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CERTIFIED PUBLIC ACCOUNTANTS

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

Healthier Washington Medicaid Transformation

Independent Assessment of Semi-annual Report 3

Reporting Period January 1, 2019 – June 30, 2019

Findings Report: September 2019

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1. Overview

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the state's Healthier Washington Medicaid Transformation (Medicaid Transformation), Section 1115 Medicaid waiver. The focus of the Independent Assessor's work is on Initiative 1, Transformation through Accountable Communities of Health (ACHs).

As part of this engagement, and as required by the Special Terms and Conditions (STCs) of the waiver, Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. These reports must demonstrate progress and attainment of project-specific milestones and metrics achieved during the reporting period to receive incentive dollars. This findings report represents Myers and Stauffer's assessment of ACH semi-annual reports for reporting period January 1, 2019 to June 30, 2019.

2. Independent Assessor Review Process

The Independent Assessor (IA) used the following process to conduct the assessment to review submitted semi-annual reports (SAR).

- **Minimum Submission Requirements Review.** Upon receipt of each ACH's report, a high-level review was conducted to confirm the ACH submitted responses to all questions. Where missing information was identified, a request was made to the ACH for an updated submission.
- **Detailed Assessment.** Primary reviewers conducted detailed assessments of the ACHs' report, and quality improvement strategies. The IA assessed that each ACH addressed all sections of the report and that responses provided detail to confirm progress is being made. Each response to a question within a report sub-section was assessed as complete or incomplete. In addition, the IA assessed each ACHs' reported Implementation Plan progress updates. Where the primary reviewer found a response to be incomplete or requested an additional review for confirmation, a secondary reviewer conducted additional assessment.
- **Requests for Additional Information.** The IA sent requests for additional information (RFIs) to seven ACHs. The RFIs served as an opportunity for ACHs to offer clarification to responses that were initially found to be incomplete and to address identified gaps.

3. Highlights of the ACHs' Semi-Annual Report 3

The following summary describes findings and highlights examples of activities noted by ACHs within their SAR 3 narratives, workbooks or implementation plans update.

- **Achievement Award.** All ACHs submitted their SARs by the July 31, 2019 deadline. Upon submission of RFI responses, all SARs included sufficient detail to show progress made during the reporting period of January 1, 2019 to June 30, 2019. The Independent Assessor recommends HCA approval and full credit awarded to ACHs for achievement.
- **Governance and ACH Support: ACH Leadership and Staff.** While there has been consistency and stability in ACH staffing over the course of the Medicaid Transformation Project (MTP), there has been turnover and open positions during the last two reporting periods that include leadership positions. For example, three CEOs/Executive Directors turned over in the prior period and one during this reporting

period. As ACHs have turnover, and particularly in senior leadership positions, they should monitor closely if and how turnover is impacting the strategic vision of the ACH and need to revise course. A new vision may, for example, slow progress on implementation as changes are identified and communicated to partnering providers. We recommend HCA consider ongoing monitoring of such staffing transitions to assure significant delays in progress do not occur.

- **Training and Technical Assistance.** ACHs continue to provide thorough training and technical assistance opportunities to providers. Onsite technical assistance, learning collaboratives and webinars are commonly provided. At least six ACHs have contracted with Comagine Health (formerly Qualis Health) and/or the AIMS Center of the University of Washington to support training and onsite coaching. Additionally, ACHs are regularly obtaining feedback from providers to assure topics are on target to address provider needs. They have also identified providers who may have best practices in place or who are further along in implementation of certain strategies, and work to provide linkages to other providers who have requested information or support. These exemplary providers may also be asked to present within larger forums, including during learning collaboratives. ACHs are also effectively using their websites to provide and collect training information. For example, Better Health Together (BHT) has an online Technical Assistance Form for use by providers to submit requests.

  We continue to recommend that the ACHs continually consider opportunities to pool resources, for example to offer statewide training or shared trainings, which will support consistent, statewide messaging and education.

- **National Engagement.** ACHs are pursuing opportunities nationally to bring additional perspective to the local MTP transformation. For example:

  - Elevate Health joined a national consortium of service providers and researchers, hosted by the Massachusetts Institute of Technology and Staten Island Performing Provider System (PPS), to address the opioid crisis at the national level. The group shares best practices, policies, and programs that have effectively impacted and reduced addiction and opioid crisis, design policy, and assess capacity and technology needed to replicate and scale best practices, allowing MIT to assess outcomes. Meetings were held in May and July 2019.

  - HealthierHere was selected to participate in Data Across Sectors for Health's (DASH) Mentor Program. The DASH Mentor Program is a national peer-to-peer learning network of the Robert Wood Johnson Foundation, and includes a 10-month mentorship to advance local efforts to share and use multi-sector data to improve community health. The mentorship cohort will be led by HealthInfoNet with a focus on integrating social determinants of health (SDOH) data with clinical data. Topics will include investigating existing technical capacity, assessing current resources available, and exploring how multi-sector data will be used in day-to-day workflows.

