual practitioner or care team CQM reports
• Monthly meetings with the Practice Transformation Navigator are mandatory
• The use of CollectiveMedical is mandatory 2020
• The practice must attest to using OneHealthPort by Quarter 2
• Sites will be expected to show an increase of the percentage of patients receiving follow-up calls after an ED visit or hospitalization
• The following Learning Collaboratives will be mandatory in 2020: Billing training, Shared Care Plans, Shared Decision-Making aids, and Self-Management tools
**SAR 6 UPDATE:** Except for the combination of some reporting requirements, the revenue sharing model for year three of practice transformation is one-half of the revenue sharing model for year two. Reporting requirements were combined for Care Management, and Training and Learning Collaboratives. This allows for greater flexibility in scoring these sections. The contract language now specifies which milestones exclude certain provider types, e.g., empanelment excludes hospitals, dental clinics and Urgent Care since these provider types do not empanel patients.

**AMENDMENT FORM**

**NO. 2**

Pursuant to Section 15, the following changes are hereby incorporated into this Contract:

A. **Description of Change:** Extend the Completion Date to January 15, 2022 and replace Exhibit “A.1” Revenue Sharing Model in its entirety with the following:

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<table>
<thead>
<tr>
<th>Milestones</th>
<th>2021 Quarterly Maximum Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exhibit A.1: 2021 Revenue Sharing Model - Cohort 1</strong></td>
<td><strong>Quarter 1</strong></td>
</tr>
<tr>
<td>1A.1 Budget Developed</td>
<td>$609</td>
</tr>
<tr>
<td>1A.2 Budget Reconciled</td>
<td>$0</td>
</tr>
<tr>
<td>Care Management ($4,500 total per quarter)</td>
<td></td>
</tr>
<tr>
<td>2A.1 Empanelment (Excludes Hospitals, Dental, Urgent Care)</td>
<td>$4500</td>
</tr>
<tr>
<td>2A.2.2 Risk Stratification/2A.2 Risk Stratification Statistics (Excludes Dental)</td>
<td></td>
</tr>
<tr>
<td>2A.3 Opportunities for those at Highest Risk (Excludes Dental)</td>
<td></td>
</tr>
<tr>
<td>2B.2 Self-Management Support</td>
<td></td>
</tr>
<tr>
<td>2B.3 A Medication Management</td>
<td></td>
</tr>
<tr>
<td>3A.1 Access and Continuity</td>
<td></td>
</tr>
<tr>
<td>4A.1 Patient Centered Interactions</td>
<td></td>
</tr>
<tr>
<td>4A.2 Shared Decision Making</td>
<td></td>
</tr>
<tr>
<td>2B.1 Bi-Directional Integration</td>
<td>$1,825</td>
</tr>
<tr>
<td>5A.1 QI Team</td>
<td>$1,875</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td>6A.2 MCO Roster Reporting (Primary Care Only)</td>
<td>$500</td>
</tr>
<tr>
<td>5A.3 Practice Transformation Implementation Workplan (PTIW)</td>
<td>$609</td>
</tr>
<tr>
<td>Care Coordination ($2,217 total per quarter)</td>
<td></td>
</tr>
<tr>
<td>6A.1 Selection A (Clinic) Follow up contact within one week of ED Discharge</td>
<td>$2,217</td>
</tr>
<tr>
<td>6A.1 Selection B (Clinic) Follow up contact within 72 hours of IP Discharge</td>
<td></td>
</tr>
<tr>
<td>6A.1 Selection B (Hospital) IDentify patients without PCP and make referral</td>
<td></td>
</tr>
<tr>
<td>6A.1 Selection C Care Compact/Agreements</td>
<td></td>
</tr>
<tr>
<td>Training &amp; Learning Collaboratives ($2,738 total per quarter)</td>
<td></td>
</tr>
<tr>
<td>7A.1 Training/Mentoring</td>
<td>$2,738</td>
</tr>
<tr>
<td>7A.1 Practice Transformation Learning Collaboratives</td>
<td></td>
</tr>
<tr>
<td>6A.1 HAP Attestations (Collective Medical, DSM, One Health Port)</td>
<td>$500</td>
</tr>
<tr>
<td>Assessments ($1,000 total – earned during the quarter performed)</td>
<td></td>
</tr>
<tr>
<td>8A.1 Patient Centered Medical Home Assessment (PCMH-A)</td>
<td>$500</td>
</tr>
<tr>
<td>8A.1 Maine Health Access Foundation (MeHAF)</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Total 2021 Maximum Available Revenue</strong></td>
<td><strong>$19,739</strong></td>
</tr>
</tbody>
</table>
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Step 4: Develop Learning Collaboratives specific to the needs of PT organizations for successful implementation of the change concepts and evidence-based practices in the four project areas: Bi-Directional Integration, Opioid Crisis, Chronic Disease Management and Transitional Care. Trainings will be identified to support the project areas from the Current State Assessment (CSA) tool, the PCMH-A and MeHAF assessments. Provide in-person assistance through site visits, technical training, or opportunities for the providers to participate in training seminars, webinars, and learning sessions as part of Quality Improvement program. Learning Collaboratives provide learning opportunities on how to achieve Milestones in the contract working in collaboration with PT Navigators, Director of Practice Transformation, and exemplar organizations.

STATUS: A curriculum for the Learning Collaboratives, based on the Milestones and Current State Assessment results has been developed, and monthly Learning Collaborative sessions have been in effect since January 2019. To date the following sessions have covered:

- Reviewing the PCMH contract – January (2.5 hours)
- Reviewing and Developing a Budget – February (2 hours)
- Behavioral Health Integration with Exemplars – March (2.5 hours)
- EMS and Community Paramedicine – April (2.5 hours)
- PDMP, Medication Management, P4R, MAT training – May (2.5 hours)
- Opioid Use Disorder and Trauma Informed Care Summit – June 20-21 (2-day event)

The curriculum for the rest of the year includes:

- Access and Continuity and the CSI Portal – July 19 (2.5 hours)
- Chronic Disease, Self-Management Support, Motivational Interviewing, Transitional Care Management – August 1-2 (2-day event)
- QI Metrics/VBP and technology – September 19 (2.5 hours)
- Exemplar clinics with residency programs – October 19 (2.5 hours)
- Lessons Learned and Success Stories – November 15 (2.5 hours)

The Opioid Use Disorder and Trauma Informed Care Summit was a two-day event attended by more than 250 providers, offered Continuing Medical Education credits and included 30 speakers who were national, state, regional and local experts in their respective areas. The four learning tracks included the following:

- Strategies for Managing Patients with OUD
- Patients, Payment, and Stigma
- Trauma Informed Care
- Innovative Models of Care

Each Partnering Provider selected for PCMH receives $14,598 for attending Learning Collaborative sessions based on the evidence-based practices and Change Concepts.
all members of the PT organization’s Quality Improvement Team attend the in-person sessions held by GCACH, but credit is given for attending learning webinars remotely, or attending other learning webinar or professional development activities. Partnering Providers must attest to their participation in the Learning Collaboratives, Leadership Council meetings, monthly webinars, or other professional development opportunities.

**SAR 4 UPDATE:** The curriculum for the Learning Collaboratives in 2020 builds on Year One, and includes:

- Reviewing and Developing a Budget - January
- Crisis Services - February
- The Art of Person-Centered Care - March
- HIPAA Policy Changes - April
- Shared Decision Making and Self-Management Tools – June (Mandatory)
- Shared Care Plans – July (Mandatory)
- EHR breakout session - August
- How to Maximize Medicaid Reimbursements – September (Mandatory)
- Practice Transformation Recognition Dinner, Exemplar Panel - October
- Cultural Sensitivity/ Cultural Competency - December

There is one schedule for all Cohorts, and each site will be incented $14,596 by attending four Learning Collaboratives throughout the year with three sessions that are mandatory. In 2020, the GCACH Marketing Department is teaming with the Practice Transformation Department to provide materials that relate to each topic. For example, GCACH will provide hot/cold packs for the Crisis Services Learning Collaborative session.

