Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 7.0

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

DY5 Q1-Q2

Template Release Date: March 15, 2021
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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 January 1 – June 30, 2021*

<table>
<thead>
<tr>
<th></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><strong>Number of Projects in ACH Portfolio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/support of Independent External Evaluator (IEE) activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Report on quality improvement plan (Replaced by COVID-19 Response)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total AVs Available</strong></td>
<td>18</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>34</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 2. Potential P4R AVs for Project Incentives, January 1 – June 30, 2021

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

**Reporting requirements**

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

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (January 1 – June 30, 2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>Section 1. ACH organizational updates</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Section 2. Project implementation status update</td>
</tr>
<tr>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Section 4. Pay-for-Reporting (P4R) metrics</td>
</tr>
</tbody>
</table>
There is no set template for the semi annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

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

File format

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

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

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

Semi-annual report submission instructions

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

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

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

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

The folder path in the ACH’s directory is:

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

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

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

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

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

**Contact information**

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.
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 ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Carol Moser</td>
</tr>
<tr>
<td>Phone number</td>
<td>509-851-7601</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:cmoser@gcach.org">cmoser@gcach.org</a></td>
</tr>
<tr>
<td>Secondary contact name</td>
<td>Hayde Hill</td>
</tr>
<tr>
<td>Phone number</td>
<td>509-851-7912</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:hhill@gcach.org">hhill@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>1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Primary care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

https://wahca.box.com/s/nfesjalde5m1ye6aobhiou13xemoeh26

Semi-annual reporting guidance
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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.*

**Attachment:** GCACH Organizational Chart *(Please see attachment 1 on page 30)*

**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

**GCACH Response:** GCACH drew down funding from the WA FE Portal in the amount of $25,000 on 1/26/2021 for the Yakima Masking Campaign to educate and raise awareness on the importance of wearing protective face masks to Yakima County residents (English and Spanish speaking). GCACH spent total of $26,895.46; $9,662.60 at the start the campaign in December 2020 and $17,232.86 as of June 30, 2021.

**Attachment:** Payment Reconciliation – Covid. *(Please see attachment 2 on page 31)*

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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).
• 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 FE Portal 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.

**GCACH Response:** GCACH has expended all of the $10,183,916.00 of Behavioral Health Integration Incentives to support integrated managed care (IMC) for our behavioral health (BH) providers. Technical assistance for IMC is coming out of the project management use category. This technical assistance includes addressing any concerns or questions raised by the BH providers in terms of billing codes, clinical authorizations, supplemental data requirements, new Series guide changes and updates, behavioral health performance measures, state legislative bills impacting BH providers, ASAM requirements, and billing codes pertaining to telehealth.

Most of this technical assistance is delivered through the monthly ACH/HCA/BHO/MCO meetings that are coordinated and facilitated by the GCACH Program Director. The Executive Director and Practice Transformation Team members attend these meetings in order to stay on top of the information flow, and to assist the BH Providers when issues arise.

<table>
<thead>
<tr>
<th>Use of incentives to assist in the transition to integrated managed care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of Use</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Staff Technical Assistance</strong></td>
</tr>
</tbody>
</table>

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4 The HCA issued non-COVID reconciliation spreadsheet can be found at the following link: [https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx](https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx).
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.

Attachment: GCACH.SAR7 Implementation work plan.08.02.

13. Partnering provider roster.

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

Instructions:

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

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

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

5 Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).
b) Update partnering provider site information as needed over each reporting period.

  Submit updated partnering provider roster.

  Attachment: GCACH.SAR7 provider roster.08.02.2021

**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

  Attachment: GCACH Quality Improvement Plan *(Please see attachment 3 on pages 32-74)*

**Narrative responses**

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

**15. COVID-19**

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

  GCACH Response:

  **PPE and Cell Phone Distribution:** GCACH played a supporting role to United Way of Benton and Franklin Counties (UWBFC) for PPE distribution and referrals. In March and April UWBFC distributed over 600,000 pieces of PPE to fifty-five agencies. July will be their last month to distribute PPE. GCACH received 316 cell phones through CMS and the Healthier Washington initiative in June that were distributed to our Foundational Community Supports providers. GCACH held a webinar in May for the providers to assure everyone understood the program and reporting requirements.

  **Yakima Masking Communications Campaign - Round Two:** After a successful first-round of the Yakima Masking Communications Campaign, GCACH launched the second round of the campaign at the beginning of January. This time, the campaign focused on

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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.
both the English-speaking and Spanish-speaking populations residing in Yakima county. The Spanish advertisements were consistent with the first round; highlighting well-known community members and honing in on the Lucha Libre theme. The English advertisements were created with the help of a media vendor, again highlighting community leaders and their reasoning and inspiration behind wearing masks, maintaining safe distancing from others, and using hand sanitizer. The media mix included radio, television and social media with bi-lingual advertisements.

**Community Resiliency Campaign:** GCACH launched a regional media and educational resiliency campaign at the February Leadership Council meeting. The campaign, “Practice the Pause,” was geared to address the psychological fallout from the COVID-19 pandemic, specifically the “disillusionment” phase of the disaster which is typically characterized by clinically significant behavioral health symptoms such as depression, acute stress, increases in domestic violence, and post-traumatic stress disorder. In September 2020, Dr. Kira Mauseth, who developed the Cope, Calm, Care model, spoke to the GCACH Leadership Council about the behavioral health impacts of COVID-19. Dr. Mauseth, a practicing clinical psychologist and a member of the Washington State Behavioral Health Strike Team, normalized the shared experience of a disaster. Dr. Mauseth discussed common responses, symptoms, and challenges that people face, and presented information on what to do to increase resilience factors.

Based on Dr. Mauseth’s resilience model, GCACH hired Field Group marketing agency to develop toolkits in English and Spanish, and contracted with Catholic Charities to provide clinical training and consultation to implement the toolkits. Field Group developed a bi-lingual media campaign that ran for three months across the GCACH region which

![Figure 1: Cope, Calm & Care Toolkit](image)
included advertising on television, radio, billboards, and social media. The toolkits were tailored for three age groups: youth ages 5-12, teens ages 13-18, and adults 18+.

Over 136,000 students in fifty-eight school districts received printed toolkits made possible from a grant from Cambia Health Solutions. Analytics from digital and social media chronicled 15,396 ad clicks, 2,619,277 Facebook impressions, 368 Facebook page likes, and 10,507 clicks on Tik Tok. While most schools received their training and disseminated the toolkits in the spring, the school districts in Benton and Franklin Counties have chosen to receive training and distribute the toolkits when school begins in August 2021. As of this report, sixty-seven trainings to schools, public health agencies, community-based organizations, behavioral health agencies, parent groups, case workers, and counselors had been conducted.

GCACH has also distributed resiliency toolkits to skilled nursing and assisted living facilities, community colleges, domestic violence agencies, faith based organizations, food banks, public health districts, and to behavioral health providers including the Yakama Nation Behavioral Health Services. Local Health Improvement Networks are distributing the toolkits to their partners, and the United Way of Benton and Franklin Counties will be distributing the toolkits through AmeriCorp volunteers in August and September 2021. The Community Engagement Specialist continues to make presentations to the community and the toolkits will be made available until GCACH is out of stock. The total cost of the campaign was approximately $700,000.

**Participation in Local, Regional, and State Meetings and Webinars:** The Executive Director participated in the Local Decision Makers meetings coordinated by the Benton-Franklin Health District, the Department of Health’s COVID-19 Vaccine Implementation Collaborative, and the Vaccine Community Engagement Committee. Information gathered from these valuable meetings was disseminated to the Board, staff, and community as needed.

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

**GCACH Response:**

**Community Health Worker (CHW) Internship Program:** The decision to implement a Community Health Worker Internship program was accelerated by the pandemic as it increased the need for outreach to people requiring resources and linkages to social services. Based upon their life experiences and roles as health influencers within their communities, CHWs have the potential to address social determinants of health needs
and can work to reduce disparities in health care delivery among vulnerable or under-served populations. CHWs can improve health outcomes and the quality of care while achieving significant cost savings in health care, and institutional and social services spending.

While GCACH does not provide direct services to community members, our provider organizations do, and GCACH is committed to help them build capacity to provide better care for their patients. Most importantly, GCACH found an advocate, Providence St. Mary Medical Center in Walla Walla, that was able to demonstrate the value of promoting CHWs as part of a primary care team. While many providers have been reluctant to bring on CHWs because they are not reimbursed for their services, Providence could demonstrate the financial savings and value-add of this unique position.

The purpose of the CHW Internship program was to increase the adoption and capacity of care coordination by using Community Health Workers within GCACH primary care organizations. GCACH’s Workforce Committee in collaboration with the Department of Health and Health Care Authority developed the policy, program and application. The funding opportunity was posted on GCACH’s website, distributed through mail-chimp to all contracted provider organizations, and advertised in the community newsletter. Practice Transformation Navigators reached out to their sites to inform them of the opportunity.

COVID-19 impacted many primary care organizations’ ability to pursue a CHW position due to revenue losses. Eleven organizations applied and were awarded the $50,000 contract in May, however GCACH had budgeted for sixteen positions. GCACH will offer the program again in January of 2022, or when the revenue projections for primary care have improved.

COPE, CALM, CARE Resiliency Campaign: The 2021 DSRIP budget anticipated a large emphasis on the Cope, Calm, Care Resiliency campaign and budgeted $500,000 which was approved by the Board of Directors in 2020. Thanks to a large grant from Cambia Health Foundation and funding from the Yakima Health District, another $313,000 was available which allowed the campaign to have a larger focus on the training and toolkits.

JEDI Specialist Position and Staff Training: COVID-19 greatly influenced the establishment of a new program area for GCACH; diversity, equity and inclusion (DEI). A social justice, equity, diversity, and inclusion (JEDI) specialist position and a pilot program was approved at the June 17th Board meeting. The JEDI Specialist is establishing a pilot program in partnership with the Tri-Cities Regional Chamber of Commerce’s Inclusion Council to form a Speakers Bureau to educate the community on DEI efforts, and to
bring together all DEI committees and councils in Benton and Franklin Counties to discuss racism, disparities, and inequities that exist in the region. Organizations will be encouraged and incented to take a DEI survey which will establish a baseline for Benton and Franklin Counties with respect to where they are at in the DEI journey. GCACH has hired a DEI consultant who will begin training in August so that each staff member can take their own journey, and further their leadership at the individual, interpersonal, organizational, system, and social justice movement level. GCACH will scale the program across the region in 2022 after studying the effectiveness of the pilot.

**Social Determinants of Health Funding:** While the budgeted 2021 funding of $1.4 million to address the social determinants of health (SDoH) did not change, the priorities for each Local Health Improvement Network have differed from the 2019 SDoH distribution due to the pandemic. More focus on behavioral health, housing, food insecurity, and domestic violence emerged from the effects of the pandemic compared to 2019.

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

**GCACH Response:** The Yakama Tribe was essentially closed for business during the first six months of 2021, however the Behavioral Health program was eager to receive the Practice the Pause community resiliency materials, and arranged for training with Catholic Charities. Renewed conversations with Heritage University regarding their behavioral health curriculum include a potential scholarship program for Yakama students seeking a career pathway in behavioral health.