- **Workforce Challenges.** ACHs are continuing to identify workforce challenges and discuss opportunities to address workforce issues, with behavioral health workforce shortages a top concern. ACHs noted a lack of qualified applicants in rural communities, particularly for: data analysts, nurse care managers, and chemical dependency providers. One ACH noted this shortage impairs implementing evidence-based protocols, "There are workflows partners would like to implement if they could get the correct staff to complete the work. The high turnover rate of quality improvement staff, or the lack of an established quality improvement team, makes it difficult for rural clinics to have a well-established process for updating policies and procedures and documenting them in a format that is easy to

manage." Workforce gaps are not only regional, but statewide and national. We recommend HCA continue to consider opportunities for strategic collaboration with the ACHs and MCOs from a statewide perspective.

- **Integrated Managed Care (IMC).** Claims payment lags and denials are identified as challenges when moving to IMC. Examples were provided where the ACHs worked with HCA, MCOs, and providers to identify and resolve reasons for the claims issues. However, we recommend the ACHs monitor progress on this issue, and that HCA monitor provider complaints submitted directly to HCA and to the MCOs about claims payment to identify any ongoing issues or trends.

- **Finances.** As noted in Table 1, during the reporting period, an average of 60% of total funds earned were distributed. A wide variance of fund distribution was observed across ACHs from a low of 26% of total funds distributed during the reporting period to a high of 113%, which appears to indicate that one ACH released funds that had been in reserve from prior periods. On average, the greatest portion of funds distribution is allocated to the traditional Medicaid provider at 40%.

Table 1. Funds Earned and Distributed During the Reporting Period[1]

	BHT	CPAA	GCACH	HH	NCACH	NSACH	OCH	EH	SWACH	Average
Total Funds Earned During Reporting Period	$ 17,396,295.00	$ 11,313,792.00	$ 21,829,660.00	$ 33,463,618.50	$ 6,130,010.00	$ 16,820,688.50	$ 4,705,518.00	$ 19,109,624.00	$ 8,136,037.00	$ 15,433,915.89
Total Funds Distributed During Reporting Period	$ 8,172,008.70	$ 10,283,804.50	$ 12,712,570.68	$ 8,534,645.37	$ 2,299,824.70	$ 18,998,932.88	$ 3,233,070.01	$ 9,902,672.80	$ 4,030,482.01	$ 8,685,334.63
% of Funds Distributed by ACH During Reporting Period, by Provider Type										Average %
ACH	11%	33%	12%	32%	0%	33%	20%	0%	21%	23%
Non-Traditional Provider	11%	16%	26%	18%	24%	10%	4%	0%	9%	15%
Traditional Medicaid Provider	50%	32%	42%	3%	37%	40%	46%	78%	38%	40%
Tribal Provider (Tribe)	1%	1%	0%	0%	0%	2%	7%	0%	0%	3%
Tribal Provider - Urban Indian Health	3%	0%	0%	0%	0%	0%	0%	0%	0%	3%
Shared Domain 1 Provider	25%	18%	20%	47%	40%	14%	23%	22%	32%	27%

[1] ***Note:*** *Data presented in this table comes from the Financial Executor Portal reports prepared by the Health Care Authority (HCA). Data was extracted and compiled on July 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019. Percent calculations were computed by the Independent Assessor.*

- **Partnering provider progress in adoption of policies, procedures and/or protocols.** Each ACH is gathering information to confirm partnering provider progress to implement policies, procedures and/or protocols. ACH confirmation occurred through a variety of structured and unstructured methods. We have provided project specific examples below.

    - **ACH Highlight.** In response to Question 13, North Sound ACH provided comprehensive statistics in their SAR 3 submission documenting partnering provider progress on developing guidelines, policies, procedures, and protocols by strategy. In total, North Sound ACH noted that 79.7% of partnering providers reported progress on developing guidelines, policies, procedures, and protocols to support the strategies to which they have committed to implement. The below graphic represents a sample from Table 1 of their submitted document "NorthSoundACH.SAR3.7.31.19Revised.pdf."

Table 1: Summary of Partner Self Report on Progress on Guidelines, Policies, Procedures and Protocols				
Strategy	Not Started	In Progress	Fully Implemented	Delayed
3.2: Integrate Physical Health Services in Behavioral Health Settings	12.5%	87.5%	-	-
3.3: Integrate Reproductive Health Services in Clinical and Community Settings	18.7%	75.0%	6.3%	-
3.4: Integrate Oral Health Care into Physical Health or Behavioral Health Settings	-	100.0%	-	-
Average:	14.5%	79.7%	5.1%	0.7%

- **Project 2A: Bi-directional Integration.** ACHs noted examples of providers changing their policies and procedures to accommodate bi-directional integration of services, as well as examples of progress in changing behaviors. For example, Greater Columbia ACH (GCACH) noted that a clinic found they were identifying, but not addressing behavioral health needs. To address this issue, the clinic has modified workflows to alert the provider when a patient had taken the Patient Health Questionnaire (PHQ-9) and scored 22 or above, flag the need for discussion and referral during the visit, and to update the Electronic Health Record with the information.