**SAR 6 UPDATE:** The following curriculum for Learning Collaboratives is geared at helping providers become ready for PCMH certification, should they decide to take that step.

- Working with Navigators/Reporting - January
- PCMH Certification - February
- TeamSTEPPS with Dr. Karen Hill - March
- Practice Transformations Successes and Difficulties while starting during COVID - March
- How to Screen for Social Determinants of Health - April
- MCO Rosters to Manage Populations - May
- Self-Management Support - June
- Cultural Competency – Donald Warne, MD, MPH, Director, Indians Into Medicine Program and Associate Dean for Diversity, Equity and Inclusion for the School of Medicine and Health Sciences at the University of North Dakota - July
- Pharmacy & PDMP – August
- Collective Medical Platform – September
- Awards Banquet: Speaker TBD - October
Step 5: Develop monitoring process through GCACH online Reporting Platform (CSI Healthcare Communities) using outside IT vendor, develop internal monitoring processes through PCMH Trackers, Practice Transformation Implementation Workplan (PTIW), Practice Transformation Reporting Workbook, Quarterly Reporting, and One-on-One technical assistance from Practice Transformation (PT) Navigators.

STATUS: GCACH developed a reporting workbook to track quarterly PCMH Milestones, and report progress for implementation activities. The reporting workbook tracks achievement through data, narratives, or through a selection of options. The reporting workbook will be transitioned over to an online web-based reporting portal, that will upload PT organization Milestone data to report progress. The PTIW creates the baseline for the Change Concepts, and records monthly site visits.

SAR 4 UPDATE: All reporting is now accomplished through an online portal co-designed by CSI Solutions and GCACH. This has reduced manual reporting time for providers, and has given the Practice Transformation Team the ability to access provider data more easily and efficiently. A Dashboard consisting of twelve measures will be aggregated across all provider sites for an overall view of the progress of all three Cohorts.

Step 6: Monitor Progress of Milestones through GCACH online reporting portal, IMC and PCMH Trackers, Practice Transformation Implementation Workplan, Quarterly Reporting, and site visits from Practice Transformation Team. Contract deliverables include Practice Transformation Change Concepts and Milestones, assessments, clinical quality measures, population health management implementation.

STATUS: Quarter 1 Milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included Assessments (MeHAF, PCMH-A, HIT/HIE), year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation has been delayed. (See Practice Transformation Scoring Report for more detail.) The site went live on June 17, and Quarter 1 reports were pre-loaded by the PT Navigators. PT organizations will be able to view this Q1 data when they begin to enter their Q2 reporting Milestones due July 15. GCACH and CSI conducted online trainings for using the reporting portal on June 26th, and any organization can receive one-on-one technical assistance from GCACH staff. Additionally, PT Navigators meet with each clinic monthly to track progress toward Change Concepts and goals in the PTIW, and track the progress of each clinic on a monthly basis which is reported out at the monthly Board meetings. If organizations have a deficiency during the reporting period, the Practice Navigator will do a follow up with the clinic to discuss the deficiency. The clinic will then have a 6-day grace period to work with the Practice Navigator to correct the deficiency in order to receive the full value of the point system assigned to that Milestone. The Director of Practice Transformation will reevaluate the deficiency for full, partial or no point payment. Additionally, PT Navigators refer to the PTIW for baseline data, and to record monthly site visits. Milestone progress for each clinic is reported out at the monthly Board meetings through the PCMH or IMC Tracker document. After Quarter 2 reports have
been input into the Portal, GCACH will work with CSI on a Reporting Dashboard to capture aggregated data that best represents Cohort progress toward implementing the Milestones.

SAR 4 UPDATE: Four quarters of metrics are now available electronically through the CSI portal, and all Practice Transformation Cohort providers are entering quarterly data using the platform. The entry of data is much more efficient for both the providers and the Navigators. GCACH is recommending slight improvements to the Milestones. Drop-down menus, and automatic calculations for Milestones requiring numerator and denominator data make monitoring and evaluation more efficient for the Practice Transformation Team, however some erroneous data entry is occurring which is being corrected. The Reporting Dashboard is almost complete with weekly conference calls with CSI to work out the final details. The Dashboard report aggregates the reporting from all sixty-two clinic sites, allowing a quick analysis of twelve metrics as shown in Figure 4. Cohort 3 will be added once they begin quarterly reporting in April 2020.

![Figure 4; GCACH Reporting Dashboard](image)

Step 7: Share results with PTW and Providers. Adjust measures and processes as needed to implement Change Concepts by PCMH Cohort, and review with PTW. PT Navigators review progress towards Milestones with Partnering Providers with every site visit.

STATUS: Milestones are continuously reviewed for each Partnering Provider by the Practice Transformation Navigators at their monthly site visits to make progress toward transformation efforts. Quarter 1 Milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation has been delayed.

SAR 4 UPDATE: Quarter 2 and 3 Milestones were reviewed by the Practice Transformation Workgroup on July 25 and November 7th. All organizations have implemented processes for all four project areas, chosen a model of bi-directional integration, and are working with the Managed Care Organizations to implement population health management tools like EDie, a
web-based technology that provides real time information to reduce ED utilization, improve transitions of care and enhance care coordination. Some of the barriers that were identified from reporting in Quarters 2 and 3 included:

- Provider communication within organizations
- Staff turnover, recruiting barriers (more in rural areas)
- Leadership and clinical staff disagreeing on metrics to track/which are more valuable to track based on clinic location or patient population
- Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, population health management
- Electronic Health Record transitions
- 42 CFR Part 2: sharing information from behavioral health (BH) to primary care physician (PCP) or PCP to BH
- Opportunity to enhance billing workflows that will allow for sustainability
- Internal transitions and/or protocols
- Culture change
- MCO sponsorship for CollectiveMedical
- Staff not working at the ‘top of their license’
- Reworking the reporting to make it more relevant to hospitals.

**Step 8:** Assess each work step and Provider resources for successful implementation of population health management tools (e.g., staffing for risk stratification, enhancements to EHR, PMP), and how they will improve health systems, community capacity building, and health equity.

**STATUS:** The Practice Transformation Team meets with each Partnering Provider organization monthly to ensure that they are making progress toward using population health management tools, selecting and reporting quality metrics, and optimizing their EHRs. The Executive Director, Deputy Director, Finance and Contract Director, and the Practice Transformation Director started an initiative in May 2019 to make site visits with hospital and clinic leadership to ensure that transformation efforts, reporting requirements, Milestones, Learning Collaboratives, and implementation of population health management tools were going smoothly, and to determine if any mid-year corrections to the transformation process were needed.

Site visits with the following Partnering Providers have been accomplished:

- Astria Toppenish Hospital, Astria Sunnyside, Astria Yakima
- Kadlec Regional Medical Center/Providence St. Mary’s Hospital
- Virginia Mason Memorial Hospital
- Garfield Hospital
- Pullman Hospital
- Columbia County Health System
- Kittitas Valley Healthcare
- Tri-Cities Community Health
These meetings were extremely productive, and Leadership from these organizations reported favorable feedback regarding the Practice Transformation Navigator’s technical assistance in finding resources, re-thinking workflows, and re-evaluating PCMH strategies. They seem pleased with the “descriptive but not prescriptive” nature of the PCMH program as it allows them flexibility to use their revenues to meet local needs, however the lack of structure also creates confusion among some provider organizations. Greater Columbia is using this feedback to make improvements to the reporting platform, to minimize the work in reporting on Milestones, and to get referrals for potential Partnering Providers for future Cohorts.