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

**GCACH Response:**

**Extensions to Contracts/Reporting:** GCACH continued virtual support for all partnering providers in the Practice Transformation Program during the reporting period. Extensions for Quarter 1 reporting were allowed due to COVID-19, and extensions to contracts for partners precepting behavioral health interns were extended to June, 2022. These extensions were necessary as the behavioral health interns were not able to be hired during the pandemic, or experience face-to-face clinical work.

**Revenue Sharing Model Combines Milestones for Year 3 Contracts:** The revenue sharing model for year 3 as shown in figure 2 combines milestone payments for care
management and care coordination. While all of the original milestones are retained under each category, this change reinforces that all milestones are necessary in order to produce quality care management and coordination. The combined payment methodology reinforces this concept as well. There was no change to the level of payment for year three; third year payments remain at one-half year two payments at $74,738.

Provider Fallout: Due to the pandemic, GCACH lost one provider with two clinic sites, Chaplaincy Healthcare, at the end of May. GCACH and Chaplaincy Healthcare are in the process of negotiating a substitute site for practice transformation.

Clinic Changes: Astria Health was allowed to transition their Summitview clinic site to a Zillah site due to the closure of Summitview.

Community Health Worker Program: The CHW program attracted two new behavioral health providers, Blue Mountain Health Cooperative and Three Rivers Therapy,
expanding GCACH behavioral health partnerships. The payment allocation to providers was influenced by GCACH’s experience with the Behavioral Health (BH) Internship program; GCACH will allocate the second $25,000 payment after the CHW intern has finished their training from the Department of Health, and reporting will be required on a quarterly basis. This will allow better tracking of each site and more information sharing between providers and GCACH. GCACH is also facilitating regular training for the CHW cohort which will bring the CHWs together on a regular basis. Some of these trainings will be in person to allow for more relationship building which was identified as important to a successful CHW program.

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

**GCACH Response:**

**Risks:**

- Primary Care Doctors Internal Medicine sites – unable to recruit and retain.
- Behavioral Health Specialists – recruit and retain – unable to offer competitive wages.
- Over 80 unfilled Certified Medical Assistant positions – recruit and retain, unable to compete with wages offered for unskilled jobs, such as fast food service.
- Administration - turnover and restructuring.
- Registered Nurse - unable to get applicants.
- Substance Use Disorder Counselors and Care Coordinator - MCO reimbursements are too low to cover costs so the site cannot even post the positions due to lack of funds to pay for them.
- Certified Nursing Assistants - unable to get applicants.
- Long-Term Resourcing – current staffing success is tied to the financial support received from GCACH but due to the lack of reimbursement from MCO’s it is very unlikely they will be able to retain staffing levels.

**Underlying Issues:**

- Unable to Offer competitive wages.
- MA programs in the area stopped clinical training due to COVID-19 temporarily
decreasing the supply of new MA graduates.

- A general lack of applicants for MA positions.
- Due to the recent workforce conditions, some staff do not want to return at all, some want to return at a reduced Full-Time Employment status, and some do not want to return to work until the extra Unemployment Insurance (UI) ends.
- Adding to barriers of returning to work is the issue of childcare; children were at home for school during the pandemic and needed parental supervision. Infant child care is extremely difficult to find and expensive. Remaining on UI benefits is outweighing the costs to return to work.
- These positions require special training and education, staff are leaving these low paying jobs in search of more lucrative careers. They need better reimbursement from MCO’s and other private insurance.

**Mitigation strategies/activities:**

- The new priority is employee engagement, retention, and recruitment.
- A program for employees who make a successful employment referral receive a financial bonus.
- Use of Temporary Agency to recruit staff – without success.
- GCACH Behavioral Health Internship and Training Fund.
- GCACH Community Health Worker Internship Program
- Providers have increased pay and offered sign-on bonuses (without success).
- Many of our sites claim the issue is with pay, they have increased as much as they can and have offered sign on bonuses but still cannot compete with places like Burger King offering $16-19/hr. without any education requirements.

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

**GCACH Response:** Covid-19 hit Pullman hard last year, at one point being an epicenter in the State of Washington and the US as a whole. This was in large part due to the WSU campus students being young and unresponsive to the serious threat that Covid represented. This year Pullman pulled together as a community and tackled getting people vaccinated. Several sites participating in GCACH's practice transformation program came together: Pullman Regional Hospital and clinics, Palouse Family Medicine, and Palouse River Counseling. With other community members from Washington State
Univeristy, pharmacies, emergency management services, and Pullman fire department these sites worked to put up vaccination hubs all over town. All the sites used their empanelment lists to contact patients to come in for their vaccination and started mobile vaccine outreach those without access to transportation. As of June 2021, Whitman County reports some of the highest percentages of people vaccinated against Covid-19 in the state.

Kittitas Valley Healthcare (KVH) and Kittitas County were recognized by CNN for their outstanding work with the vaccinations. View the CNN article here. Kittitas Valley Health, with two family medicine sites and a hospital site, teamed up in a community effort to get the county residents vaccinated per the state’s schedule. KVH worked with Kittitas Fire and Rescue Chief and other county groups to successfully set-up, staff, and run vaccination clinics with zero vaccine waste. Kittitas Valley Health staff and leadership worked after hours and throughout weekends to vaccinate all eligible individuals.

Providence Walla Walla Population Health Team spearheaded the COVID-19 Vaccination efforts for Walla Walla County. Becky Betts, RN, Population Health Manager functioned as the Volunteer Coordinator for the county. The population health team was a great support to the Health Department and worked in collaboration with them to meet the demands of COVID vaccinations. The Mobile Outreach Service Team (MOST) RV (as shown in figure 3) is used to go out into the community for COVID-19 vaccinations to be administered.

![Figure 3: The Mobile Outreach Service Team (MOST) RV](image-url)
16. Scale and sustain update

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

**GCACH Response:**

**2021 Budgeting:** GCACH’s approved budget for 2021 included funds for programs to scale and sustain ACH investments in workforce, social determinants of health, technical assistance for providers in practice transformation, local partnerships, and health equity:

- $1,400,000: Community Health Fund – supports social determinants of health needs in each County – **UPDATE:** $1.4m allocated to high priority SDoH as prescribed by Local Health Improvement Networks

- $850,000: CHW Internship Program – supports whole-person care, care coordination, behavioral health integration, primary care teams – **UPDATE:** Ten agencies have received the first half of contractual funding, $25,000 to support CHWs. Second half of funding, $25,000 will be distributed when their CHW completes their core training from the Department of Health

- $1,500,000: Community Paramedicine Program – supports transitions of care, care coordination, emergency department utilization, expansion of workforce and displaced healthcare workers – **UPDATE:** Planning for program underway

- $500,000: Cope, Calm, Care Community Resiliency campaign – supports COVID-19 relief efforts, community resiliency – **UPDATE:** Cambia Health Foundation and Yakima Health District added $313,000 to campaign. Media campaign has been completed. Some schools receiving training in August/September timeframe. Materials being distributed through Community and Tribal Engagement Specialist.

- $125,000: JEDI (justice, equity, diversity, inclusion) Specialist, Speakers Bureau, Staff Training, community assessments, community training and education – **UPDATE:** Program kicking off on August 19th with the first two speakers presenting at Columbia Center Rotary.

- $7,687,473: Practice Transformation, 3 Cohorts, 80 sites: technical assistance to support practice transformation, bi-directional integration, care coordination and management, learning collaboratives, assessments, reporting – **UPDATE:** on track with all 3 Cohorts. $4,872,989.04 distributed to date.
2022 Budgeting: The Medicaid Transformation Project (MTP) was a five-year Section 1115 demonstration from the Centers for Medicare & Medicaid Services (CMS), however due to COVID-19, the Health Care Authority (HCA) worked with CMS and the state legislature to extend the waiver for a sixth year, 2022, called the “bridge year.” The extension would allow Washington State to continue its COVID-19 relief efforts through each of the MTP initiatives, and further the continued implementation of the MTP’s transformation goals and progress toward value-based care.

HCA coordinated discussions with Tribal governments, MTP partners and stakeholders, and state agencies. One hundred thirty nine million dollars ($139m) of unallocated MTP funding was available, and HCA and the ACHs developed a funding formula based on a minimum threshold of $5 million per ACH region, and an updated Medicaid client count by region. The HCA pursued a 100% pay-for-reporting arrangement to avoid a payment lag so that distributions could be made in 2022 and 2023 for work accomplished during 2022.

HCA and the ACH’s also negotiated a scope of work for the bridge year. The HCA sees the greatest opportunity to explore alignment and shared vision within the following activities:

- Addressing social needs to address equity and health
- Community-based Care Coordination
- Community Information Exchange
- Participation, support, and/or coordination of various HCA initiatives and payment models to advance the vision of “Paying for Health” (This activity is in line with ACH collaborative discussions about the ACH role of being an “innovation center,” providing technical assistance/training, shared learning and convening to support the transformation of care delivery)
- Behavioral Health Integration
- Workforce

GCACH is vetting budget ideas for 2022 that align with year six bridge year activities as agreed upon by the Health Care Authority and the ACHs which include:

- $4.5 million for a community information exchange that will come from DSRIP funding
- $3.1 million to continue practice transformation incentives for Cohorts 1 & 2 with emphasis on care coordination, care management, bi-directional integration, quality metrics, and assessments
- $2.4 million has been obligated for 4th quarter 2021 incentive funding for all three Cohorts
- $.25 million to support Local Health Improvement Networks
- $.2 million to support Yakama students enrolling in a behavioral health program
• $0.5 million for a second round of funding for the CHW Internship program, and scaling up the DEI campaign across the region

GCACH is finalizing its business plan to include a menu of services that will be reviewed by the Board in August 2021 and finalized in September. Figure 4 shows a preliminary menu that identifies four program areas that align with the bridge year activities for year six and have the potential of being sustained beyond the Waiver.

<table>
<thead>
<tr>
<th>Service</th>
<th>Features</th>
<th>Target Audience</th>
<th>Value Proposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Assistance for Providers</td>
<td>Care Management, Bi-Directional Integration, Quality Measures</td>
<td>Healthcare provider organizations (QI leads, leadership) that serve multiple payers, commercial insurers, HCA</td>
<td>Guidance on creating workflows that encompass improved patient outcomes, lower costs, etc. as well as align with state and regional initiatives, readiness for VBP contracting</td>
</tr>
<tr>
<td>Regional Health Collaborative Membership</td>
<td>Monthly meetings featuring educational topics of interest identified by community, Participation in a community information exchange, Access to resources including regional health assessments and data analytics, professional development opportunities, networking with organizations and professionals with similar mission</td>
<td>Healthcare provider organizations, social service organizations, community based organizations, individuals, professionals, general public, state agencies</td>
<td>Gain access to the local and regional healthcare landscape, contribute to identifying and addressing regional health priorities, access to current health data and statistics which can be curated to use for programming and grant applications</td>
</tr>
<tr>
<td>Workforce Capacity Building</td>
<td>Behavioral Health preceptorships, CHW interns, Paramedicine, Learning Collaboratives for partnering providers, CHAPS</td>
<td>Healthcare provider organizations and social service organizations, community colleges, universities, LHJs</td>
<td>Assistance to successfully recruit, hire, train, and retain healthcare professionals</td>
</tr>
<tr>
<td>Regional Health Campaigns, Tools, and Resources</td>
<td>Resilience (ACES, C3), Population Health (vaccinations), DEI, Summits, Regional Health Assessments and Data Dashboards</td>
<td>Leaders in community and state, general public, civic groups and organizations, LHJs</td>
<td>Public education and awareness of regional health issues, Insight into tools that inform work / mission, benchmarks against other communities/states, understanding regional priorities</td>
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</tbody>
</table>

Figure 4: GCACH’s Tentative Menu of Services

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

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

GCACH Response: Yes, $2.4 obligated for 2022 from 2021 DSRIP. This includes final year for Cohort 1 $843,750; Cohort 2 $638,350; and Q1-Q3 of Cohort 3 $1,012, 500 while Q4 of Cohort 3 is obligated for 2023 from 2021 DSRIP.

ii. What types of entities are those funds obligated to?
iii. Will the ACH retain some of this funding for post-2021 admin?