  ACHs further noted integration challenges exist for organizations with dissimilar cultures and information technology systems impact the exchange of data and management of shared patients. However, with AIMS Center support provided by ACHs, partnering providers are receiving tools to track shared client rosters and training to improve staff coordination.

- **Project 2B: Pathways HUB Model.** Some ACHs noted development of policies and procedures by HUB lead agencies as well as support to providers in their development of policies and procedures. Specifically, North Central ACH (NCACH) indicated that the Pathways Community HUB lead agency developed and adopted the Action Health Partners Pathways Community HUB General Operations Policies and Procedures Manual. The manual includes policies and procedures, documentation protocols, HUB Monitoring and Quality Improvement protocols, HUB operations, and contracts and forms and was adopted before launching the HUB on Oct. 1, 2018.

  ACHs raised concerns with sustainability of funding for the Pathways Hub Model due to MCOs lack of engagement in contracting to pay for outcomes under the model.

  We recommend HCA consider collecting additional interim performance data from ACHs to capture the reach and impact that the model is generating for care coordination systems throughout the state to establish long-term program viability. Cascade Pacific Action Alliance (CPAA) has already reported that their care coordinating agencies (CCAs) are serving over 450 Pathways clients, which exceeds their 2019 goals. Interim measures could include measures that ACHs currently collect on the number of referrals, clients assigned and pathway disposition.

- **Project 3A: Addressing the Opioid Use Disorder.** ACHs also provided information about progress on addressing opioid use. Examples were provided of partnering providers developing policies and procedures for opioid prescribing. NCACH indicated development of a county-wide opioid network, and the ACH has developed Rapid Cycle Opioid Awards to provide funds to organizations for initiatives to address the opioid epidemic. Additionally, ACHs have held events for providers specific to opioid use and treatment. For example:

    - NCACH's partnering provider, the Confederated Tribes of the Colville Reservation, hosted a site in Nespelem during the Opioid Response Conference: Pathways to Prevention in March 2019. The Nespelem site drew more than twenty participants and developed opioid-focused community action plans. Following the conference, the Tribes entered a formal contract with the ACH to host opioid overdose response trainings and distribute Narcan (naloxone) overdose response kits for use.

    - GCACH co-sponsored The Opioid Use Disorder and Trauma Informed Care Summit which was a two-day event attended by more than 250 providers. The Summit included 30 speakers who were national, state, regional and local experts in their respective areas. The four learning tracks included: Strategies for Managing Patients with OUD; Patients, Payment, and Stigma; Trauma Informed Care; and Innovative Models of Care.

- **Pay for Reporting (P4R).** Twice per year, ACHs will gather detailed partnering provider implementation information at a clinic/site level and report aggregate results to the state. P4R metrics provide detailed information on partnering provider progress.

  During this reporting period, questions that pertained to Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation requested summary statistics related to partner completion of the Maine Health Access Foundation's (MeHAF) Site Self-Assessment Survey. For Project 3A: Addressing the Opioid Use Public Health Crisis, P4R metric data, sought to gather information related to use of prescribing guidelines and protocols in place to support patients with opioid use disorders.

  Table 3 captures respondent counts by provider type per ACH as reported by each ACH via their submitted ACH P4R Reporting Template. The level of reported participation of community based organizations (CBOs) by HealthierHere and Elevate Health is particularly notable.

Table 2. P4R Respondent Summary by Provider Type

4. Regional Quality Improvement Strategy

The regional quality improvement strategy conveys ACH support partnering providers in establishing and engaging in quality improvement processes and defines the feedback loop for partnering providers to report to the ACHs on transformation progress. The strategy is defined at the ACH level, and the process is defined at the partnering provider level, either for the organization or site level.

The ACH quality improvement strategy addressed:

- **Partner responsibilities**. Expectations and responsibilities for partnering providers in continuous quality improvement.
- **Regional framework.** A regional framework for supporting quality improvement processes by partnering providers.
- **Monitoring.** Approaches to monitor and understand partnering providers' progress and connect partners with resources and technical assistance.
- **Support.** Methods to support partnering providers in making necessary adjustments to optimize transformation approaches.
- **Dissemination.** Methods to disseminate successful transformation approaches and lessons learned across ACH partnering providers, and potentially across ACHs.

The partnering provider process addressed the following:

- Identifying aims.
- Defining measures and tracking data to assess transformation approaches.
- Adjusting transformation approaches.
- Reporting progress and developments to the ACH.

- **Overview of Quality Improvement Strategies**

  - **Frequency.** Five ACHs (NCACH, GCACH, North Sound ACH, Elevate Health, and SWACH) are requiring quarterly reporting. Three ACHs (BHT, HealthierHere, Olympic Community Health) are requiring semi-annual reporting. CPAA is following a mixed approach requiring change plan milestones to be reported quarterly while implementation partners are asked to submit interim metrics semi-annually.

  - **Submission.** Many ACHs have developed online portals as the vehicle to collect reporting information from partnering providers. Several are utilizing the same portal, HealthcareCommunities.org. According to the Healthcare Communities website, this site offers nearly 70 virtual communities and more than 30,000 users from different healthcare-related organizations to work together on shared interests and goals, regardless of location. The site was originally developed in 2005 to support HRSA's Health Disparities Collaboratives.