**SAR 4 UPDATE:** While the majority of primary care sites are making steady progress toward PCMH, two primary barriers exist for the behavioral health providers in successfully implementing population health management tools:

- Having an ONC Certified EHR, and
- Access to the CollectiveMedical Platform

Prior to Integrated Managed Care, behavioral health providers received compensation for services based on a contract with the Greater Columbia Behavioral Health Organization (BHO). Now that the providers are submitting claims to the MCOs for reimbursement, their patient data and claims information has to be collected, stored, and billed through an ONC Certified electronic health records system. Behavioral health providers have been using the incentive funding from the IMC transition to purchase new EHRs, and setting up their EHRs systems. Navigators have assisted fifteen (15) behavioral health organizations transition to new EHRs.

The CollectiveMedical Platform is an admission, discharge, transfer (ADT) notifications system and a care collaboration platform that unifies a patient’s entire care team. In the Greater Columbia region, the network includes hospitals, primary and behavioral health care providers, health plans, and even one emergency medical system (EMS), an innovation for this system. Each clinic must be sponsored by a Managed Care Organization, unless it is a primary care practice affiliated with a hospital. Each organization must also complete a “Discovery Form” in order to be added to the CollectiveMedical network. The Discovery Form also requires the upload of a patient eligibility file (patients paneled to the provider organization), which some organizations have had to produce manually, because they are in the process of switching to an ONC Certified EHR.
In order to facilitate access, GCACH staff and the MCOs came together in the Summer of 2019 to develop a workflow to lay out a process for the provider organizations. However, there are a few organizations not yet connected.

Figure 5 demonstrates the workflow for MCO sponsorship to the CollectiveMedical Platform.

**Figure 5; MCO Sponsorship to CollectiveMedical**

**Step 9:** Health Care Partners, Primary Care, and Behavioral Health develop and agree on shared care plans, how to exchange information. Training for an implemented shared care plan dependent upon specified evidence-based model, e.g., Transitional Care Model, Community Para-medicine model.

**STATUS:** GCACH contracted with Quad+Aim Partners to develop a community information exchange (CIE) called the Health Commons to electronically connect health and social service providers together to improve patient/client care transitions between agencies. Through a competitive process, the Kittitas County Healthcare Network was chosen to pilot this project as they had an established network of providers identified as “The A Team” that were trying to develop such a system, and were relying on manual processes to manage patients common to their organizations. The CIE manages digital consents, health record integration and information exchange. Patient Health Information (PHI) is stored on Amazon Microsoft’s secure cloud infrastructure and is under contract to Quad+Aim Partners to ensure proper technology integration as well as quality and consistency of service. The pilot includes Kittitas
Valley Fire and Rescue Paramedics, Kittitas Valley Healthcare, and Comprehensive Mental Health, and will add additional partners after successfully demonstrating a live patient experience.

Additionally, GCACH has a Memorandum of Understanding with the Yakama Nation to implement a Health Commons that will connect several programs related to family reunification. The Yakama Nation will be working with Quad+Aim to organize and digitally connect services to a community-wide care coordination system.

Practices are also encouraged to use direct secure messaging. Direct secure messaging is an electronic communication technology, that sends messages and data packets between provider EHRs but also includes secure (HIPAA-compliant) web e-mail to communicate with organizations with no EHR. It is designed typically for the exchange of patient health information but can also convey information relating to a patient’s social service needs.

GCACH is also working with CollectiveMedical and the Managed Care Organizations to implement EDIE and PreManage. EDIE is a care management tool that provides alerts to emergency department providers regarding patients who visit the emergency department more than five times or have an inpatient admission in a 12-month period. PreManage combines information from participating healthcare partners, including hospitals and emergency departments (EDs), primary care practices, and behavioral health agencies (BHA), and synthesizes the information into brief, actionable information about individual clients. It is a valuable tool for identifying and tracking high-risk, high-utilizing clients and assisting providers with developing strategies to stabilize clients and reduce unnecessary hospital and emergency department (ED) utilization by facilitating real-time alerts and care coordination. In its implementation, the GCACH seeks to find ways to fully integrate PreManage into the practice’s EHR, reducing the need for a separate sign-on for accessing data.

**SAR 4 UPDATE:** In addition to accessing the CollectiveMedical platform for providers, GCACH staff is exploring a secure texting platform developed by Karuna Health. Karuna integrates with customers’ electronic medical record systems and lets users schedule appointments, organize transportation, and repeat messages to patients automatically, such as reminders to take medication.

GCACH is investigating a Community Information Exchange (CIE) called NowPow, and received a demonstration of this product in December. GCACH is also working with the other ACHs to discuss a common strategy in implementing a statewide CIE or, at the least, update electronic community resource directory of social service providers.

The Yakama Nation has a signed contract with Quad+Aim Partners for the Health Commons project, a community health information exchange focused care management of high risk individuals with co-occurring disorders and social service needs. This work is projected to start in January 2020.
**SAR 6 UPDATE:** Due to the pandemic, a common Community Information Exchange is being implemented by the Department of Health using the CCS platform for those ACHs implementing the Care Coordination project. Greater Columbia has been in conversation with North Central ACH and Better Health Together to examine WIN 2-1-1’s platform for referral management.

**Step 10: Scale and Sustain**

**STATUS:** GCACH selected a second Cohort in May 2019 (Scale), the seventeen community Behavioral Health organizations that transitioned to Managed Care in January 2019. These organizations will be using the same QI model, PCMH, to transform their practices. While integration with primary care is preferred, the BH agencies will have flexibility in developing their integration models. Integrating with SUD or mental health agencies, schools, dental offices, skilled nursing facilities, emergency departments, fire departments, or other community settings is encouraged.

A third Cohort is planned for October 2019. The third Cohort will be comprised of remaining hospitals that want to incorporate PCMH Change Concepts, additional clinics with large Medicaid populations in Yakima and Benton Counties, and possibly, care coordination and transitional care facilities such as skilled nursing facilities, and palliative care programs. GCACH is using the same process to select the third Cohort; LOI/CSA submission, independent scoring, PTW confirmation, and Board approval. As the composition of the Cohorts evolves, the LOI/CSA is revised to include questions specific to that aspect of the healthcare delivery system.

GCACH has modeled its projected cash flow through 2023 (Sustain), and has committed to fund all three Cohorts through 2022. Funding steps down from approximately $283,598 in year 1, to $149,454 in year 2, to $74,727 in year 3. During this time, each organization will have received technical assistance on evidence-based practices in all four project areas, and training on how to maximize claims reimbursements based on delivering quality care, and how to negotiate a contract with managed care organizations that is value based. Figure 6 shows the Scale and Sustain funding model for all three Practice Transformation Cohorts:

![Figure 6; Cash Flow through 2023](image)
**SAR 4 UPDATE:** As recorded in Step 1, two provider Cohorts have been added to the Practice Transformation program since June 30, 2019 using the same workbook, toolkit and reporting structure as Cohort 1. The revenue sharing or cash flow model is being updated to reflect the timing of incentive payments, and to reflect the most recent financial projections from the Health Care Authority.

Cohort 3 contracts will be signed by the end of January 2020, and their first reporting period will be in April.

**SAR 5 UPDATE:** The Third Cohort comprised of eighteen provider organizations was added in January of 2020 that included Skilled Nursing Facilities, Palliative Care, and added more primary care clinics.
A Component of the Quality Improvement Plan

Patient Centered Medical Home Change Concept: Quality Improvement (QI) Strategy
- A QI strategy is an approach to change and provides a framework and tools for planning, organizing, monitoring, sustaining and scaling based upon data.
- A QI team is sponsored by leadership and focuses on the organization’s strategic priorities. QI teams will adapt to change based upon data and also keep everyone on track.

GCACH Practice Transformation (PT) Resources
- PT Toolkit
- Learning Collaboratives
- Exemplar organizations
- Technical assistance
- Healthcare Communities portal resources
- Practice Transformation Implementation Workplan
- Assessments

GCACH Practice Transformation Toolkit: Milestone 5 – Quality Improvement
- Milestone 5 guides PT organizations to take a systematic, data driven approach to drive quality improvement.
- Organizations will identify measures for quality and utilization that are important to them and their patients. They will use these Clinical Quality Measures (CQM) as guides while they test changes to their practice.
- Milestone 5 also requires that PT organizations create a Quality Improvement team that will be directed toward achieving the GCACH Milestones and working with its Practice Transformation Navigators.