**GCACH Response:** GCACH current funds flow model retains DSRIP funding to support administration salaries through 2023 amounting to $1,503,570 for Project Management, $2,585,702 for Administration, and $1,609,354 for Contingency/Reserve.

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

**GCACH Response:** Cohort 2 finishes their third year of practice transformation on June 30th, 2022, and Cohort 3 finishes their third year of practice transformation on December 31st, 2022, hence $2.4 million is obligated to pay providers for their deliverables.

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

**GCACH Response:** A tentative budget for 2022 allocates $50,000 per provider site for Cohort 1 milestones and $25,000 per provider site for Cohort 2. Cohort 2 finishes their third year of practice transformation on June 30th, 2022, and Cohort 3 finishes their third year of practice transformation on December 31st, 2022, hence $2.4 million is obligated to pay providers for their deliverables.

17. Regional integrated managed care implementation update

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

**GCACH Response:** GCACH continues to collaborate between its contracted behavioral health agencies (BHAs), MCOs, Greater Columbia Behavioral Health Administrative Services Organization (GCBH-ASO) and HCA. GCACH has continued to hold monthly provider meetings that include participation from all of these organizations. These meetings provide the BHAs a place to ask questions of HCA and MCOs and to share information between each other. GCACH has worked hard to keep the lines of communication open between all parties. There are ongoing issues 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 MCOs have been an issue since the inception of IMC. 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 MCO provider contacts within each of the MCOs. Payment delays have improved, but some MCOs continue to perform better than others.

**Service Encounter Reporting Instructions (SERI) Guide:** The ongoing changes being made to the SERI guide continues to create some problems for billing the correct codes. 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 they have fee-for-service contracts and this has been very difficult for some of our smaller agencies. 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. GCACH continues to advocate for VBP contract for our BH providers.

**Challenges with submitting authorization or pre-authorization for services:** This has been an ongoing issue. 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.

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

**GCACH Response:**

**Provider Meetings:** 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. 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. GCACH is invited and regularly attends their monthly Executive
Committee meetings which have been very informative and often lead to further collaborations with GCBH-ASO. GCACH is also able to share information with regard to practice transformation and other GCACH initiatives. 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. The Collective Medical platform has informed providers about patients with high institutional utilization. The implementation of this software has resulted from GCACH’s relationship with the MCOs who are subsidizing the related software costs. The process of following-up on patients after they receive hospital services is also an essential component of the GCACH Practice Transformation milestones. Prior to IMC, 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:** GCACH contracts with two Opioid Resource Networks (ORNs) that provide a bridge between behavioral health and primary care providers. For providers who 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, the ORN is there to provide these resources. Practice Transformation Navigators look for opportunities to connect primary care providers to the local ORN for treatment and wraparound services.

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

**GCACH Response:**

**Integration Assessments:** All providers contracted with GCACH have a milestone related to conducting assessments for integration. Providers are incented to use the Patient-Centered Medical Home (PCMH-A) and the Maine Health Access Foundation (MeHAF) assessments. These assessments are lengthy, time-consuming for providers and staff, questions can be interpreted differently depending on who answers the assessment, and they do not adequately assess provider level of integration. GCACH Navigators provide assistance in filling out the assessments, and generally meet with the Quality Improvement Team at each site to get input from a cross section of the organization. These challenges are not unique to GCACH as discovered in an exercise
that Artemis Consulting conducted for all ACHs. Attached to this SAR is a document called *Summary of ACH Approaches to BH Integration Assessments* that includes challenges from all ACHs, and Managed Care Organizations that includes the key themes across all ACHs to integration assessments and tools.

Artemis Consulting collected input from all ACHs and the MCOs in June of 2020. See figure 5 below for some of the key themes across all ACHs.

![Figure 5: Key Themes Across ACHs](image)

During this reporting period, Quality Behavioral Health (QBH), a BH provider located in Clarkston, was given the opportunity to participate in the Integration Assessment Pilot Project led by HealthierHere. The purpose of the project was to identify an assessment tool that could be implemented statewide, measured integration progress more accurately, and give providers a better understanding of where they stood on their integration journey. QBH participated in a three month pilot using a complementary set of tools, the Continuum Based Framework for Behavioral Health Integration into Primary Care and Continuum Based Framework for General Health Integration into Behavioral Health. QBH is using the experience to improve their integration efforts and prioritize quality improvement efforts. Their hope is if the tool is implemented statewide, communication increases between primary care and behavioral health care providers. Recommendations for moving forward with a framework for statewide adoption were released in a June 30, 2021 summary report from HealthierHere.

*Attachment: Summary of ACH Approaches to BH Integration Assessments (Please see attachment 4 on pages 74-83)*
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>Item</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<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>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
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<tr>
<td>• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</td>
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</table>

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

**Attachment:** Identifying Interviewees at Provider Organizations in our Region (email thread)  
*(Please see attachment 5 on pages 84-89)*
Section 3. Pay-for-Reporting (P4R) metrics

Documentation

19. P4R Metrics

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

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

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

Instructions:

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

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

Format:

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

Narrative responses:

20. If the ACH is not providing updates on the MeHAF this reporting period, please describe what, if anything, the ACH is doing instead to assess partnering provider implementation progress at a clinic/site level? Still collecting MeHAFs; ask Martin for specific MeHAF data. CSI data. Look at Wes’ data on PCMH-A. Specific questions on bi-directional integration

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

Optional: The ACH may submit P4R metric information

Attachment: GCACH.SAR7 P4R metrics. 08.02.2021

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7 https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121
Organizational Changes made during reporting period
1. The Marketing Manager, Lauren Noble, resigned in February 2021 and the Administrative Assistant, Chelsea Chapman, was promoted. The position as been updated to “Business Development Manager”.
2. The Opioid Resource Network Project Manager, Diane Halo, was promoted to Program Director in February 2021.
3. The Director of Finance and Contracts, Haydee Hill, was hired in March 2021.
4. The Office Manager, Damia Safford, was hired in March 2021.
5. The Deputy Director, Wes Luckey, resigned in May 2021.
## ACH: Greater Columbia

**Contact**  
**Name/Title/Email:** Carol Moser Executive Director cmoser@gcach.org

**Date form completed:** 7/13/2021

<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>Expender detail (To whom was the payment made to (provider/facility name, etc.)? How did this payment support the partnering provider and/or community in their response to COVID-19?)</th>
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**Expenses paid from January 1st - June 30th 2021**  
- Lauren Noble Travel to Yakima Campaign expense: $185.60  
- Bustos Media Holdings, LLC: $1,080.00  
- Bustos Media Holdings, LLC: $1,440.00  
- Spotted Fox: $2,016.50  
- SMG Yakima: $2,266.00  
- Spotted Fox: $2,674.50

**Expenses paid in December 2020 listed in blue**  
- $9,662.60

**Total**  
$26,895.46

**Brief description:** The funds listed above were pulled down from the Financial Executor portal and paid to the ACH, however the funds represent payment activity not captured in the portal. ACHs used these funds to support their partnering providers and communities who were impacted by COVID-19. This template provides an opportunity for ACHs to clarify payments made outside of the portal.

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**Carol Moser**  
ACH Signature of Authority  
8/2/2021

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).*

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*Payment reconciliation form, October 2019*
QUALITY IMPROVEMENT PLAN
JANUARY 2020
**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 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.

![Figure 1; PCMH Change Concepts](image)

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.
SAR 4 UPDATE: 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.

**AMENDMENT FORM**

**NO. 1**

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

**A. Description of Change:** Extend the Completion Date to January 15, 2021 and replace Exhibit “A.1” and Exhibit “A.2” Transformation Incentive Allocation Weights and Values Revenue Sharing Model in its entirety with the following:

**Maximum Available Revenue Sharing for 2020 Scale and Sustain**
Partnering Clinic: Catholic Charities Serving Central Washington 2139 Van Giesen St. Richland, WA 99352

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<th>Milestones</th>
<th>2020 Quarterly Maximum Revenue Sharing based on Milestones</th>
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<td>Quarter 1</td>
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<td>2A.2 A Risk Stratification/2A.2 B Risk Stratification Statistics</td>
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<td>6A.1 Selection A (Hospital) identify patients without PCP and make referral</td>
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<td>6A.1 Selection B (Clinic) Follow up contact within 72 hours of IP Discharge</td>
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<td><strong>Total 2020 Maximum Available Revenue Sharing</strong></td>
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*Figure 3; 2020 Revenue Sharing Model*

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 Collective Medical 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**

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

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

**Maximum Available Revenue Sharing for 2021 Scale and Sustain**

**Period of Performance:** January 15, 2021 to January 15, 2022

**Partnering Organization:** CATHOLIC CHARITIES OF THE DIOCESE OF YAKIMA

**Partnering Clinic/Hospital:** Catholic Charities of the Diocese of Yakima - Catholic Charities (Tri Cities)

**Address:** 2139 Van Giesen St, Richland, WA 99352

### Exhibit A.1: 2021 Revenue Sharing Model - Cohort 1

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<tr>
<th>Milestones</th>
<th>2021 Quarterly Maximum Revenue</th>
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</thead>
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<td>Quarter 1</td>
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<tr>
<td>1A.1 Budget Developed</td>
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<td>1A.2 Budget Reconciled</td>
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<td>Care Management ($4,500 total per quarter)</td>
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</tr>
<tr>
<td>2A.1 Empanelment (Excludes Hospitals, Dental, Urgent Care)</td>
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</tr>
<tr>
<td>2A.2 Risk Stratification/2A.2 Risk Stratification Statistics (Excludes Dental)</td>
<td>$4500</td>
</tr>
<tr>
<td>2A.3 Opportunities for those at Highest Risk (Excludes Dental)</td>
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</tr>
<tr>
<td>2B.2 Self-Management Support</td>
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<tr>
<td>2B.3 Medication Management</td>
<td>$1,825</td>
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<td>3A.1 Access and Continuity</td>
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<tr>
<td>4A.1 Patient Centered Interactions</td>
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<tr>
<td>4A.2 Shared Decision Making</td>
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<tr>
<td>2B.1 Bi-Directional Integration</td>
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<tr>
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<td>Reporting</td>
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<td>5A.2 Clinical Quality Metrics</td>
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</tr>
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<td>6A.2 MCO Roster Reporting (Primary Care Only)</td>
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</tr>
<tr>
<td>5A.3 Practice Transformation Implementation Workplan (PTIW)</td>
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</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>
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<tr>
<td>6A.1 Selection B (Clinic) Follow up contact within 72 hours of IP Discharge</td>
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</tr>
<tr>
<td>6A.1 Selection B (Hospital) Identify patients without PCP and make referral</td>
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<tr>
<td>6A.1 Selection C-Care Compact/Agreements</td>
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</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 HTF 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>Total 2021 Maximum Available Revenue</td>
<td>$19,739</td>
</tr>
</tbody>
</table>

Revised: 1-28-20

Quality Improvement Plan
SAR 7 UPDATE: Greater Columbia ACH had an opportunity to participate in a pilot project for testing behavioral health integration into primary care practices using a new framework. The financial and regulatory resources of bringing systematic screening, treatment or referral and follow-up to the primary care setting are challenging for smaller practices, so the Health Care Authority contracted with Healthier Here to identify and pilot a new assessment.