  - **ACH Highlight**. NCACH noted that their portal was designed to accept entry of numerators and denominators for measures that a practice wants to improve. The system calculates the actual measure based on the numerator and denominator and then allows the practice to view a dashboard of measures over time so that progress toward improvement can be monitored.

    Additionally, in the spirit of transparency, all member organizations can view one another's measure results.

- **Feedback.** Each ACH has developed various mechanisms to capture and synthesize provider information and to complete feedback loops and broadly disseminate lessons learned. Below are examples:

  - **BHT**. Creates a summary report showing the proportion of each partner's milestones that are complete/on track versus at risk/not started. If a partner's report indicates that 25% of the milestones are at risk, BHT follows up directly with the partner to develop a mitigation plan.

    BHT contracts with Providence CORE to provide a suite of monitoring reports covering MTP P4P measures, enrollment trends, population demographics, select health care utilization markers by payer, and potentially preventable hospitalizations. In particular, BHT identifies the "number needed to reach target" to clearly understand how providers must meet metric targets.

  - **Cascade Pacific Action Alliance (CPAA).** Created an access database to track all partnering provider participation, including tribes and CBOs, in MTP activities at the clinic/site level. CPAA issues quarterly performance emails to individual MTP partners and a regional report to the broad stakeholder group. The regional performance report includes an overview of finances, training opportunities, community engagement, and Community CarePort (Pathways) data.

- **Greater Columbia ACH (GCACH).** Reviews provider report submissions to identify organizations that have a deficiency during the reporting period. The Practice Navigator follows up with the clinic to discuss the deficiency and offers a 6-day grace period to work with the Practice Navigator to correct the deficiency to receive the full value assigned to that milestone. The Director of Practice Transformation then reevaluates the deficiency for full, partial, or no point payment.

  GCACH disseminates positive progress by sharing PCMH success stories monthly in their Community Newsletter that is distributed to over 1,100 individuals associated with GCACH, and reviewed monthly with the GCACH Board of Directors.

- **HealthierHere.** Reviews provider report submissions and informs clinical partners when their scores indicate they are not making sufficient progress. This initial outreach may happen via email and a phone call from the assigned Practice Transformation Manager. Additionally, the team may schedule an in-person meeting (or, if not practical, an extended virtual meeting) to discuss and analyze situation in greater depth.

- **North Central ACH (NCACH).** Tracking progress using both structured and organic feedback loops. NCACH notes that, "QI expectations and framework are much more structured for "traditional" clinical providers (based on the Institute for Health Improvement (IHI) model for improvement), while non-traditional Medicaid providers are encouraged to learn and improve through more informal mechanisms." To begin the process successfully, NCACH scheduled one-on-one conversations following the first round of reporting to provide positive and constructive feedback on their narratives, charters, and measures.

- **North Sound ACH.** Conducts a qualitative analysis of partner reporting, and indicated in its report that it planned to begin site visits in July 2019 to understand implementation strategies that are working well, which partners are experiencing delays, and to clarify partner requests for technical assistance/training.

- **Olympic Community Health (OCH).** Synthesizes all partner inputs to assess overarching regional progress, successes, barriers, and needs which inform future investments by OCH in training, technical assistance, and resources. Results are shared with all partners and the Board of Directors. Partner convenings feature presentation and discussion of HCA P4P quantitative data and annual targets, partner success stories, and partner networking.

  OCH shares partner spotlights in monthly e-newsletters distributed to its broad dissemination list and sends weekly community briefing emails with upcoming meeting and event information, resources, trainings, and updates.

- **Elevate Health.** Expects to track and publicize P4P measure results. Beginning Q1 2020, funding from Elevate Health to direct partners will be contingent upon performance improvement.

- **SWACH.** Will summarize and share results of reporting with staff and leadership as part of monitoring activities. These reports will enable SWACH to identify partners at risk of not meeting agreed-upon milestones in a timely fashion and curate emerging promising practices and lessons learned that can be spread across the region.

Some project specific content from partner reports will be summarized for workgroup or cohort use cases (e.g., the Opioid Taskforce may wish to monitor the frequency and spread of guideline training across the region) on a quarterly or ad hoc basis.

- **Recommendations.** The below recommendations are made to ensure a thorough quality improvement strategy plan is maintained and updated by ACHs.

    - We recommend ACHs consider incorporating their AIM statements, driver diagrams, and/or logic models into their quality improvement strategies. This will ensure that new and existing staff continuously reinforce the goals the region is striving to achieve.

    - While ACHs met requirements for submission of quality improvement strategies and included the requested detail, we recommend HCA with the IA consider offering recommendations for future quality improvement strategy updates in each SAR. For example:

        - Elevate Health and North Sound ACH provided information and updates in a helpful and clear manner that others may want to consider. This allows stakeholders to more readily monitor and disseminate progress and lessons learned over time.