GCACH Practice Transformation Workgroup (PTW) Review
- PTW reviews PT Milestone reporting results on a quarterly basis
- Obstacles to Practice Transformation implementation are assessed
- Possible solutions are identified

PT Milestone Reporting
- PT organizations transmit Milestone reporting deliverables to GCACH
- Uploaded CQMs correspond to MTP Pay-for-Performance measures

Improvement Strategy Translation
- GCACH responds and assimilates findings from PTW review and translates them into PT process changes

Practice Transformation Organizations
- Continuous Improvement
- Leadership
- Plan
- Act
- Do
- Study
- Admin, Staff
Summary
ACH Sustainability Report
February 2020

Introduction
In the Spring of 2019, Washington State’s nine Accountable Communities of Health (ACHs) contracted with Artemis Consulting to provide strategic guidance, planning and support for collaboration, and identification of opportunities for alignment, with a specific exploration of HIT/HIE and sustainability. One of the major outputs from this engagement was the creation of a shared framework for sustainability of the ACHs, including recommendations for action steps. This deliverable was based on interviews with each ACH leader and their teams; interviews with MCO CEOs; review of materials from ACHs and HCA; and ongoing discussion with and input from all of the ACH Executives.

Recommended Areas of Focus
In Washington, as well as throughout the country, health care systems are evolving rapidly with a focus on reducing costs and improving health. The list below highlights those areas of change within the health care sector for which ACHs have developed some competency and should consider focusing on moving forward.

- **Quality Care** – There is growing focus on improving health care quality and on value-based payment for care. Providers of care are increasingly being asked to improve the management of clinical conditions, achieve better outcomes, and reduce health care costs.
- **Health Related Social Needs/Social Determinants** – Over the past decade, the health care sector has begun to acknowledge that addressing health-related social needs (e.g., housing, food insecurity, interpersonal violence, transportation) can improve health and lower health care costs.
- **Reducing Health Disparities** – Many communities and racial and ethnic groups experience poorer health and health care outcomes than the population as a whole; efforts to reduce these disparities are a fundamental part of many health care transformation efforts.
- **Care Coordination** – There is an increasing body of knowledge that demonstrates that comprehensive care coordination can help lower health care costs and improve outcomes.
- **Patient Centered Medical Homes** – As with care coordination, care provided through patient centered primary care homes has been shown to lower costs and improve outcomes. Connecting individuals to strong primary care delivery and ensuring these systems coordinate care is foundational for success.
- **Behavioral and Physical Health Integration** – Washington, like many other states, is moving to better integrate behavioral and physical health care delivery, payment and administration.
- **Community Information Systems** – Measuring and improving health outcomes requires information systems that provide clinical and community providers with access to records from care and service settings impacting health, including social services.
• **Local Control** – There is growing recognition that health care is local, and a number of states, through Medicaid waivers, are placing more emphasis on approaches to health system transformation that allow for regional rather than statewide approaches.

**Recommended Approach**

Having established themselves throughout Washington, sustainability for ACHs lies in their ability to link to emerging efforts to improve the health of communities and to make health care more affordable for all. As such, ACHs should pursue a collective, statewide path for sustainability as well as local efforts within their regions. The Artemis Team recommends the following steps as potential approaches to securing ACH sustainability.

**Recommended ACH Activities**

1. **ACHs Should Articulate their Value**: ACHs have done an excellent job demonstrating their individual value and purpose and highlighting the strengths and activities unique to each individual ACH. However, if ACHs are going to work together to obtain sustainability funds, they need to develop a clear and consistent message that articulates the ACH value proposition. ACHs, through their cross-sector collaborations, provide a mechanism for improving health through an integrated approach to addressing health and social need. This is a key value all ACHs bring, regardless of individual strategies and/or tactics. ACHs would greatly benefit from communication materials that articulate and demonstrate this value.

2. **ACHs Should Explore Opportunities to Collaborate with Partners**:  
   
   - **MCOs**: ACHs should collaborate with MCOs on three key areas:
     - **Improved Reimbursement for Care Coordination** – ACHs should collaborate with MCOs on legislation/advocacy to secure reimbursement for care coordination. Increased Medicaid reimbursement for care coordination could, if structured appropriately, provide ACHs with revenue for some community-based care coordination functions.
     - **Addressing Health Related Social Needs** – Almost all MCO CEOs expressed a desire to better address health related social needs and indicated that ACHs, with their connections to community-based social service agency agencies, are well positioned to help. ACHs could contract with MCOs to develop and deliver programs and services in this arena.
     - **Specific Projects** – Each ACH has a unique set of competencies and collaborations that could benefit MCOs in their efforts to lower costs and improve care. There is an opportunity to better align current ACH projects with MCOs to help both types of organizations, coupled with the opportunity for these projects to assist with the long-term sustainability of ACHs.
The HCA and other state agencies:

- **The HCA** – The HCA needs to continue to define its approach to community-based care coordination. As such, there still remains the potential for ACHs to have a clear, explicit and funded role in community-based care coordination. Given the cross-sector collaborations that ACHs have developed, they are in a unique position to do this work.

- **Other State Agencies:** Given the partnerships that ACHs have established, there is the potential to work with other state agencies on issues of mutual importance. For example, the Washington State Department of Health, senior services, and early learning agencies are all potential partners.

Local Health Systems and Health Improvement Initiatives:

- ACHs are well positioned to assist local health care delivery systems, MCOs, local governments and other groups in their efforts to improve the health of their community and should work with these organizations on projects of mutual interest. As health care systems take on increasing amounts of responsibility and risk for cost and quality, they will likely need the assistance of ACHs to help implement activities across the region. ACHs know best the strategic opportunities and partners in their communities.

Recommended Statewide Funding Options to Consider

1. **Waiver Renewal** – ACHs were established through federal SIM and 1115 Waiver funding. Washington’s current 1115 Waiver spans through 2021. It is likely that Washington will propose new innovative approaches to improving health through an 1115 Waiver mechanism. This presents a great opportunity for ACHs to work with the HCA on developing a concept that builds upon what ACHs have done to date. ACHs could partner with HCA to explore other waiver opportunities beyond the current DSRIP model, for example North Carolina’s recently approved waiver to support Social Determinants of Health.

2. **Other Federal Grants/Initiatives** – Often there are innovation grants or a potential opportunity to work with the HCA to expand the programs to include a role for ACHs. For example, Washington is now implementing a Medicaid Quality Improvement Program (MQIP). This represents an opportunity to work with the HCA to expand the program to include a role for ACHs. There may also be opportunities to partner with other state agencies that address the health needs of special populations such as the elderly, people with disabilities, children in foster care, veterans.

3. **Direct Appropriation from the Legislature** – Another option for ACHs to consider is a direct appropriation to support their work. For example, ACHs could be “designated” as the implementation arm of state-wide efforts to transform the health care system and the Medicaid delivery system and to be financially supported for this work. ACHs are uniquely positioned for this role through their community partnerships and relationships with health care providers and social service agencies.
Community-Based Care Coordination (CBCC) reduces fragmentation and improves access, coordination and support for individuals and families across the care continuum. CBCC can help providers manage the transition to value-based care, but it is broader than medical care coordination. CBCC is truly locally based and includes addressing social determinant of health needs.

Our vision is that every person in the state should receive the community-based care coordination support they need to make improvements to their health.

The System Washington Needs

In order to improve health care and outcomes, support health equity and reduce the rate of growth of health care expenditures, Washington must develop a statewide system for community-based care coordination that:

- Is community-based, seamless and flexible;
- Crosses local geographic boundaries while also allowing for local control;
- Balances community-based care coordination with any existing medical care coordination, utilizing the skills and experience of Community Health Workers (CHWs) and peers with lived experience;
- Meaningfully engages the person being served;
- Reduces burden on individual clinical and community providers; and
- Has a secure, sustainable funding source.