Healthier Here reached out to several ACHs with rural behavioral health providers, including GCACH, who found a willing provider Quality Behavioral Health to pilot the assessment. It is a continuum-based framework for integrating behavioral health and primary care clinics with the goal to advance behavioral health integration into primary care. While the assessment has not been fully vetted, GCACH is allowing Cohort 2 to test it out across the region in lieu of completing two other assessments that have accomplished the same purpose: the MeHAF, and PCMH-A. The NY assessment covers the same content of these two assessments but is more comprehensive and asks more relevant questions. GCACH believes this will be a good process improvement for our providers, but is testing it all with Cohort 2 Behavioral Health providers for 2021-2022 as shown below.

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. Ideally, 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 2021 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 with NCQA- 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

**SAR 7 & UPDATE:** The Learning Collaborative curriculum above has been helpful in providing opportunities to advocate for Patient-Centered Medical Home (PCMH) to the Health Care Authority (HCA). As a result of our Learning Collaborative in February, representatives from the National Committee on Quality Assurance reached out to HCA to speak with them about
PCMH and its value to the state. The Learning Collaborative on Managed Care Organization (MCO) rostering gave GCACH the opportunity to advocate for empaneling patients, and the June Learning Collaborative was attended by the HCA Manager of Quality Measurement & Improvement, Clinical Quality & Care Transformation Division, who encouraged GCACH providers to submit their decision aids on behavioral health to her.

Please see Learning Collaborative flyers on Appendix pages 65-73.

**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 2\(^{nd}\) 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.

**SAR 7 UPDATE:** All three Cohorts (82 sites) are reporting in the CSI portal. The dashboard is reviewed by the Practice Transformation Workgroup to measure progress and show trends.

![Figure 6; GCACH Reporting Dashboard – updated 6.28.21](image-url)
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 Collective Medical
- Staff not working at the ‘top of their license’
- Reworking the reporting to make it more relevant to hospitals.

SAR 7 UPDATE: GCACH continues to meet with the Practice Transformation Workgroup to review quarterly progress, and obtain feedback on milestones. Figure 6 has been updated to reflect the latest reporting cycle, Quarter 1 of 2021.

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
- PMH Medical Center
- Lourdes Health Network
- Yakima Neighborhood Health Services
- Quality Behavioral Health
- Comprehensive Health Care
- Columbia Basin Health Association

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 Collective Medical 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 Collective Medical 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 Collective Medical 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 Collective Medical Platform.
**SAR 7 UPDATE:** Utilization of Collective Medical has increased over time, and 95% of providers are using this platform to follow-up on emergency department utilization and hospitalizations. Because of GCACH’s success in implementing this platform, they are facilitating other providers to gain access to Collective Medical. Catholic Charities of Spokane is building a permanent supportive housing complex in Pasco, and has asked GCACH to help them get access to Collective Medical.

**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 Collective Medical 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 Collective Medical 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.

**SAR 7 UPDATE:** HCA is pursuing a statewide strategy to implement community information exchanges, (CIE) and launched a white paper in March 2021 that describes the various modules that are part of a CIE. HCA is forming a CIE committee that will include ACH representatives. The GCACH Executive Director is part of that committee and their first meeting is scheduled for July 9, 2021.

**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 4; 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.

**SAR 7 UPDATE:** GCACH added a Community Health Worker Intern Cohort in June 2021. Community Health Workers (CHW) play a critical role in improving the health of communities, by linking diverse and underserved populations to health and social service systems. Eleven organizations responded to the internship funding opportunity with nine CHW’s starting the
formal Department of Health CHW training program in July 2021. Training for supervisors of CHW’s occurred on June 22\textsuperscript{nd} and monthly trainings for the Cohort are planned through the end of the program - December 2022. The $50,000 contract with providers requires that the CHW Intern is integrated into the organization’s clinical care processes so that the CHW Intern gains adequate clinical care exposure and training along with a host of other requirements. See example of CHW contract on Appendix pages 57-64.
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

Continuous Improvement

Practice Transformation Organizations

Revised: 7-27-2019
COMMUNITY HEALTH WORKER
INTERNSHIP AGREEMENT

THIS COMMUNITY HEALTH WORKER INTERNSHIP AGREEMENT ("Agreement") is entered
into by and between Greater Columbia Accountable Community of Health, a Washington
nonprofit corporation ("GCACH") and ________________________, a Washington__________________________________ ("Organization").

RECITALS

A. GCACH is a provider of care coordination activities seeking to broaden its purposes
through the expanded use of non-clinical workers or Community Health Workers (CHW) in coordinating the acute need of adult social services, chronic care conditions
and ‘wraparound’ care for those with co-occurring Behavioral Health conditions under
the terms and conditions of this Agreement.

B. The term “Behavioral Health” means the promotion of mental health, resilience, and
wellbeing; the treatment of mental and substance use disorders; and the support of
those who experience and/or in recovery from these conditions along with their
families and communities.

C. The Organization desires to employ a Community Health Worker Intern (“CHW Intern”)
skilled in providing the extended care to those in need of social services, including the
expanded services and conditions to the effectiveness of this Agreement. A CHW is a
frontline public health worker who is a trusted member of and/or have a unique
understanding of the community served. This trusting relationship enables the
workers to serve as a liaison/link/intermediary between health/social services and the
community to facilitate access to services and improve the quality and cultural
competence of service delivery. (Definition taken from the American Public Health
Association)

D. During the Term, the Organization desires to employ a CHW Intern meeting the ‘CHW
Intern Qualifications’ set forth in Section 4 below who is willing to assist, learn and
contribute to the discharge of Intern’s contract with the Organization through a
‘Supervisor’ providing a professional learning experience that offers meaningful,
practical work related to the Intern’s field of study or career interest to the CHW Intern
(“Internship”).

In and for consideration of GCACH’s and the Organization's faithful and full performance under
this Agreement, the parties agree as follows:

1. AGREEMENT. The Organization agrees to manage, administer, fund, instruct and employ a
qualified Intern for the Internship during the Term set forth below in consideration of GCACH
funding the Internship in an amount set forth below.
2. **TERM.** Notwithstanding the execution date hereof, this Agreement shall remain in full force and effect from the Effective Date, June 10, 2021 until the Completion Date, December 31, 2022.

3. **FUNDING.** This Agreement provides financial support for the Organization to mentor, supervise, and provide an internship for one (1) CHW Intern in the amount of $50,000. This Agreement must be completed and signed by all Parties before the CHW Intern may begin the Internship. The first $25,000 payment will be distributed as soon as the contract is signed and the organization is registered in the WAFE Portal. The second $25,000 payment will be distributed after the organization has verified that their CHW has completed their training through the Department of Health.

4. **RESPONSIBILITIES/WARRANTIES OF ORGANIZATION.**
   a. Organization shall provide a Certificate of Insurance to GCACH upon signing this agreement. Organization’s policy shall name GCACH as an “additional insured”.
   c. Organization shall employ or engage one or more Supervisors, with a ‘Supervisor’ being defined as an experienced professional who provides the CHW Intern with: a structured learning experience; training and observation that identify best practices and problem-solving situations; and, structuring the learning process to achieve a set of formally identified learning outcomes, e.g. a licensed nurse who is employed by the facility in which the clinical experience takes place, and who agrees to provide supervision to a CHW Intern for a specified period of time during the Supervisor’s scheduled work hours in order to assist the CHW Intern to meet identified learning objectives.
   d. Organization shall not displace any currently employed worker or alter any current workers’ promotional opportunities, with the Organization warranting that the Organization has not terminated any regular employee or otherwise reduced the workforce in order to hire a CHW Intern.
   e. Organization will work with the CHW Intern to customize and structure their training curricula to address their specific role within the organization.
   f. Organization will conduct a quarterly evaluation of the CHW Intern to report on training and progress using the template in Exhibit A, incorporated herein by this reference. Failure to provide quarterly evaluations will constitute a breach of this contract, and GCACH may seek legal remedies to enforce this requirement.
   g. Organization will provide a written plan documenting training activity for the CHW Intern.
   h. Organization will integrate its CHW Intern into the Organization’s clinical care processes so that the CHW Intern gains adequate clinical care exposure and training.
   i. Organization will provide the CHW Intern with livable wages and benefits (see 1 Adult, zero Children at [https://livingwage.mit.edu/states/53/locations](https://livingwage.mit.edu/states/53/locations)).
j. Organization will encourage CHW Interns to network within the community to understand local resources and services.

k. Organization is encouraged to provide travel reimbursement or transportation, childcare and meals for both online and in-person trainings for CHW Interns.

l. Organization will participate in a training on how best to utilize and support a CHW Intern.

m. Organization will, in addition to the quarterly evaluations required above, evaluate the CHW Intern’s performance and the program of work to demonstrate efficacy of the process after the Term and Internship period has been completed. Such evaluation of the CHW Intern will include:
   1) An estimated return on the Organization’s CHW Intern investment;
   2) Intern and Organization Success stories;
   3) Suggest possible alternative payment streams;
   4) Grant opportunities resulting from the CHW Intern experience; and,
   5) Potential models to sustain the Internship experience.

m. Organization will allow the CHW Intern to participate in a Learning Cohort throughout their internship. A ‘Learning Cohort’ is defined as a collaborative learning style in which a group of individuals advance through an educational program together.

n. Organization certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded in any Washington State or Federal department or agency from participating in transactions (debarred). The Organization agrees to include the above requirement in any and all sub-contracts into which it enters, and also agrees that it will not employ debarred individuals. The Organization must immediately notify GCACH if, during the term of this Agreement, the Organization becomes debarred. GCACH may immediately terminate this Agreement by providing the Organization written notice and remand the unused portion of the CHW intern’s salary if the Organization becomes debarred during the term hereof.

5. CHW INTERN QUALIFICATIONS AND ORGANIZATION ENGAGEMENT OF CHW INTERN.

a. CHW Intern must be a U.S. citizen, permanent resident (I-151 or I-551), or Deferred Action for Childhood Arrivals (DACA) student or provide work authorization to work in the United States. Individuals on temporary visa are not eligible. Additionally, individuals must be authorized or eligible by law to work in the United States.

b. The CHW Intern will enroll in the Washington Department of Health core training for CHWs and receive a certificate of completion at the end of the training.

c. The CHW Intern will participate in other training opportunities throughout their Internship as needed by the Organization.
d. The Organization must not illegally discriminate in training or hiring practices because of race, color, sex, national origin, religion, disability, political beliefs or affiliations, or age.

e. The Organization shall pay all CHW Intern employment related taxes, assessments and fees from the Funding or otherwise, all without further financial assistance by GCACH.

f. The Organization understands that GCACH is only a funding source for Intern and at no time will Intern be considered an employee or contractor of GCACH.