        - Performance accountability and improvement, along with sustainability are on the near horizon for ACHs to address. For those ACHs that do not include measures in their quality improvement strategy, we recommend ACHs consider incorporating, minimally by reference to an associated document, a list of measures (interim and/or outcome) are monitored.

    - In particular, North Sound ACH raised the concern that there may be an insufficient number of partners committed to each strategy to make significant change in the region. North Sound ACH indicated that it is mitigating this risk through efforts such as engaging King County Public Health to obtain access to data for key metrics. We recommend that this potential risk area continue to be monitored by HCA, and the IA will also be working to obtain detailed information during the Mid-Point Assessment.

    - ACHs have developed report dashboards and are gathering data from various pertinent sources. We recommend that HCA continue to support ACH cross-collaboration to assist all ACHs in developing analytic capabilities that supports monitoring and disseminating progress and lessons learned over time.

5. Summary Recommendations for Payment of Incentives

Tables 4 through 6 below provide an overview of ACH projects, Achievement Values (AVs), and incentives that can be earned by ACH for achieving milestones for the reporting period January 1, 2019 to June 30, 2019. Each ACH can earn 1.0 AV per milestone per project. After review of responses to requests for additional information, the Independent Assessor found all ACH reports to be fully responsive and complete and recommend full credit be awarded for all milestones as noted in Table 5.

Table 3 provides the total potential AVs for each ACH by project that can be earned. If an ACH is not participating in a project, the table will display a dash (-).

Table 3. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period January 1 – June 30, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	8	6	-	-	7	-	-	6	27
Cascade Pacific Action Alliance	7	6	6	-	7	6	-	6	38
Greater Columbia ACH	8	-	6	-	7	-	-	6	27
HealthierHere	8	-	6	-	7	-	-	6	27
North Central ACH	8	6	6	6	7	-	-	6	39
North Sound ACH	8	6	6	6	7	6	6	6	51
Olympic Community of Health	7	-	-	6	7	6	6	6	38
Elevate Health	8	6	-	-	7	-	-	6	27
SWACH	8	6	-	-	7	-	-	6	27

Table 4 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the independent assessment.

Table 4. Potential P4R Achievement Values (AVs) by ACH for Semi-annual Reporting Period January 1 – June 30, 2019

	BHT	CPAA	GCACH	HH	NC	NS	OCH	EH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	6	8	6	4	4
Potential AVs for semi-annual reporting period January 1 – June 30, 2019									
Milestone: Description of partnering provider progress in adoption of policies, procedures and/or protocols	4	6	4	4	6	8	6	4	4
Deliverable: Completion and approval of quality improvement plan	4	6	4	4	6	8	6	4	4
Milestone: Attestation of successfully integrating managed care (Project 2A / early and mid-adopters only)	1	-	1	1	1	1	-	1	1
Deliverable: Completion of Semi-annual Report	4	6	4	4	6	8	6	4	4
Deliverable: Completion/maintenance of partnering provider roster	4	6	4	4	6	8	6	4	4
Milestone: Engagement/Support of IEE Activities	4	6	4	4	6	8	6	4	4
Deliverable: Report on quality improvement plan	4	6	4	4	6	8	6	4	4
Milestone: Completion of all P4R metrics (Project 2A, 3A only)	2	2	2	2	2	2	2	2	2
Achievement Values for First Reporting Period									
Assessed September 2019	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	27	38	27	27	39	51	38	27	27
Total AVs Available	27	38	27	27	39	51	38	27	27

For each ACH, Table 5 provides incentives available by funding source for completion of Semi-annual Report 3.

Table 5. Total P4R Project Incentives Available by ACH for Achievement of the Implementation Plan Milestone

ACH	Earned AVs	Project Incentives
Better Health Together	27	$4,502,756
Cascade Pacific Action Alliance	38	$4,093,415
Greater Columbia ACH	27	$5,730,781
HealthierHere	27	$9,005,512
North Central ACH	39	$2,046,707
North Sound ACH	51	$6,140,122
Olympic Community of Health	38	$1,637,366
Pierce County ACH	27	$4,912,098
SWACH	27	$2,865,390
Total		**$40,934,146**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

6. Key Considerations by ACH

In addition to the overall trends identified in Section 4 across ACHs, Tables 6 through 23 below provide examples of key considerations, including examples of progress and strengths and examples of adjustments and opportunities for each ACH for HCA review for purposes of ongoing monitoring and that may want to be shared across ACHs. Identified opportunities are based solely on information provided in the semi-annual reports. Upon requests for additional detail or discussion, ACHs may be found to have more extensive work occurring in the identified areas. Recommendations provided by the IA for HCA or the ACH are noted. Each ACH may also assess whether the recommendation should be implemented within their region.