Essential Components of a CBCC System

Washington’s ACHs have worked together to identify the following core components of a community-based care coordination system. Washington must develop a system that:

- Crosses systems and is implemented across conditions, services, and settings;
- Addresses social determinants of health along with physical, behavioral and oral health needs;
- Leverages trusted community-based workers;
- Bridges historically siloed community and clinical resources;
- Provides a continuum of care for individuals and families through referrals, follow-up, communication and collaboration;
- Transforms care delivery from episodic to a patient-centered and community-based health and wellness focus, including management through transitions of care;
- Utilizes a system of standardized processes that identify, define and resolve coordination needs for individuals along the care continuum; and
- Actively manage their health conditions through patient engagement and education.

About Washington’s ACHs

Washington’s ACHs are an integral part of the state’s Medicaid transformation efforts. There are nine ACHs covering the state, each serving a distinct region. Each ACH is unique yet they share a common approach to improving the health of their communities and transforming health care delivery. They are tackling complicated problems through cross-sector collaborations and investments in innovative approaches. Over the past four years, ACHs have led efforts to transform local health care systems, connecting health care and social services, and investing millions of dollars into providers and community partners. To learn more about Washington’s ACHs, visit us at www.washingtonach.org.
Community Information Exchange (CIE) is an integrated network of health care and community services partners that use a shared language, a database of available resources, and an integrated technology platform to facilitate data sharing and care coordination. CIE is a component of the ACH vision for Community Based Care Coordination (CBCC), providing a technology platform that enables care coordination. CIE is consistent with the Washington’s vision for Health IT (HIT) and the exchange of information between health care providers but focuses on addressing the disconnect between health care and community services organizations.

CIE is More Than a Technology Platform

Our vision is to improve coordination and planning so that people receive appropriate services and supports to advance whole person care by strengthening linkages among clinical providers, social services providers, and the people they serve through community engagement and technology. CIE exists on a continuum from information flowing through traditional mechanisms to the use of emerging IT platforms. When ACHs use the term “CIE,” it includes the use of a technology platform as well as all of the people, policies, processes and resources needed to make a CIE system work.

Principals for the Development of a CIE

We believe the following five principals should guide the development of a CIE system in Washington:

1. Keep the client/patient at the center, improving care coordination, reducing disparities, addressing equity of outcomes, and contributing to client well-being.
2. Respect and protect client/patient privacy so that all, including the patient/client, feel secure and in control of sharing information.
3. Make the solution a low barrier and simple for end-users and clients/patients.
4. Exchange only information that will improve care and equity to avoid unnecessarily complicating the system and increasing privacy risks without sufficient value.
5. Relationships, community input, accountability, and engagement are key to success -- the technology aspects of CIE alone will not create collaboration or improved care coordination.

Washington’s ACHs have worked together to identify the following core components of a community information exchange system. Washington must develop a system that includes:

- **Shared language**: a common language that bridges clinical care and community services to enable effective and accurate communication;
- **Resource Database**: a searchable inventory of available resources and supporting services and information;
- **Bi-directional closed-loop referrals**: A component of a CIE that allows health care providers to refer patients to community services, community service providers to refer clients to health care providers and/or other community services, and for all service providers to know that the referral took place and the outcome of the referral.

Closed-loop referrals are a common, but not necessarily required, use case and CIE component. Other use cases might take the place of closed-loop referrals in some communities. Closed-loop referrals alone, without the other essential components, does not constitute CIE.

- **Community network partners** – Community-based services providers that participate in the CIE are listed in the resource database, send and receive referrals, and are represented in the longitudinal record (see the next page), that may include housing services, food services, transportation services, and other supports.
- **Clinical network partners** – Health care providers that participate in the CIE are listed in the resource database, send and receive referrals, and are represented in the longitudinal record (see the next page), that may include primary care, acute care, behavioral health, and mental health.
Advanced or Future CIE Components

A more advanced CIE might also include the following components as CIE in the community matures:

- **Longitudinal Record** – A complete longitudinal record of the health care and community services sought and delivered for each individual client. The longitudinal record in a CIE is a history of the services and supports used by a client, and not necessarily a longitudinal health record.
- **Analytics** – Support for data analytics that can be used for process improvement and to demonstrate not only activity but improved outcomes.

Community and State Support is Critical for CIE

Successful community information exchange systems also require that the state and communities support all of the following:

- process and data governance;
- community outreach;
- interoperability among partner systems;
- network operations;
- a concept of data ownership;
- accountability among network partners;
- network funding; and
- sustainability for the purposes of care coordination and efficient health care and community services information sharing.

Community Engagement and Involvement

Engagement of communities and clients is also critical to the success of CIE. Washington must engage clients/patients to ensure they understand the potential for sharing their information, how their information will be used, and how their privacy will be protected. Obtain consent to share information with appropriate network partners. Community service providers must also be engaged and supported in order to understand the capacity they have to participate in the CIE and to work with them to identify resource gaps and advocate for needed community investments. Lastly, outreach must be done with health care providers and payers to ensure they understand the value of coordination with and referrals to community services, understand the potential improvements for outcomes, and are willing to learn the system and spend the additional time/effort required for success.

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Accountable Communities of Health (ACHs) are community-based partnerships that bring together health care payers and providers, public health, social services, community-based organizations, the justice system, schools, tribal partners, community members, and local government leaders to address community health. ACHs seek to improve care, lower costs and strengthen communities.

There are nine ACHs in Washington representing distinct regions of the state. Collectively, the ACHs contract with hundreds of clinical and community organizations to increase integration of care, support the management of chronic disease, address the opioid crisis, and transform the care Medicaid beneficiaries receive.

ACHs Promote Equity

While each ACH is separately governed, they share a common approach to improve the health of their communities: they tackle challenging problems through cross-sector collaborations and investments in innovation. Equity is an intentional and significant component of this work. ACHs prioritize equity through a variety of efforts, such as elevating community voices on the impact of systemic racism, funding efforts to address the social determinants of health, and partnering with tribes. ACHs work with their communities, clinical partners, board and staff to make equity central in the transformation of Washington’s Medicaid system.

ACHs Invest in Equity Strategies

ACHs are investing in strategies to prioritize equity in their regions. ACHs fund organizations led by and serving people of color to advance health system transformation. ACHs also collect and analyze quantitative and qualitative data to better understand the needs of all communities. And ACHs work with their communities to address the disparate impact of COVID-19 on populations affected by the virus.

ACHs Address Social Determinants of Health

To promote equity, ACHs and their partners have sought to address social determinants of health (SDoH) -- the conditions in which people are born, grow, live, work and age that shape our health. ACHs believe that the success of transforming Washington’s health system rests on its ability to better coordinate care, break down silos across systems and address complex social needs.

To focus on the upstream factors that impact health, ACHs have created “Community Resiliency Funds” that support initiatives to break down barriers between clinical and social service or community-based providers. ACHs also have partnered with local organizations to address regional needs around transportation, housing and nutrition. A number of ACHs have developed community-based care coordination programs and referral systems to connect people to the care and social support services they need.

ACHs Support Tribal Relations

ACHs have strong relationships with tribes in their regions. Tribes are represented in ACH governance structures and help guide the work of ACHs. Many of the ACHs have made investments that support innovation in tribal clinics and to help tribes respond to the COVID-19 pandemic. ACHs also work with the tribes to inform clinical and social service providers outside tribal clinics about the needs of tribal members.

To learn more about Washington’s ACHs, visit us at www.washingtonach.org.
Examples of ACHs Promoting Equity and Investing in Social Needs

Better Health Together
BHT and its contracted partners and county-based collaboratives are working together to expand a common definition of equity, to identify projects centered on equity, and to link the health care system with community providers focused on social determinants of health. BHT recently awarded $1 million of its Community Resiliency fund to organizations led by and serving impacted communities, with priority to those groups run by black and indigenous community members.