6. RESPONSIBILITIES OF GCACH.

a. GCACH will assist the Organization to register in the Washington Financial Executor Portal.

b. GCACH will provide access to resources, training, and organizational infrastructure tools for the Organization, ensuring that training programs meet approved standards are recognized by employers across the GCACH region. Such training will include themes identified by the 2018-2019 Community Health Worker Task Force and conducted in English and Spanish such as:

   o How to communicate with people who speak other languages or who have disabilities, as well as how to ask nonverbal questions to identify people who may need resources
   o How to develop trust in relationships
   o Mental health, including mental health first aid training, addressing adverse childhood experiences, trauma-informed care, and crisis intervention
   o Community Health Worker self-empowerment, self-esteem, self-care, establishing and maintaining healthy boundaries, and handling second-hand trauma
   o Cultural awareness, diversity, and bilingualism
   o Advocacy and self-advocacy – how to make your case and identify processes for resolution

c. GCACH shall provide the Organization with an evaluation template.

7. MISCELLANEOUS. Time is specifically declared to be of the essence. GCACH and Organization agree to cooperate fully in all matters related to or arising out of this Agreement. Organization acknowledges that the GCACH attorney drafted this Agreement. Organization is strongly encouraged to engage independent legal counsel to assist them. In addition, Organization is also strongly encouraged to engage independent accounting and tax counsel. This Agreement shall be given a fair and reasonable interpretation, without consideration or weight being given to one of the parties. If Waiver by any party of a breach of any covenant, agreement or undertaking contained herein shall be made only by written waiver, and no such waiver shall operate or be construed as a waiver of any prior or subsequent breach of the same covenant, agreement or
undertaking. Except as otherwise specifically provided herein, the exercise of any remedy provided
by law or otherwise and the provisions of this Agreement for any remedy, shall not exclude any
other remedy. GCACH and Organization execute this Agreement solely as contracting parties. No
partnership, joint venture or joint undertaking shall be construed from these presents, and no
third party may rely upon any provision of this Agreement for its direct benefit except as provided
herein. This Agreement is deemed entered into in the State of Washington and shall be governed
under the laws of the State of Washington. Any legal action between the parties arising out of or
pertaining to this Agreement shall be commenced and maintained in a court of competent
jurisdiction in Benton County, State of Washington, which action shall award all attorney’s fees
and costs associated therewith to the prevailing party. The parties hereto understand and agree
that they each have a duty to act in good faith on each and every term and condition of this
Agreement. Every duty and every act which must be performed under this Agreement imposes an
obligation of good faith in its performance or enforcement unless discretion is otherwise allocated
to one of the parties hereto. The parties agree that this Agreement is the entire agreement
between the parties, that all preceding and contemporaneous oral and written statements,
representations and warranties, whether consistent or inconsistent herewith, are agreed to be of
no force and effect unless expressly stated herein. In that regard, GCACH and Organization
stipulate that each and every provision of this Agreement has been fairly bargained for, that the
execution of this Agreement memorializes the intent of GCACH and Organization after thoughtful
consideration of all risks and knowingly and voluntarily assumed such risks. This Agreement shall
only be supplemented or modified in a signed writing by GCACH and Organization. GCACH and
Organization warrant that no broker, agent, consultant, real estate agency or similar person or
entity has assisted in procuring this Agreement. All exhibits, attachments and schedules are hereby
incorporated herein by this reference as if fully set forth herein. In the event a circumstance where
performance by a party is frustrated or impossible due to circumstances beyond a party’s control
(without limitation, acts of God, significant casualty episode (fire, etc.), pandemic, severe acts of
nature, governmental changes in law, regulations or funding, war, terrorism) The parties agree
that their signatures and notary acknowledgments that are faxed to each other shall, when
accumulated, operate as originals. This Agreement may be executed in counterparts.

8. DISPUTE RESOLUTION. All claims and disputes relating to or arising out of this Agreement that
are less than the jurisdictional limit shall be filed in the Small Claims Division of the Benton County,
Washington, District Court with waiver of the provisions of RCW 12.40.080, meaning that the
parties may be represented by legal counsel. The Parties hereby knowingly and voluntarily waive
any right to appeal on any Small Claims judgment, including, without limitation, alleged
procedural errors. All claims and disputes related to or arising out of this Agreement in excess of
the jurisdictional limit or involve equitable remedies, shall be subjected to binding and non-
appealable arbitration as the sole and exclusive remedy. If the parties cannot agree on an
arbitrator, the Presiding Judge of the Benton County, Washington Superior Court shall appoint an
arbitrator versed in the subject matter of the claim or dispute, which arbitrator need not be a
lawyer unless legal interpretation of the Agreement is required. If the arbitrator is a lawyer, the
arbitrator may engage the services of any expert to ascertain specialized factual determinations.
Substantive discovery shall be allowed in the sole discretion of the arbitrator. The arbitration shall
commence not later than ninety (90) days after an arbitration demand. The arbitrator may award damages and injunctive relief and may register a judgment in the court of competent jurisdiction in Benton County, Washington including judgment by default. In any suit, arbitration, proceeding or action to enforce any term, condition or covenant of this Agreement or to procure an adjudication or determination of the rights of the parties hereto, the most prevailing party shall be entitled to recover from the other party reasonable sums as attorney fees and costs.

9. INDEMNITY. Organization hereby agrees to defend, indemnify and hold GCACH harmless from any and all claims that arise out of or are related to the Intern or any other claim that the Organization receives that names GCACH as a party, with the Organization providing specific indemnity to GCACH for any act, omission or claim relating to any and all Organization employees and contractors, including without limitation, Intern. Such indemnity includes without limitation all fees, costs and attorney’s fees.

10. INSURANCE. Organization shall maintain at Organization’s sole expense, general liability insurance from the Effective Date until the Completion Date. The minimum insurance shall be $1,000,000.00 per occurrence, and Organization’s policy shall name GCACH as an “additional insured”, further requiring that Organization’s insurer notify GCACH in the event Organization’s insurance will be canceled. Organization shall provide a Certificate of Insurance to GCACH not later than the Effective Date and shall, upon reasonable notice, provide GCACH adequate assurances of continuing coverage during the performance of the Agreement.

11. NOTICES. Any Notices or other communications shall be in writing and shall be considered to have been duly given on the earlier of (1) the date of actual receipt or sent via electronic transmission, or (3) three days after deposit in the first-class certified U.S. mail, postage prepaid, return receipt requested. By their signatures below, the parties agree to Electronic Transmission of any and all notices to the parties at the emails below:

If to GCACH: Carol Moser
Executive Director
8836 W. Gage Blvd Suite 202A
Kennewick, WA 99336
cmoser@gcach.org

If to Organization: TBD
TBD
TBD
TBD
TBD
This Agreement is executed by the persons signing below, who warrant that they have the authority to execute it.

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

By: Carol Moser
Its: Executive Director
Date: _____________________________

TBD

By: _____________________________
Its: _____________________________
Date: _____________________________
CHW Internship Program Quarterly Report

EXHIBIT A

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<td>Organization:</td>
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<td>Name of Intern:</td>
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<td>Date:</td>
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1. Please describe how the CHW Intern has been integrated into the organization’s clinical care processes during their internship.

2. Please provide an evaluation of their experience(s) with the CHW Internship Program.

3. Please provide some examples of how the CHW is connecting patients with resources in the community to address their Social Determinants of Health? (success stories or barriers).

4. Please provide any feedback on the additional trainings provided by GCACH.
Learning Collaborative Meeting

Topic: TeamSTEPPS Training

The coordination and delivery of safe, high-quality care demands reliable teamwork and collaboration.

TeamSTEPPS has incorporated the best practices from research into a program to improve the quality, safety, and efficiency of health care by improving communication and other teamwork skills. These skills lead to higher, quality care by:

- Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients
- Increasing team awareness and clarifying team roles and responsibilities
- Resolving conflicts and improving information sharing
- Eliminating barriers to quality and safety

GCACH is excited to have Dr. Karen Hill, Senior Consultant of Health Management Associates, conduct a training on this approach.

Please plan on joining us!

Join Us!

Friday | Feb 26
10:00 am - 4:30pm
(Break from 12-2pm)

REGISTER HERE:

bit.ly/gcach-learning

Find more information on the GCACH calendar at www.gcach.org!
Learning Collaborative Meeting

Topic: Business Case for PCMH in Washington State

Greater Columbia ACH is excited to invite the National Committee for Quality Assurance (NCQA) to present a business case on the Patient-Centered Medical Home (PCMH) model in Washington State.

This model is deeply embedded within the Greater Columbia Cares Model (GCCM) practice transformation program.

PCMH is a model of care that puts patients at the forefront of care. Research shows that **PCMHs improve quality and the patient experience, and increase staff satisfaction**—while reducing health care costs.

PCMH prepares providers for successful value-based payment (VBP) contracting.

During this webinar, NCQA will provide an overview of the PCMH model, review the process for NCQA PCMH Recognition, explain how PCMH Recognition leads to improved health care quality, and provide examples of how PCMH Recognition has increased reimbursements and decreased expenses.

Join Us!

Friday | Mar 26
10:00 am-12:00 pm

**REGISTRATION IN ADVANCE IS REQUIRED**

https://education.ncqa.org/content/business-case-pcmh-washington

Continuing Education Credits offered!

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Please join us Friday, March 26th from 10:00am-12:00pm.
Registration in advance is required.
Please see instructions on the following page.
Learning Collaborative Meeting
How to Register for the March Convening

The Business Case for PCMH in Washington, presented for the Greater Columbia Accountable Community of Health (GCACH) and their learners, will be hosted by the National Committee for Quality Assurance (NCQA) through its learning management system (LMS) and delivered live through Zoom. This event will take place on Friday, March 26th 2021 from 10am-12pm.

Please follow the instructions below to register for this course.

1. Navigate to the NCQA LMS homepage: https://education.ncqa.org/.

2. Login or create a new account:
   - If you have an existing account with my.ncqa.org or with education.ncqa.org:
     Please select the “login” link in the middle of the page and then enter your email and password on the next screen.
   - If you do not have an existing account with my.ncqa.org or with education.ncqa.org:
     Please select the “create an account” link in the middle of the page and then the “CREATE ACCOUNT” link on the next screen. Please enter the requested information.

3. Once logged-in, navigate to the course page for this training: https://education.ncqa.org/content/business-case-pcmh-washington.
   - Click on the Register tab and then the “Add to cart” button.
   - In the Shopping Cart, select Checkout.
   - On the Checkout page, confirm that your information was populated correctly, then select “continue” and then “finished.”

You will receive an email from ncqalms@ncqa.org confirming your registration. Please be sure to add this email address to your approved sender list. Program materials and additional instructions on how to join the live training through Zoom will be sent closer to the training date.