Better Health Together (BHT)

Table 6. Better Health Together (BHT) Key Considerations

Findings for Better Health Together (BHT)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• BHT has made progress in its support of Tribal Partners, and provided two good examples of their collaboration: - Tribal Partners are discussing a collaboration to implement a community-based care coordination project. With the Medicaid state plan amendment, they can designate as Tribal FQHCs, bill for services outside of their clinics, and contract with other providers to expand care coordination services. They will create a referral network to allow better service with their tribal health systems. - BHT approved an alternative payment method for Tribal Partners to have flexibility to implement transformation efforts that are culturally appropriate within their health systems. Projects selected include care coordination, mental health peer support specialists in a rural school district, dental health aide therapy implementation, and EHR system implementation. • Starting April 1, 2019, BHT is contracting with 19 behavioral health and primary care partnering providers. An additional 22 will enter into contracts in October, 2019. • BHT offered a monthly Learning Cohort with opportunities for training, technical assistance, and shared learning between partnering providers. Topics included Introduction to Change Management, Planning Sustainable Team Roles, Whole Person Chronic Care Management, and Creating a Culture of Patient-Centered Care. • BHT maintains an integrated managed care (IMC) webpage to provide a one-stop resource including meeting notes, provider questions/answers, resources from the state and MCOs, and a list of upcoming meetings and trainings.	• BHT continues to note behavioral health workforce issues as a top concern and that the shortage of providers may impact regional capacity for service and transformation. ***HCA Recommendation:*** Domain 1 includes the development and implementation of resources to support workforce strategies at statewide and regional levels. HCA may seek to expand methods for regular collection and strategic collaboration for workforce development. • BHT continues to have challenges related to MCO contracting to pay for outcomes under the Pathways Hub model. There is concern that without MCO engagement, funding for this model is not sustainable. ***HCA Recommendation:*** HCA may consider sharing successful approaches that maximize coordinated HUB incentives. • BHT notes that Health Information Technology (HIT), including health and/or community information exchange, needs a statewide vision and solution due to the need for statewide interoperability and the significant investment that will be required to move this work forward.

Table 7. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$2,183,154
2B: Community-based Care Coordination	6	6	$1,500,919
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$272,894
3D: Chronic Disease Prevention and Control	6	6	$545,789
Total	**27**	**27**	**$4,502,756**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

Cascade Pacific Action Alliance (CPAA)

Table 8. Cascade Pacific Action Alliance (CPAA) Key Considerations

Findings for Cascade Pacific Action Alliance (CPAA)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• Of the 949 milestones identified in CPAA's partners' progress reports, 607 were completed and 253 remain in progress. This represents an 80.41% (weighted average) Regional Compliance Score. CPAA notifies partners on a quarterly basis of their compliance score as well as the compliance score for the region. • CPAA held 13 trainings during the reporting period including the first certified peer counselor training.	• CPAA had changes in leadership and other staffing during the reporting period. ***ACH Recommendation:*** CPAA should monitor closely if/how staffing changes and vacancies impact the ACH's strategic vision or be prepared to revise course if outcomes are not favorable to meeting stated goals. • In response to the workforce shortage, CPAA is routinely providing regional training opportunities. ***ACH and HCA Recommendation:*** Domain 1 includes the development and implementation of resources to support workforce strategies at statewide and regional levels. It is commendable that CPAA is providing training to combat the workforce shortage, and we recommend continuation of such opportunities. HCA may seek to expand methods for regular collection and strategic collaboration for workforce development. • CPAA uses a vendor to provide technical support for up to 25 organizations that request assistance implementing any of the six projects areas. ***ACH Recommendation:*** As the vendor is responsible for the key component of in-house support to build capacity for practice transformation (e.g., workflow workshops, optimization of EHR reporting), CPAA should ensure there is a comprehensive quality management plan in place to monitor and evaluate vendor performance.

Table 9. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	7	7	$1,559,396
2B: Community-based Care Coordination	6	6	$1,072,085
2C: Transitional Care	6	6	$633,505
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$194,925
3B: Reproductive and Maternal and Child Health	6	6	$243,656
3D: Chronic Disease Prevention and Control	6	6	$389,849
Total	**38**	**38**	**$4,093,415**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

Greater Columbia ACH (GCACH)