Cascade Pacific Action Alliance
CPAA made a significant investment in Community CarePort, which includes a technology platform, training, coaching, and incentives for a regional system of community-based care coordination. Ten agencies, using over 40 care coordinators, provide free, ongoing care coordination services to an active caseload of 1,000 high-risk clients across the region. Outcomes include more than 4,000 connections to social services, including permanent housing for 300 people. CPAA also launched a special COVID-19 response to assist with isolation and quarantine and invested almost $1 million to combat the virus’s impact on the region.

Elevate Health
Elevate Health has used its investment arm, OnePierce Community Resiliency Fund, to support equity and address social needs. Elevate Health is working with the African-American faith community to develop strategies that will address COVID-19’s disparate impact on residents of Tacoma’s Hilltop neighborhood, historically a low-income area experiencing rapid gentrification. They also are working with churches and housing developers to understand and address the causes of health inequity, including the lack of affordable and supportive housing and workforce opportunities.

Greater Columbia ACH
Greater Columbia ACH has made substantial investments in its community to address the social determinants of health. The ACH has funded $600,000 in housing initiatives; almost $90,000 to support transportation in the community; and $100,000 to promote good nutrition. These grants have been provided to community-based organizations with strong ties to the groups they serve.

HealthierHere
In partnership with the Center for Multicultural Health, HealthierHere gathered the voices of over 2,700 Medicaid members and other low income households through its Community Grants Program. HH worked with partners to develop a culturally appropriate survey, translated it into 13 different languages and funded partners to learn about community members’ experiences with the health care system – what works, what doesn’t and what could make it better – through surveys, focus groups and interviews. HH captured insights from voices within more than 30 ethnic communities and integrated that information into its Medicaid Transformation work.

North Central ACH
NCACH led an effort to target outreach and messaging to Spanish-speaking and farmworker communities about COVID-19. They also have partnered with the Colville Tribe and invested in the tribe’s roadmap to improve the health and well-being of tribal members and their descendants. Recently, North Central held convenings to discuss how to best address the social determinants of health in its region.

North Sound ACH
North Sound ACH has partnered with and supported eight tribes to promote equity and elevate community voice. In 2020, North Sound invested $600,000 ($75,000 to each of eight tribes) to assist with their COVID-19 response. The ACH also provided $300,00 to support indigenous video and podcast productions to educate the region about indigenous approaches to care and how native and non-native systems connect. This fall, an ACH-sponsored indigenous youth-led convening will inform and inspire young leaders to get involved in their communities and provide them with the resources to do so.

Olympic Community of Health
Olympic Community of Health recently analyzed how adverse social conditions across the region are impacting health, how social needs are exacerbated by the pandemic, and looked at opportunities for region-wide, collaborative interventions. OCH facilitated an environmental assessment, literature review of initiatives and approaches, and took stock of available data, providing a wide perspective of social risk factors and their impact on community health. The findings from these activities, which will inform Olympic’s future work, were shared with the region through virtual convenings, bringing together local health leaders and community members.

Southwest Washington ACH
SWACH developed and implemented a care coordination system, HealthConnect, to address social determinants of health for vulnerable populations. The program uses Community Health Workers and peers (people with lived experience) to provide culturally competent care coordination. Trusting relationships enable these workers to serve as a liaison between health and social services and facilitate access to services and improve the quality and cultural competence of service delivery.

To learn more about Washington’s ACHs, visit us at www.washingtonach.org.
Joint Statement Against Racism and Police Brutality

June 10, 2020

Washington’s nine Accountable Communities of Health (ACHs) share in the sorrow and anger of our communities and stand in solidarity with protests against police brutality. The murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and so many others expose the persistence of racism and racial violence in the United States. The health and well-being of people of color are integral to the health and well-being of our nation and our state; therefore, we are united in saying that Black Lives Matter.

The recent cases of violence against Black people and the disproportionate impact of the COVID-19 pandemic on people of color have highlighted once again the importance of combating racism as a public health imperative. All of the ACHs have made a commitment to meaningful action to advance equity in our communities. It is clear that work must not only continue but intensify. We are committed to working, individually and collectively, to develop meaningful action plans to dismantle structural and systemic racism. We call on our state, our regions, our partners and providers to join us in this fight to do better.
A Resource for Communities During COVID-19

Accountable Communities of Health (ACHs) stand ready to partner as Washington navigates the COVID-19 crisis. ACHs coordinate and elevate regional and local voices in health care delivery, serve as a bridge between health care and social services providers, and reflect the strengths and needs of their communities. We bring together health care providers, health insurers, public health, social services, community-based organizations, the criminal justice system, schools and local government leaders, as well as sovereign Tribal nations, to improve the health of our communities.

ACHs have the flexibility and experience to ensure the COVID-19 crisis response meets the needs of individual communities, while also supporting aligned and consistent communications statewide. We are trusted, locally-led organizations and have established relationships with providers and a track record of facilitating multi-sector collaborations. During this unprecedented time, ACHs are ready to support the important work of our Local Health Jurisdictions. ACHs can coordinate regionally across clinical and community partners to support community engagement and align response strategies.

Local Support for Providers

ACHs can provide on-the-ground assistance to clinical and community providers who are busy caring for patients and on the front lines of the crisis, including:

- Disseminating information on best practices so providers are up to date with treatment and care recommendations, statewide guidelines and changes to billing requirements.
- Providing training and technical assistance on utilizing telehealth or telephone encounters instead of office visits as well as other business changes necessitated by the pandemic.
- Helping to leverage COVID-19 capacity building investments to address business impacts of the pandemic for health and social services providers.
- Acting as a bridge between clinical efforts and community response and resources, making sure there is high quality community care coordination.
- Providing support to programs critical to maintaining community health and resiliency, such as food banks, meal delivery services, community action agencies, local coalitions and other programs that support at-risk community members.
- Connecting community members to needed supports such as housing, delivery of food or clothing, or other needs to help individuals and communities remain healthy and safe through local care coordination and connection mechanisms (e.g., 211 and/or other regional community information exchange systems).
- Ensuring maximization of investments via local, state and federal resources. ACHs are well positioned to act as intermediaries based on our understanding of the needs of vulnerable community members and our existing contractual relationships with providers.

Over the past four years, ACHs have led efforts to transform our local health care systems connecting health care and social services, developing plans to support health across sectors, and investing millions of dollars with providers and community partners. We look forward to partnering with state agencies, community organizations, and others to address the pandemic.

You can find out more about what your ACH is doing to help with the COVID-19 crisis at www.washingtonach.org.
Background
Social needs are critical determinants of both community and individual health. The importance of social determinants has become increasingly apparent during the COVID-19 crisis as the economic impact of the pandemic throws even more families into poverty and in need of social supports. As a case in point, the number of people turning to Apple Health for health care access could increase by as much as a third in the coming months.

Although there is widespread recognition among states, health insurers, health systems and clinical providers that unmet social needs adversely impact health outcomes and drive avoidable health care costs, there is no consistent nor sustainable funding mechanism in place to help meet these needs.

In addition to the lack of sustainable financing, communities across Washington face the challenge of how to best coordinate the delivery of services and information between health and community service providers. The establishment of a coordinated system could address the health disparities and inequities that exist in our communities and assure that social needs are being met. This effort requires multi-sector collaboration, policy and systems transformation, and strong partnerships between the clinical and social service worlds.

Washington’s Accountable Communities of Health (ACHs) are ideally suited to address this challenge given their five-year track record of facilitating multi-sector collaborations and championing equity. They are trusted, locally-led organizations that have established relationships with clinical providers and social service organizations across the state.

Model Concept
In order to assure health care services are being paid for and delivered, health insurers are held to a medical loss ratio (MLR). MLR is a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs. Currently, Medicaid managed care plans and large health insurers are held to an 85% MLR across the nation. Unfortunately, no such requirement has existed for spending on social determinants.