Please reach out to Chelsea (cchapman@gcach.org) if you have trouble registering.
For Practice Transformation inquiries, please contact your Practice Transformation Navigator.
Learning Collaborative Meeting
Continuing Education Credits Offered

In support of improving patient care, the National Committee for Quality Assurance is jointly accredited for Continuing Medical Education (ACCME), the American Nurses Credentialing Center (ANCC), the American Academy of Physician Assistants (AAPA), the American Psychological Association (APA), and the Association of Social Work Boards (ASWB) to provide Interprofessional Continuing Education for the healthcare team.

This educational activity is approved for:
2.0 AMA PRA Category 1 Credit™, ANA CNE, AAPA, APA, and ASWB ACE contact hours.

The assigned universal program number: JA0004597-0000-21-004-L04-P. Upon successful completion of this program (attending the full session and completing a program evaluation), participants will access CPE Monitor on the ACPE website to locate and track their CPE statement of credit.

This program grants 2.0 Continuing Education Unit (CEU) points for PCMH Certified Content Experts. This program is not considered a required CCE quarterly webinar.
This learning collaborative is designed to assist practice transformation sites in screening and addressing Social Determinants of Health (SDOH) needs in the clinical setting. *A recent publication estimates that SDOH issues are responsible for up to 40 percent of all preventable deaths in the United States.*

This will be an interactive session with discussions, polls, and break-out rooms. To prepare, we ask that participating organizations bring any screening tools and resource lists they have to share. If an organization has SDOH needs or challenges related to this work, please feel free to email those to Laurel (lavila@gcach.org) or Brittany (bfoxstading@gcach.org) in advance.

*During the learning collaborative, organizations will get to learn about best practices, tools to use, and resources available for SDOH.* We are excited to utilize our collective experience and knowledge to find some solutions to identify and address needs associated with the SDOH. We look forward to participation at the SDOH Learning Collaborative on Friday, April 30, 2021 at 2pm!
Meeting Information

Title: GCACH Learning Collaborative
Date: Thursday, April 30th 2021
Time: 2:00-4:00pm
Location: Zoom - www.bit.ly/gcach-learning

Agenda

2:00 Welcome & Introductions – Recap from April Leadership Council on CIE
2:10 Tools for Social Determinants of Health
3:00 Breakout Sessions – How are other organizations collecting SDOH through EHRs?
3:40 Report Out from Breakout Sessions and Discussion
4:00 Adjourn

CIE - Community Information Exchange
SDOH - Social Determinants of Health
EHR - Electronic Health Records
Knowing which patients are attributed to you by each payer and how value-based payment programs affect different segments of your patient population will help you target your health care team’s resources most effectively. 

*Understanding how attribution works, working your patient rosters and empanelment are important steps to succeeding in effectively managing your patient population, quality metrics and the new payment environment.*

Patient empanelment is considered to be a cornerstone of a high performing primary care system and is believed to improve continuity and access. Panel management, also known as population management, is a proactive approach to health care.

Please join us for the Learning Collaborative on Managed Care Organization (MCO) Rosters on May 21, 2021 where each MCO will present their processes for patient attribution, physician assignment, how to obtain your patient roster, expectations of managing the rosters and how that coordinates with alignment of quality metrics, payment arrangements and better patient outcomes.
Meeting Information

Title: GCACH Learning Collaborative
Date: Friday, May 21st 2021
Time: 2:00-4:00pm

Agenda

2:00  Welcome & Introductions by Sam Werdel and Diane Halo, GCACH

2:10  Roster Overview by Each Managed Care Organization (20m each)
  – Molina Healthcare
  – Community Health Plan of Washington
  – Amerigroup
  – Coordinated Care

3:30  Open Discussion by Sam Werdel, GCACH

4:00  Adjourn

Meeting Takeaway
Walk away with a better sense of how to obtain and manage rosters for each Managed Care Organization (MCO)

Target Audience: Primary Care

Special Thanks to:
Have you explored ways to improve communication and understand evidence important to decision-making in health care?

Central to this discussion has been the notion of “shared decision making,” a term first used by the 1982 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to underscore the key role of patients in the decision process. It has been more than 30 years since the President’s Commission urged the adoption of shared decision making (SDM) as a means to reform physician-patient communication and to improve the day-to-day implementation of meaningful informed consent to medical treatments.

During this Learning Collaborative, we will look at barriers to widespread adoption of SDM in clinical settings. This includes:

- Measuring SDM taking place
- Clinical training in the use of proven SDM methods
- Competing agendas for the agendas for the clinical encounter
- Integration in the electronic medical records (EMR)
- Uncertainty to promote change and invest time in SDM

This discussion seeks to stimulate action toward embedding SDM—which has been called the “pinnacle” of patient-centered care—into clinical practice. Particular attention on the need to ensure the quality, integrity, and availability of patient decision aids, though we recognize that SDM requires not just the use of a tool—it will also require the deployment of skill sets, attitudes, infrastructure, policies, and systems that fully support the meaningful patient-clinician conversations necessary to arrive at truly shared decisions.

Please join us on Friday, June 25th from 2-4pm. Click here to register on Zoom.
## MCO Current Approaches to Assessment of Behavioral Health Integration

*June 9, 2020*

<table>
<thead>
<tr>
<th>MCO</th>
<th>How Integration has been Assessed</th>
<th>Specific Measures/Tools Used</th>
<th>Lessons Learned (Successes/Challenges)</th>
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<tbody>
<tr>
<td>Amerigroup</td>
<td>We have not been broadly assessing integration with a specific tool. Instead, we discuss levels of integration in our individual provider meetings, particularly with our FQHCs.</td>
<td>We haven’t been using a specific tool. We were wary about proceeding with a tool and duplicating efforts of the ACHs. It has always been our plan to build off ACH efforts.</td>
<td>Challenge has been different approaches to assessment being done in different regions. While this is necessary and keeps health care local, from Amerigroup’s perspective of being statewide, any additional assessment we would perform would either be duplicative or confusing what the ACHs had done—we wished we had coordinated with ACHs earlier in a more formal way through MOUs or data sharing agreements.</td>
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| Community Health Plan of WA | • We have systematically assessed our CHCs to understand behavioral health services provided: services, capacity and planning; including for MAT, addressing needs of children, special populations and telehealth.                                                                                                       | Per the HCA contact, we have utilized the SAMHSA framework to assess integration of behavioral health agencies. We also provide CHCs that are engaged in CHPW’s Mental Health Integration Program (MHIP) with resources developed by the AIMS center to assess and advance integration of behavioral health integration through utilization of a clinical registry and other implementation best practices. | • Successes: Assessing integration efforts have allowed for a conversation with providers about their needs and where we can provide support; also, this work has led to one-on-one engagement with clinics. For example, we are working with a pediatric provider in a North Sound to support implementation of the Collaborative Care model to support integration and increase access to behavioral health.  
• Challenge: Coordination among various entities and providers to support integration efforts |


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| Coordinated Care   | From a data analysis perspective, we continue to monitor bi-directional access: MH penetration rates (at the provider and regional level), monitor and drive toward an increase in physical health claims from BH providers, as well as increase in Primary Care BH claims. In meeting with providers and health systems, gauging where providers are at with clinical integration efforts, and what projects or work do they have in motion or areas where they are interested in building capacity or doing process improvement to move in the direction of integration. | • See Q1 response for an example of some specific measures  
• The approach has been to not duplicate efforts with the ACH and other entities while we stabilize the system— for the most part, providers are mainly focused on getting paid.                                                                   | • A reminder of Maslow’s hierarchy of needs: providers need to feel secure in this new environment, get paid, and develop team-based capacity before moving practice focused initiatives  
• Success has been meeting providers where they are at, providing clinical transformation resources (i.e. SBIRT change guide—how to manage addiction in primary care or ideas for universal screening tools) and starting the conversation, and building relationship. |
| Molina Healthcare  | We use a Molina Provider Self-Assessment Tool (since 2017), developed based on SAMHSA, Bree, and Collaborative Care models with additional provider questions (based on provider feedback) to assess integration and support needs. Have assessed pediatric/youth and adult BH and PH providers. Our assessment tools have developed and expanded based on results, advancement of integration and provider feedback. We’ve measured BH and PH providers use of standard evidenced based screening tools, registries or other tracking systems, numbers served in an integrated practice (various choices for type of integration, status and next steps). Assessment tools to date have focused more on process and systematization than outcomes. | • Providers have been engaged and transparent  
• (93% + return survey) and eager to advance integration (typically). Very favorable feedback about our tool and the details imbedded in terms of helping them assess their integration efforts and possibilities for advancement. With IMC expansion to all regions the challenge has been having a way to disseminate the survey, collect results and follow-up with an exponentially increasing number of providers (and many providers are involved with ACH’s so not wanting to duplicate work or create provider burden). |
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<td>UnitedHealthcare</td>
<td>UnitedHealthcare has a copyrighted assessment and a Practice Transformation Guide to assist practices following assessment results. A lot of evidence-based work went into the development using MEHAF, AIMS, BREE and SAMSHA best practices and questions to gauge integration, i.e – we cross-walked work from each of these sources and created an assessment that combined all of the questions.</td>
<td>See Q 1 response – all evidence based and combined and now copyrighted with permission for use granted for the iPAT.</td>
<td>We have assessed 69 providers with 65 responding to date (a 98% response rate). We assessed all ACOs, FQHCs and CMHCs. To date we have provided ratings to all assessed providers and begun our practice transformation work with 17 of the responding practices. 55% of the responding providers showed as Integrated already (registering at a level 4 or above on the iPAT score).</td>
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Summary of ACH Approaches to BH Integration Assessments

June 8, 2020

<table>
<thead>
<tr>
<th>ACH</th>
<th>MeHaf</th>
<th>PCMH-A</th>
<th>Reporting on Initiatives / Projects</th>
<th>Other Progress Reporting</th>
<th>Tracking IMC issues/challenges</th>
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Lessons Learned: Key Themes Across ACHs

- **Providers need support (esp. BH providers)**
  - You need to meet partners where they are with their progress on integration and their goals
  - Behavioral health providers are struggling to implement more than primary care providers.
  - Unclear how VBP will factor into integration, adding added pressure to BHAs to believe they need to achieve a certain level of volume or look a certain way to survive
  - Integration has focused primarily on integration at the primary care/outpatient behavioral health level; there are many other parts of the continuum where integration should be looked at and assessed
  - There is not a lot of support available to providers to either a) assist with the assessment and b) do something with the assessment once complete – know where to go and what to do next.
  - Needs to be a clearer vision for what we mean by integration. Providers feel pressure to co-locate and/or achieve full integration (mergers) under the SAMSHA continuum; however, that is not realistic for all.

- **MeHaf Challenges**
  - The MeHAF tool is interpreted differently by behavioral health and primary care providers which may lead to inaccuracies in reporting.
  - Some MeHAF survey items are not a great fit for BH organizations / seem to cause confusion at times

- **Challenges based on who does the reporting**
  - Most integration tools are agency self-report and results are only as good as the time/effort an organization puts into doing a thoughtful, honest assessment of where they are
  - Staff turnover gets in the way. Often different folks are filling out the MeHAF due to turnover so there can be large changes in responses due to personal perceptions.
  - Person doing the reporting is not always communicating with the folks on the ground who may have a more accurate perception of the level of integration.
  - Requiring a separate MeHAF for each clinic site may not be worthwhile, unless the assessment is explicitly part of a clinic-level, facilitated practice transformation curriculum. Not uncommon for organizations with multiple clinic sites to submit the same ratings for all clinics, or sometimes the same data in the 2nd, organizational domain.