Table 10. Greater Columbia ACH (GCACH) Key Considerations

Findings for Greater Columbia ACH (GCACH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• GCACH's report narrative points to forward movement on initiatives. For example, as a result of required milestones, many partnering providers have incorporated new procedures into daily workflows and most have updated procedures to be able to accurately empanel patients and complete risk stratification of high risk patients. • GCACH has had success in supporting relationship building and collaboration across partnering providers. Providers are sharing materials, such as procedures and job descriptions, and best practices. During the reporting period, an exemplar organization that is PCMH certified discussed the pros/cons of certification with another organization, which the ACH will use as a panel discussion at an upcoming Learning Collaborative. • GCACH's quality improvement strategy includes a thorough approach and description of support to providers such as Practice Transformation Navigators (PTNs) and monthly learning collaboratives. Several resources and tools are available to providers for reporting and review of milestones and barriers. • GCACH has processes for identifying adjustments and lessons learned. Based on partnering provider input, have already made adjustments to approaches, and have asked providers to present lessons learned at learning collaboratives.	• GCACH originally planned to support the Yakama Reservation with its need for a Dental Health Aid Therapist. The GCACH redirected resources to the Health Commons project due to legal challenge by CMS. GCACH identified an opportunity to support the Yakama Nation Behavioral Health Services for internet upgrades and to work with a consulting firm to establish a Health Commons that will act as a communications and information exchange between applicable Yakama Nation programs to implement the Family Reunification Workflow project. • Behavioral health providers experienced challenges with claims rejection and payment after the January 2019 transition to managed care. GCACH met with HCA, the MCOs, and providers to resolve challenges, and reported that claims reprocessing was to be completed in June. ***ACH and HCA Recommendation:*** In addition to GCACH monitoring progress on this issue, we recommend HCA monitor provider complaints submitted directly to HCA as well as to MCOs about claims payment processing to identify any ongoing issues or trends. • Workforce challenges continue to be a concern. While GCACH has provided partnering providers with funding for use to enhance recruitment and/or retention, staff turnover and recruiting are noted as barriers in rural areas. ***ACH and HCA Recommendation:*** Domain 1 includes the development and implementation of resources to support workforce strategies at statewide and regional levels. HCA may seek to expand methods for regular collection and strategic collaboration for workforce development. • Provider leadership and buy-in has been particularly challenging for organizations with a hospital participating in practice transformation. The GCACH Executive Team has met with several hospital leadership teams to promote the importance of transformation. ***ACH Recommendation:*** Continue to monitor leadership buy-in to make ongoing adjustments as needed to support transformation success.

Table 11. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$3,217,280
2C: Transitional Care	6	6	$1,307,020
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$402,160
3D: Chronic Disease Prevention and Control	6	6	$804,320
Total	**27**	**27**	**$5,730,781**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

HealthierHere

Table 12. HealthierHere Key Considerations

Findings for HealthierHere	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• HealthierHere was selected to participate in Data Across Sectors for Health's (DASH) Mentor Program. The DASH Mentor Program is a national peer-to-peer learning network of the Robert Wood Johnson Foundation, and includes a 10-month mentorship to advance local efforts to share and use multi-sector data to improve community health. The mentorship cohort will be led by HealthInfoNet with a focus on integrating SDOH data with clinical data. Topics will include investigating existing technical capacity, assessing current resources available, and exploring how multi-sector data will be used in day-to-day workflows. • HealthierHere is developing a structured interview guide and data collection tool to assess progress with implementation and identify opportunities for partners to enhance workflows, etc. • HealthierHere is also planning for site visits and conduct of routine audits to ensure accuracy of the information submitted to HealthierHere.	• HealthierHere noted challenges with setting up population health tools, such as patient registries and risk stratification tools. Several partners expressed a desire for support developing patient registries (e.g., to identify patients at risk of OUD relapse or who have chronic conditions) to allow for more proactive outreach and intervention. HealthierHere has provided partners with coaching through Comagine Health and other resources to overcome this challenge. HealthierHere will continue to identify and evaluate opportunities to support partners' applications of population health tools. ***ACH and HCA Recommendation:*** Domain 1 includes development and implementation of resources to support population health strategies at statewide and regional levels. HCA may seek to expand methods for regular collection and strategic collaboration for patient tracking. • Challenges with interoperability across IT platforms: Several clinical partners noted challenges with integrating the Collective Ambulatory platform with their Electronic Medical Record so that it does not require a separate log-in or duplicative data entry. Others noted challenges in sharing patient information with organizations for which they do not have established relationships. HealthierHere is funding practice coaching and optimization support for the Collective Ambulatory platform and exploring establishment of a regional CIE and Shared Care Plan to facilitate information sharing among and across clinical and community partners. HealthierHere will use clinical partners' feedback and experiences to inform additional investments in Collective Ambulatory coaching and optimization as well as involve them in the potential development of a CIE. ***ACH and HCA Recommendation:*** Domain 1 includes development and implementation of resources to support population health strategies at statewide and regional levels. HCA may seek to expand methods for regular collection and strategic collaboration related to the Collective Medical platform and shared care planning.

Table 13. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$5,055,726
2C: Transitional Care	6	6	$2,053,889
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$631,966
3D: Chronic Disease Prevention and Control	6	6	$1,263,932
Total	**27**	**27**	**$9,005,512**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

North Central ACH

Table 14. North Central ACH Key Considerations

Findings for North Central ACH (NCACH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• Two formerly open Practice Facilitator positions have been filled (2.0 FTEs). Practice Facilitators support each stage of practice transformation in a clinical setting from design to implementation to spread of best practices. • NCACH designed its portal to accept entry of numerators and denominators for measures that a practice wants to improve. The system calculates the actual measure based on the numerator and denominator and then allows the practice to view a dashboard of measures over time so that progress toward improvement can be monitored. Additionally, in the spirit of transparency, all member organizations can view one another's measure results. • NCACH is contracting with other organizations to provide telehealth. • NCACH provides training to help partners with value-based care/the rural multi-payer model, and is allocating funding to the development of a CDP Apprenticeship.	• Regarding funds distribution, North Central ACH indicated no funds have been distributed during the reporting period in the Administration category or to Tribal providers. Further, approximately 60% of design fund balance remains (slight improvement from what was reported on SAR 2.0, 76%). ***Recommendation:*** HCA should continue to monitor distribution of funds to ensure the ACH is adequately supporting administrative/operational functions to support achievement of overall program goals. In addition, HCA should continue to monitor funds distributed to Tribal providers to ensure the ACH is leveraging all opportunities to engage such providers. • ACH has distributed approximately 20% of incentives to assist BH providers in support of IMC, up only 6% from SAR 2.0 period. ***Recommendation:*** HCA should continue to monitor distribution of funds to BH providers to ensure ACH is appropriately positioned to meet overall integration goals.