Washington could develop and implement a Social Investment Ratio model to fund social determinant needs and community-based care coordination for those in need in every region of the state. Funding could come from Medicaid dollars (with private philanthropy helping to draw down federal matching funds) and potentially from other state funds, hospitals and health systems, local governments and others to allow for a designated investment - a Social Investment Ratio (SIR) - in social supports.
These dollars would be managed by ACHs through a contract with the Health Care Authority - with participation in governance of these investments by those who contribute resources, and those who are most directly involved with the delivery of community and social supports.

Social Investment Funds would be used to address social determinant of health needs, such as housing/homelessness, food and behavioral health supports, as well as develop and manage systems and resources for community-based care coordination. The Social Investment Fund will serve as a key strategy for improving health equity and addressing disparities in communities across the state.

Using social investment funds, ACHs could work with partners in their regions to manage:

- Value-based payment arrangements with community-based social service providers and infrastructure necessary to pay for the provision of social services;
- Development and implementation of a standardized, shared social needs screening tool which would allow for consistent collection of data and reporting on needs;
- A system to manage social investments, coordinate care and improve population health, well-being and equity.

ACHs also will help develop standardized approaches across Washington to issues such as broadband internet access and transportation, while addressing community-specific social needs.

**Value of the ACHs**

The COVID-19 pandemic has magnified the need for a proactive effort which coordinates the delivery of health care, public health and social services throughout Washington. Immediate steps are required to assure the public health system, the health care system and community social supports are coordinated and linked. The nine Accountable Communities of Health are uniquely positioned to bring together the necessary partners across their region – public health, community service organizations, ACOs, and health and behavioral health providers. Creating a supporting infrastructure will result in a more coordinated COVID-19 response and recovery as well as dollars saved on efficient utilization of high cost health care services, adequate staffing of front-line caregivers, and coordination of care that is managed and maintained in the community with both clinical and non-clinical partners. In addition, the ACHs are committed to finding areas for alignment to achieve administrative efficiencies and consistency while also allowing for flexibility and local solutions.

**Next Steps**

The ACHs seek to partner with HCA as well as other state agencies to refine this concept and then begin to meet with MCOs, health and social service providers, policymakers and other stakeholders to get input and determine next steps. The current health and economic challenges provide a window of opportunity for investing in social determinants and addressing unprecedented need in our state. Thoughtful but urgent action is needed to take advantage of increased federal funding and flexibilities, as well as to keep Washington’s communities healthy and moving forward.
Accountable Communities of Health (ACHs) are community-based partnerships that bring together health care payers and providers, public health, social services, community-based organizations, the justice system, schools, tribal partners, and local government leaders to improve the health of their communities. ACHs are an emerging model around the country and here in Washington. More than 33 states and over 100 communities have implemented the ACH model. Although ACHs are a relatively new model, they have already demonstrated early evidence of success.

ACHs Provide Trusted, Local Leadership

Washington ACHs are an integral part of the state’s Medicaid transformation efforts. There are nine ACHs covering the state, each serving a distinct region. ACHs elevate regional and local voices in the transformation of health care delivery and reflect the strengths and needs of their communities, rather than using a one-size fits all approach. ACHs are uniquely able to provide leadership for change within their communities because they serve as neutral convener, able to partner closely with all types of health and social providers in their regions and able to look across systems and sectors without a vested interest.

Each ACH is unique yet they share a common approach to improving the health of their communities: they tackle challenging problems through cross-sector collaborations and investments in innovation. Complicated, uncoordinated and duplicative systems and services make health care more expensive for everyone. ACHs are leading the way to break down silos between systems and achieve health equity. ACHs support community collaboration and strengthen local partnerships, including coordination between clinical providers and community-based organizations. And ACHs are investing funds into a portfolio of interventions, linking health care and social supports and helping providers across the spectrum of services work better together. In fact, most of ACH funds are being put directly into the hands of local providers.

ACHs Invest in Local Partners

The vast majority of the funds ACHs receive are invested directly into local providers and community organizations. Since 2018, ACHs have provided over $225 million to support initiatives proven to reduce the rising cost of health care and improve health outcomes.

- $150 million to primary care and behavioral health providers across the state. These resources have helped providers integrate physical and behavioral health care, strengthen their ability to serve patients with complex care needs and increase the availability of Substance Use Disorder (SUD) treatment.
- An additional $16 million to help these providers and local public health meet the demands of the COVID-19 pandemic.
- Almost $20 million into programs to reduce the overuse of emergency departments, including the use of community health workers (CHWs) and community paramedicine
- Over $40 million into community-based care coordination systems and programs, as well as for resources to address social determinants of health, including housing, transportation and food security.
- A significant portion of these investments have focused on improving health equity, as well as making investments directly into tribal clinics.

To learn more about Washington’s ACHs, visit us at www.washingtonach.org.
Examples of the Important Work of Washington’s ACHs

Helping Providers and Communities During the COVID-19 Crisis
ACHs have stepped up to help primary care and behavioral health providers, community-based partners and local public health departments meet the demands and navigate the challenges of the COVID-19 pandemic. ACHs have invested over $16 million to help providers adopt telehealth, sanitize offices, increase the availability of health navigators and care coordinators. These investments have also helped provide food and other needed goods for people impacted by COVID-19. ACHs are also working with their communities to address the disparate impact of COVID-19 on populations affected by the virus. Lastly, ACHs have helped the State quickly and efficiently distribute over [number here] personal protective equipment (PPE) to clinics and social service providers.

Supporting the Integration of Care
Strengthening the integration of primary and behavioral health care is a proven strategy for lowering health care costs while improving health outcomes. ACHs have invested over $150 million into [number here] primary care and behavioral health providers across the state. These funds have helped providers improve team-based care, develop care compacts between different types of providers for shared care planning and referrals, create registries to do a better job of managing patient needs and risks and increase important physical and behavioral health screenings. ACHs have also funded technical assistance and training for providers on service delivery and financial integration, support for transitioning billing systems, and investments in population health management systems and electronic health records. Throughout this work, ACHs have convened providers and community-based organizations to participate in peer learning collaboratives to support practice change.

Reducing Emergency Department Utilization and Hospitalizations
ACHs have invested roughly $20 million in keeping people out of the hospital when they don’t need to be there. Avoidable hospitalizations and visits to emergency departments are among the major factors contributing to rising healthcare costs, where services can cost over ten times more than in a primary care office. Unfortunately, the ED is a usual source of care for some Medicaid patients with complex care needs. To combat this problem, ACHs are working with their health systems and making strategic investments in innovative approaches, such as community paramedicine. Community paramedicine is a relatively new and evolving healthcare model that allows paramedics and emergency medical technicians (EMTs) to operate in expanded roles by assisting with public health and primary healthcare and preventive services to underserved populations in the community. The goal is to improve access to care and avoid duplicating existing services. This model is especially useful in rural settings, where patients lack access to primary care. ACHs are also investing in initiatives to improve “transitions of care,” the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Ineffective care transitions lead to worse health outcomes, as well as higher hospital readmission rates and costs.

Strengthening Care Coordination
Strengthening care coordination is another important strategy for lowering health care costs while improving health care outcomes. All of the ACHs view care coordination as a core component of their efforts, and they have invested more than $10 million into this strategy thus far. ACHs are building linkages between clinical settings and community-based organizations that provide social services. Many of them are investing in community information exchange platforms that enable clinical and community partners to share information and make referrals. Six ACHs are implementing the Pathways Community HUB (HUB), a model that provides a comprehensive patient risk assessment, and each identified risk factor is translated into a Pathway that involves coaching and linkages to community and clinical resources, carried out by a community health worker.