- **Organizational culture is a critical component**
  - Leadership/ provider buy-in
  - Communication within organizations, clarity/training on protocols
Better Health Together

BHT has primarily used the MeHAF survey to assess integration, since that was already required for pay-for-reporting metrics. There have been three rounds of reporting to date, and participation in the 3rd round was small due to COVID-19. BHT is also assessing integration by having partners set and report on their own AIMS and milestones around integration of care (chronic disease, bi-directional integration, Opioid). Year-end reporting for the first contract period is ongoing, but so far about 85% of integration milestones have been met/achieved. Providers also chose from a set of Pay for Achievement measures that further support organizational integration efforts and have to report on progress towards meeting those measures.

In addition, BHT is using the county Collaboratives to connect organizations across sectors (including primary care, behavioral health, SDOH, education, and local government) to facilitate space for creative partnerships and integration of services. The Spokane Collaborative is tracking these partnerships via the Wilder Collaborative Factors survey, implemented every 6 months beginning January 2020. The initial survey identified dozens of partnerships that had been started or strengthened between Collaborative members.

Specific Measurement Tools Used:
- MeHaf
- Aims & Milestones Reporting for contracted partners
- County Collaboratives Survey

Lessons Learned:
- Among BHT respondents, MeHAF scores appear to be increasing slightly over the three time periods
- Some MeHAF survey items are not a great fit for BH organizations / seem to cause confusion at times
- Requiring a separate MeHAF for each clinic site may not be worthwhile, unless the assessment is explicitly part of a clinic-level, facilitated practice transformation curriculum like GCACH or NCACH are running. In BHT’s experience, it’s not uncommon for organizations with multiple clinic sites to submit the same ratings for all clinics, or sometimes the same data in the 2nd, organizational domain.

Cascade Pacific Action Alliance

CPAA leads the IMC Provider Readiness Workgroup in our region which is a collection of cross-sector stakeholders engaging in problem-solving dialogue. This workgroup is the venue where behavioral health agencies bring issues and problems they are having in relation to IMC to the attention of the HCA and MCOs. During the workgroup, CPAA has the opportunity to hear what the issues are, how they are being addressed, and how many agencies are struggling or succeeding. Issues that are commonly discussed include billing, credentialing, claims processing, and more recently, changes with COVID-19. As an ACH, this qualitative assessment is how we measure progress with integration. We rely on input from behavioral health agencies in our region as well as updates from the HCA and MCOs.

Specific Measurement Tools Used:
- MeHaf
- We do not use any other quantitative measures or tools to monitor IMC. This has mainly been the HCA’s role.
- We regularly update a question tracker that shows all the questions discussed during previous meetings.

Lessons Learned:
- Holding a recurring meeting focused on troubleshooting and answering BH agency questions has been crucial.
- Contracting with a technical assistance provider that offers direct assistance to agencies is helpful.
- Better preparation resulted in a smoother transition for some agencies.
- Dedicating a specific team to focus on the IMC transition is crucial.
Elevate Health

We are currently reviewing our contracts and accessing the ability for our providers to continue in the contracts at the same level. We are offering support for staffing, transitions and reporting. We are tracking risks to outcomes required by waiver so we can report our findings to the health care authority and request modifications as necessary.

Specific Measurement Tools Used:
- For those partners that are part of our CCN, we are utilizing 211/Aunt Bertha to document referrals
- Assessments located within Innovaccer to identify and document risk
- MeHAF
- AIMS center shared client roster tool

Lessons Learned:
Successes:
- Clients utilizing our Whole Person Care Collaborative care modules are able to see a Behavioral Health specialist during their Primary Care appointment which allows less waiting and paperwork and more engagement from the client.
- Integration of 211/Aunt Bertha on platform for documenting referrals

Challenges:
- The AIMS client tracker is a third-party tool which sits outside of the EHR system thus requiring additional documentation on both sides
- Due to COVID and no face to face encounters, a lot of integration work was put on hold. Clinics are beginning to open back up and integration work will begin forward progress again.
- Lack of VBP payment strategies in IMC leave gaps in financial structure, Elevate Health has assisted in identifying and addressing short term gaps, while continuing to bring payors, providers, and state agencies to the table to address these issues.

Greater Columbia ACH

GCACH assesses each site using the PCMH-A and MeHAF annually.

Specific Measurement Tools Used:
- The PCMH-A
- MeHAF

Lessons Learned:
- Provider/leadership buy-in
- Provider communication within organizations
- Staff turnover, recruiting barriers (more in rural areas) and internal transitions and/or protocol
- EMR transitions
- Leadership and clinical staff disagreeing on metrics 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
- 42 CFR: 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
HealthierHere

All clinical partners complete the MeHAF every six months and we monitor progress over time; each clinical partner has at least one test site where we are incentivizing improvement over self and additional reporting sites where they also complete the MeHAF every 6 months. HH is funding seven multi-partner integrated care innovations, each one centers the relationship between the BHA and PCP partners and how they are working together to improve health outcomes for individuals with SMI and cooccurring chronic disease conditions. We will be monitoring their progress and evaluating their success; we also hope to use these tests of innovation to “prototype” models of integrated care that can be scaled/expanded to other partners over time.

We are working closely with UW AIMS Center and Comagine Health to provide training, technical assistance, and practice coaching. Sometimes this is around specific MeHAF questions based on what area an organization needs to and would like to improve; agencies receive individualized coaching specific to their organizational needs. Additionally, we have incentivized the use of the Collective Platform to assist with transitions of care and we have introduced the idea that “care guidelines” within the Collective Platform could be shared across the multiple sectors. We are working with our statewide ACH, MCO, and HCA partners to recommend metrics related to the Collective Platform, which could enhance info sharing and integration.

Specific Measurement Tools Used:
- MeHaf (also, drilling down on MeHAF question #2 to gain deeper insights into use of screening tools in the integrated settings)
- Traditions of Health: The Culturally Relevant Integration Model by the California Consortium for Urban Indian Health is used by our Tribal Health partners
- Use of registries in care settings (does the PCP clinic have registries for BH conditions like depression, anxiety, does the BHA site have registries for physical health conditions?)
- Collective Platform use and engagement, developing metrics
- Participants in the now-completed VBP Academy also completed the Value Transformation Assessment (VTA), which is similar to the MeHAF
- Bree Collaborative and the Center for Excellence in Integrated Health Solutions’ Standard Framework

Lessons Learned:
- You need to meet partners where they are with their progress on integration and their goals
- There needs to be a clearer vision for what we mean by integration and what the “north star” is; Providers feel pressure to co-locate and/or achieve full integration (mergers) under the SAMSHA continuum; however, that is not realistic for all providers and services
- Unclear how VBP will factor into integration, adding added pressure to BHAs to believe they need to achieve a certain level of volume or look a certain way to survive
- Integration has focused primarily on integration at the primary care/outpatient behavioral health level; there are many other parts of the continuum where integration should be looked at and assessed
- Most integration tools are agency self-report and results are only as good as the time/effort an organization puts into doing a thoughtful, honest assessment of where they are
- To validate the assessments requires time and resources
- There is not a lot of support available to providers to either a) assist with the assessment and b) do something with the assessment once complete – know where to go and what to do next; also, there is no defined “north star”
  - Just because we make resources available doesn’t mean all partners will take us up on them. Need to think about how to support partners who didn’t take up the training/TA offered and provide the training and TA in multiple ways and venues. That said, following the first reporting period in 2019, having actual data available thru tools like the MeHAF and reviewing it together with providers is a best practice and we were able to encourage more partners to engage with TA and practice coaching during the clinical site visits and after reviewing their MeHAF together.
Change happens slowly and incrementally. Celebrate small changes and have reasonable expectations.

All clinical partners could benefit from additional data analytics and QI support. This would help with PDSA cycles to test new workflows and allow for more of a population health perspective.

Training BH providers on the basics of chronic conditions like diabetes, heart disease, asthma, and COPD is necessary, but not sufficient. Training needs to include how these physical conditions are experienced and/or exacerbated by BH conditions (and vice versa). For example, we had 80 employees from one organization sign up for a training on addressing chronic conditions for individuals with severe and persistent mental illness.

Organizations approach transformation differently so I think our flexible system/portfolio-focused (rather than project-focused) approach worked well and allows us to meet partners where they are. We know our partners are beginning at different places and levels of readiness when it comes to transformation and integration, which should be top of mind as we roll out initiatives.

There are many whole person integrated care initiatives in King County and throughout the state. A landscape analysis is critical to prevent duplication and work towards collective impact.

Workforce shortages remain a challenge for most (if not all) clinical partners.

The importance of interoperable electronic health records and registries cannot be emphasized enough. Clinical partners are eager to create ways to more effectively manage the shared patient populations across multiple organizations and sectors.

Recently, telehealth transitions have inspired interest in brief interventions that are theory based and that can demonstrate impact on improving outcomes. This model is often used in primary care and may have new applications in behavioral health agency setting with the increasing use of telehealth.

Our partners are creative and solution-oriented – willing to test new models of care such as:

- introducing a MA into a behavioral health team and workflow related to collecting blood pressure and engaging with PCPs around A1c labs
- creating a new role for a Wellness Nurse with a care management and population health focus within a behavioral health agency
- using peers, coaches, and community health workers to augment a health care team’s reach into a patients’ community

**North Central ACH**

Chelan, Douglas, and Grant counties began integration January 1, 2018 and Okanogan on January 1, 2019. There was no evaluation plan to assess the integration. NCACH does conduct MeHaf annually.

**Specific Measurement Tools Used:**

- MeHaf

**Lessons Learned:**

- The complaints have been the "poor reimbursement rates."
- The MCOs have informed us that the NCACH region has the lowest behavioral rates in the state.
- Our Behavioral Health Organization (BHO) went away so we have BEACON as the Administrative Service Organization as does SWACH and Pierce County.
North Sound ACH

- All partners participating in bi-directional integration strategies complete the MeHAF every 6 months. A separate MeHAF is collected for each site participating.
- Tracking which organizations have trained providers in Collaborative Care Model of Integration and Bree Collaborative.
- Partners are asked to respond to the following questions related to care integration:
  - What has changed for your organization since implementation?
  - What was challenging, and why? What held you back?
  - Describe how you are using quality improvement (QI) to support implementation.
  - How are you applying requirements and standards of evidence-based models and/or promising practices to your selected strategies within this initiative?
  - Tell us about your collaboration efforts with both ACH and non-ACH partners. Which partners are you working with for this initiative, and how are you collaborating with them?
  - Tell us what policies, procedures, or protocols you have adopted for this initiative and describe your process for implementing them.
  - What do you see as next steps for your work in this initiative? What assistance/resources could help you move the work forward?