Addressing Social Determinants of Health and Health Equity
ACHs recognize the importance of addressing social determinants of health (SDoH) -- the conditions in which people are born, grow, live, work and age that shape our health. ACHs have invested $30 million into resources and organizations that address these needs, with plans for even more investments over the next two years. To focus on the upstream factors that impact health, ACHs have created “Community Resiliency Funds” that support initiatives to break down barriers between clinical and social service or community-based providers. ACHs also have partnered with local organizations to address regional needs around transportation, housing and nutrition.
Introduction of GCACH Staff

Mission: The mission of the Greater Columbia ACH is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and engagement.
Tell Us About Yourselves!

• What committees are you on?
• What legislation are you working on?
• What do you most want from the healthcare system?
• What are the recovery plans for the communities impacted by COVID-19 in your District?
Overview of Transformation Waiver

- $1.5 billion, five year agreement between WA and CMS
- Provides incenting funding to transform the health care delivery system
- Funding includes addressing social determinants of health
- Support providers as they adopt new payment and care models
- GCACH Programs include:
  - Integration of primary care and behavioral health
  - Addressing the opioid epidemic
  - Chronic care and disease management
  - Transitional care
  - Social determinants of health
  - Health equity
ACH Regions

Washington State Tribes and Tribal Health Clinics

[Map of Washington State showing regions and clinics]
GCACH Compared to Washington State

• Higher Percentages:
  • American Indians: Yakama Nation with ~16,000
  • Hispanic: 33% (243,000) vs. 13% WA
  • Poverty Rate: 14% vs. 10% WA
  • Medicaid: 34% vs. 25% WA
  • Uninsured: Franklin and Yakima counties >10%

• Provider Shortages:
  • Primary Care
  • Behavioral Health Care
  • Dental Care (adult Medicaid)
MT Learnings

• Payment reform must accompany delivery system reform
• Support of primary care is key to improving health outcomes and reducing cost
• Social determinants of health have a stronger impact on health outcomes than medical care
• Community clinical linkages are critical to coordinating care
• Behavioral health rates have to be at parity
• Practice transformation is hard work and costly
Primary care professionals are the quarterbacks of the health system

• Relative to patients using a specialist, patients with a primary care physician have:
  • Lower mortality rates
  • A higher possibility of receiving recommended preventive services
  • Better scores on patient experience
  • Lower utilization
  • Lower costs of care
Greater Columbia is investing in Primary Care and Behavioral Health.
HCA Value-Based Payment Road Map

Pain Points:

- Providers require technical assistance to be effective at VBP
- MCOs unwilling to enter into VBP contracts with medium and smaller provider organizations

HCA Value-Based Road Map

- Reward patient-centered, high quality care
- Reward health plan and system performance
- Align payment and reforms with CMS
- Improve outcomes
- Drive standardization
- Increase sustainability of state health programs
- Achieve Triple Aim

2016: 20% VBP
2019: 80% VBP
2021: 90% VBP
GCACH contracts with numerous provider organizations and CBOs throughout its nine counties, covering 86 different sites.
## Funding Distribution by Provider

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Funding Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals/Clinics</td>
<td>$12,469,557</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$10,826,141</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>$5,337,314</td>
</tr>
<tr>
<td>SNFs/School Based Clinics/Dental/Palliative Care</td>
<td>$2,380,407</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>$1,653,297</td>
</tr>
<tr>
<td>Community Based Organizations/LHINS</td>
<td>$600,000</td>
</tr>
<tr>
<td>Tribes</td>
<td>$170,000</td>
</tr>
<tr>
<td>Public Health/Schools/Local Govt</td>
<td>$85,974</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$33,522,690</strong></td>
</tr>
</tbody>
</table>
GCACH is supporting the work of 7 Local Health Improvement Networks (LHINs). LHINs are addressing the priority social determinants of health needs of each county. The latest LHIN was formed through an MOU with the Yakama Nation in October, 2019.
## Community Health Fund Distribution

<table>
<thead>
<tr>
<th>LHINs</th>
<th>Priority Social Needs</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>BFCHA</td>
<td>Access to Care, Food Insecurity, Behavioral Health, Housing</td>
<td>$434,537</td>
</tr>
<tr>
<td>Benton + Franklin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMRHP</td>
<td>Access to Care, Housing, Education</td>
<td>$141,583</td>
</tr>
<tr>
<td>Columbia + Walla Walla</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KCHN</td>
<td>Food Insecurity, Housing</td>
<td>$99,880</td>
</tr>
<tr>
<td>Kittitas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEWARHN</td>
<td>Access to Care, Healthcare System Navigation, Food Insecurity, Behavioral Health</td>
<td>$111,067</td>
</tr>
<tr>
<td>Asotin + Garfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WCHN</td>
<td>Behavioral Health</td>
<td>$79,047</td>
</tr>
<tr>
<td>Whitman</td>
<td></td>
<td></td>
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<tr>
<td>YCHCC</td>
<td>Access to Care, Behavioral Health, Housing, Employment, Education</td>
<td>$529,085</td>
</tr>
<tr>
<td>Yakima</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yakama Nation</td>
<td>Access to Care, Behavioral Health, Youth Suicide, Poverty, Technology</td>
<td>$170,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$1,565,199</strong></td>
</tr>
</tbody>
</table>

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Medicaid Quality Improvement Program (MQIP)

- State legislature authorized MQIP spending on a onetime basis in the 2019-2021 budget to support the Medicaid Transformation
- Flexible federal funds
- Use MQIP to fund Medicaid Transformation year 5 and year 6
- Accountable Communities of Health (ACHs) have used medical funds to improve healthcare delivery system
- HCA currently provides earned incentive payments to participating ACHs through Initiative 1
“COVID-19 extension year”
- Allows for continued response to COVID-19
- More time to provide services and fully examine effectiveness
- More time to collaborate with partners and fully implement MT
- HCA requested $139 million in spending authority
Legislative Ask

• MQIP and MT Year 6
• Broadband access (rural areas)
• Social Investment
• Provider Payment Reform
Questions?
THANK YOU
Greater Columbia

July 1, 2020 - December 31, 2020

Cumulative snapshot

<table>
<thead>
<tr>
<th>Funds Earned</th>
<th>$ 80,938,133.23</th>
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</thead>
<tbody>
<tr>
<td>Funds Distributed</td>
<td>$ 52,795,826.40</td>
</tr>
<tr>
<td>Funds available</td>
<td>$ 28,142,306.83</td>
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Table 1: Incentives earned

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$ -</td>
<td>$ 1,911,298.00</td>
<td>$ 1,911,298.00</td>
</tr>
<tr>
<td>Project 2C</td>
<td>$ -</td>
<td>$ 776,465.00</td>
<td>$ 776,465.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$ -</td>
<td>$ 238,912.00</td>
<td>$ 238,912.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$ -</td>
<td>$ 477,824.00</td>
<td>$ 477,824.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$ -</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ -</td>
<td>$ 3,404,499.00</td>
<td>$ 3,404,499.00</td>
</tr>
</tbody>
</table>

Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$ 3,609.83</td>
<td>-</td>
<td>$ 3,609.83</td>
</tr>
</tbody>
</table>

Table 3: Incentive funds distributed, by use category

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adminstration</td>
<td>$ -</td>
<td>$ -</td>
<td>-</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$ 25,000.00</td>
<td>$ 25,100.00</td>
<td>$ 50,100.00</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$ 674,236.00</td>
<td>$ 1,011,951.14</td>
<td>$ 1,686,187.14</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$ 1,254,234.50</td>
<td>$ 935,090.75</td>
<td>$ 2,189,325.25</td>
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<tr>
<td>Project management</td>
<td>$ -</td>
<td>$ -</td>
<td>-</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$ 120,000.00</td>
<td>$ 270,625.00</td>
<td>$ 390,625.00</td>
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<tr>
<td>Provider performance and quality incentives</td>
<td>$ 1,022,062.00</td>
<td>$ 1,072,256.75</td>
<td>$ 2,094,318.75</td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$ -</td>
<td>$ -</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 3,095,532.50</td>
<td>$ 3,315,023.64</td>
<td>$ 6,410,556.14</td>
</tr>
</tbody>
</table>

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