Specific Measurement Tools Used:
- MeHAF
- Our Care Integration Questionnaire

Lessons Learned:
- The MeHAF tool is interpreted differently by behavioral health and primary care providers which may lead to inaccuracies in reporting.
- Often different folks are filling out the MeHAF due to turnover so there can be large changes in responses due to personal perceptions. Reporting folks are not always communicating with the folks on the ground who may have a more accurate perception of the level of integration.
- Behavioral health providers are struggling to implement more than primary care providers.

Olympic Community of Health

- Method 1 – OCH asks all behavioral health partners to take the MeHAF twice per year as a component of routine OCH qualitative reporting.
- Method 2 – Also as a part of our twice per year qualitative report, all OCH implementation partners provide and update for all outcomes (including integration outcomes) in their change plan (aka the scope of work for MTP) – there are 6 status levels and we monitor and report progress on this to our Board and through SAR. The levels are: not started, planning, testing, limited implementation, fully implemented, and scaling and sustaining.
- Method 3 – OCH implements a twice per year quantitative report with all change plan partners. We call these “intermediary metrics”. Some of the metrics relate to integration and are closely aligned with P4P and HEDIS metrics.
- Method 4 – OCH conducts 2 site visits per year with partners and we discuss MTP work including barriers and successes related to integration. We summarize results in a report that is shared back with partners and the Board. Note: partners earn incentive dollars for submitting both qualitative and quantitative reports.

Specific Measurement Tools Used:
- MeHAF
- Change plan/ outcomes reporting

Lessons Learned:
- Behavioral health providers are struggling to implement more than primary care providers.
- We are an on-time adopter for IMC so, our biggest lesson learned so far has been to work on financial integration first and then clinical, so we are likely behind other regions.
Southwest Washington ACH

The MeHAF Assessment has a built-in crosswalk to SafetyNet’s Patient Centered Medical Home change concepts. As part of the Integrated Care Collaborative, we are using these 8 change concepts as data points as well. The change concepts are: Care Coordination, Enhanced Access, Patient Centered Interactions, Organized Evidence-based Care, Team-Based Healing Relationships, Empanelment, Quality Improvement Strategy, and Leadership. See attached slide deck for more details.

At the ICC team/organization level, measures depend on their aim statement. For those in the Integrated Care Collaborative, I have attached an overview of the teams, their aim statements and measures. *(Note: This document can be shared upon request.)*

**Specific Measurement Tools Used:**
- MeHaf
- SafetyNet’s Patient Centered Medical Home change concepts

**Lessons Learned:**
- Success: The tool and change concepts have been useful benchmarks for ICC participants even though there are differences in the organizations (rural/urban, physical health/behavioral health) and in the focus of their integration work.
- Challenge: Given COVID-19 and the pause of ICC work, the timing of our mid-point assessment (originally March/April) and the timing of our final assessment (originally Sept) are going to shift.
Fantastic, thank you so much! We will reach out to Minnie.

Really appreciate your help!

Best,
Jordan

From: Sam Werdel <swerdel@gcach.org>
Sent: Wednesday, June 2, 2021 2:21 PM
To: Jordan Byers <byers@ohsu.edu>; Carol Moser <cmoser@gcach.org>
Subject: [EXTERNAL] Re: Identifying Interviewees at Provider Organizations in GCACH's Region

Hi Jordan,
Try Minnie Smith
minnies@cchd-wa.org she is involved with the hospital and on the Practice Transformation QI team.

Respectfully,
Sam Werdel

From: Jordan Byers <byers@ohsu.edu>
Sent: Wednesday, June 2, 2021 4:38:17 PM
To: Sam Werdel <swerdel@gcach.org>
Subject: RE: Identifying Interviewees at Provider Organizations in GCACH's Region

Hi Sam,

Thank you for your quick response!

Our team is hoping to speak with someone at the hospital, it’s a part of our evaluation where we are speaking with folks within hospitals and clinics. Do you by change know anyone familiar with projects at the Columbia County Health System or perhaps another hospital in the GCACH region that you are working with? Or perhaps I could reach out to Martha for ideas?

Thank you so much!
Jordan

From: Sam Werdel <swerdel@gcach.org>
Sent: Wednesday, June 2, 2021 1:00 PM
To: Jordan Byers <byers@ohsu.edu>; Carol Moser <cmoser@gcach.org>
Subject: [EXTERNAL] Re: Identifying Interviewees at Provider Organizations in GCACH's Region

Hello Jordan,
Martha would be a good contact. She was also on our Board of Directors. Martha is involved with all of our partnering providers in Columbia County. If she is unable to provide you with the information you are needing, we can definitely get you in contact with someone else
Martha Lanman  
Administrator  
Columbia County Public Health  
270 E Main Street  
Dayton WA 99328  
509-382-2181

Respectfully,  
Sam Werdel

---

From: Jordan Byers <byers@ohsu.edu>  
Sent: Wednesday, June 2, 2021 12:20:15 PM  
To: Sam Werdel <swerdel@gcach.org>; Carol Moser <cmoser@gcach.org>  
Subject: RE: Identifying Interviewees at Provider Organizations in GCACH's Region

Good morning Carol and Sam,

Hope you are both doing well! I am wondering if you would be able to help us again with some contacts?

We spoke with Cheryl Skiffington at Columbia County Health System, and she recommended we speak with an additional person who is more familiar with project implementation. We’ve been having a tough time getting in touch with Kim Emory, who was her recommendation, and I think Shane McGuire may be more familiar with higher-level financial content and we’d really like to learn about project implementation. We think it’s really important to get this perspective as we’d like to represent the work you are doing with partners!

Would either of you know of someone we could speak with at Columbia County Health System who is familiar with GCACH project work? We would very much appreciate your help! If not, we would be open to ideas for another hospital.

We are so grateful for your help! Please let me know if you have any questions.

Best,  
Jordan

From: Sam Werdel <swerdel@gcach.org>  
Sent: Wednesday, October 14, 2020 10:28 AM  
To: Jordan Byers <byers@ohsu.edu>  
Subject: RE: Identifying Interviewees at Provider Organizations in GCACH's Region

Always welcome Jordan, let me know if we can be of further assistance.

From: Jordan Byers <byers@ohsu.edu>  
Sent: Tuesday, October 13, 2020 12:25 PM  
To: Laurel Avila <lavila@gcach.org>; Martin Sanchez <msanchez@gcach.org>; Sam Werdel
Wonderful! Thank you everyone so much for your assistance! This is incredibly helpful for our team and we are very grateful.

Best,
Jordan

---

Hello,

I am looking at Brittany’s notes and it appears that Deb Watson is the main contact at Pullman Family Medicine. It looks like Deb runs the Practice Transformation meetings for the sites associated with Pullman Regional Hospital.

Deb Watson  
deborah.watson@pullmanregional.org

Laurel Avila  
Practice Transformation Navigator  
Greater Columbia Accountable Community of Health  
8836 W Gage Blvd, Suite 202A, Kennewick, WA 99336  
C 509.820.8638  |  www.gcach.org

“Advancing the health of our population.”

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Hi Sam,

Here is the contact information for Tri Sate:
Joleen L Carper JCarper@TSMH.org – Chief of Clinic Operations
Kelly Pease kpease@TSMH.org – Director of Family Practice

Not sure who the main contact is for Pullman Family Medicine.

Thanks,

Martin Sanchez
Practice Transformation Navigator
Greater Columbia Accountable Community of Health
8836 W Gage Blvd, Suite 202A, Kennewick, WA 99336
C 509.537.2138 | www.gcach.org

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From: Sam Werdel
Sent: Monday, October 12, 2020 1:09 PM
To: Laurel Avila <lavila@gcach.org>; Brittany FoxStading <bfoxstading@gcach.org>; Martin Sanchez <msanchez@gcach.org>
Cc: Jordan Byers <byers@ohsu.edu>; Carol Moser <cmoser@gcach.org>
Subject: Re: Identifying Interviewees at Provider Organizations in GCACH’s Region

Hello Practice Navigators,
Please assist me in connecting Jordan with a contact for the below requested organizations. When emailing your contact please cc Jordan and myself.
Thank you,
Sam
Get Outlook for iOS

From: Jordan Byers <byers@ohsu.edu>
Sent: Wednesday, October 7, 2020 12:15:15 PM
To: Carol Moser <cmoser@gcach.org>; Sam Werdel <swerdel@gcach.org>
Subject: RE: Identifying Interviewees at Provider Organizations in GCACH’s Region

This all sounds amazing, thank you so much! We are interviewing one hospital in the region and have prioritized a couple of practices that meet our sampling structure (one partnering clinic and one non-partnering clinic). No worries that you don’t have folks in mind for the non-partnering organizations, that makes sense. 😊

We’d love to first start with Columbia County Health System and someone from the Pullman Family Medicine practice, but also having names and emails for other folks on this list would be helpful (like the Tri-State Family Practice and the hospital contacts Carol has already listed) to have handy if folks from Columbia County HS or Tri-State are not able to or interested in participating in an interview.

Let me know if you have questions on this!! We are so grateful for your help.
Thank you!
Jordan

From: Carol Moser <cmoser@gcach.org>
Sent: Wednesday, October 7, 2020 7:58 AM
To: Sam Werdel <swerdel@gcach.org>
Cc: Jordan Byers <byers@ohsu.edu>
Subject: FW: Identifying Interviewees at Provider Organizations in GCACH's Region

Sam,
Could you and/or your navigators help Jordan out with connecting with providers as listed below?
Maybe a warm hand-off?

I know that we don’t have a relationship with Swofford and Halma, and the Selah family clinic. I know Hank Hannigan, so I can help Jordan with Whitman Hospital.

Thank you!

Carol Moser
Executive Director
Greater Columbia Accountable Community of Health
8836 W Gage Blvd, Suite 202A, Kennewick, WA 99336
C  509.851.7601 | www.gcach.org

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From: Jordan Byers <byers@ohsu.edu>
Sent: Tuesday, October 6, 2020 5:04 PM
To: Carol Moser <cmoser@gcach.org>
Subject: Identifying Interviewees at Provider Organizations in GCACH's Region

Hello Carol,

I am hoping you can help our team with something.

We are finding it very challenging and slow going to connect with representatives from provider organizations and hospitals that we have sampled/considering from our IEE VBP survey conducted last winter. I know COVID-19 might be part of why it’s been hard, but I’m sure you know much better than
me that these folks are super busy and hard to get in touch with, especially since they don’t know our team.

We are wondering if you have any contacts who could answer questions about VBP, HIT/HIE, and workforce at the following organizations (or someone who could connect us to someone to speak to at that organization):

Practices:
Pullman Family Medicine
Swofford & Halma Clinic (not a partnering organization with GCACH, but thought I’d ask in case you know someone there!) Sorry, Jordan. We have never been successful in talking with anyone at this clinic!!
Selah Family Medicine (not a GCACH partner)
Tri-State Family Practice

Hospitals:
Whitman Hospital and Medical Center – Hank Hannigan
Columbia County Health System – Shane McGuire
Pullman Regional Hospital – Deb Watson

We would be very grateful for any help or information you can provide!

Thank you,
Jordan

Jordan Byers, MPH
Research Associate
Oregon Health & Science University
Department of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
(503) 494-8376
byers@ohsu.edu
### Greater Columbia
#### January 1-June 30, 2021

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<td>Funds Distributed</td>
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<td>Funds available</td>
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#### Table 1: Incentive Funds earned

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

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

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