Table 15. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$711,898
2B: Community-based Care Coordination	6	6	$489,430
2C: Transitional Care	6	6	$289,209
2D: Diversions Interventions	6	6	$289,209
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$88,987
3D: Chronic Disease Prevention and Control	6	6	$177,975
Total	**39**	**39**	**$2,046,707**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

North Sound ACH

Table 16. North Sound ACH Key Considerations

Findings for North Sound ACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• Work with the Tribes and Indian Health Care Providers: North Sound ACH board now has seven of the eight tribal seats filled and began a Tribal and Equity Learning Series on May 22, and all 49 implementation partners had staff in attendance. • Partners requested more opportunities for cross-sector collaboration and a way to learn about which partners are implementing similar transformation approaches. North Sound ACH responded to this request by creating a directory for partners illustrating which partners are committed to and working on strategies and implementation tactics. In addition to this directory, North Sound ACH will be hosting a partner retreat on August 7-8, 2019 which will provide dedicated time to support partner collaboration and coalition building. • To address provider requests for information about Evidence Based Models, the North Sound ACH has launched a weekly webinar series that will include informational webinars on evidence-based practices hosted by content experts. • North Sound ACH has begun a required tribal and equity learning series for implementation partners, and will continue to share tribal and equity resources when available.	• A primary risk identified by North Sound ACH is insufficient number of partners committed to each strategy to make significant change in the region. The ACH is mitigating the risk through gap analysis and resulting strategy to fill gaps, incentivized partner reporting and assigned project manager, and engaged King county Public Health to get access to data for key metrics. ***HCA Recommendation:*** HCA may want to request more detailed information about the extent of the concerns for transformation, as well as interim reporting on status. Ongoing monitoring will be important to fully understand the extent of the risk. • To address challenges for partners with developing and formalizing data sharing platforms, the ACH has begun discussions with potential vendors of HIE and collaboration software platforms. ***HCA Recommendation:*** Continue to monitor progress in addressing data sharing capabilities. • The ACH indicated challenges specific to opioid strategies. The Regional Opioid Work Group was previously housed within the North South BHO. With the transition from the BHO to the BHASO, there is a potential for momentum to be lost in this work. To address challenges, ACH staff have had multiple meetings with BHO staff to understand ways in which the ACH can keep this work moving forward. The North Sound ACH staff will also work with the BHASO to develop a communication plan to effectively share news of this change with appropriate partners as it relates to opioid work in the region. ***HCA Recommendation:*** Given concern for loss of momentum, we recommend HCA conduct ongoing monitoring to assure continued progress and/or mitigation strategies if challenges continue.

Table 17. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$1,964,839
2B: Community-based Care Coordination	6	6	$1,350,827
2C: Transitional Care	6	6	$798,216
2D: Diversions Interventions	6	6	$798,216
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$245,605
3B: Reproductive and Maternal and Child Health	6	6	$307,006
3C: Access to Oral Health Services	6	6	$184,204
3D: Chronic Disease Prevention and Control	6	6	$491,210
Total	**51**	**51**	**$6,140,122**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

Olympic Community Health (OCH)

Table 18. Olympic Community Health (OCH) Key Considerations

Findings for Olympic Community Health (OCH)	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• OCH provided space for partners to share knowledge in alignment with the work and goals of MTP, build and strengthen partnerships across the region, and learn about early successes and best practices of MTP work. • Communications platform: MCOs, HCA, and providers needed an online platform that could serve as a repository for files and learning space. OCH made this available on ORCA (OCH's online reporting platform used for MTP). MCO and HCA contacts involved in IMC as well as all providers going through IMC are now registered on ORCA. • OCH staff traveled to each of the three tribal health clinics to meet with their teams and learn more about the work that each clinic does, including successes and challenges with transformation efforts. These site visits demonstrate OCH's commitment to spend time in communities throughout the region, including remote tribal communities. • Increased collaboration amongst partners including coordination of EHR and reporting systems. Convening partners allows for opportunities to connect. Partners report, "Care has never been so coordinated." • Several Implementation Partners have expanded service lines including: three new dental clinics across all NCCs, increased crisis and residential services for mental health and SUD, and investment in care coordination staff.	• Little progress was made to establish an early warning system since the SAR 2.0 Reporting period. Meetings are noted as beginning August 2019. ***ACH Recommendation:*** OCH should put into place evidence of quality improvement practices that will be evaluated to demonstrate qualitative progress on implementing the Early Warning System. • During the reporting period, OCH noted they underwent significant administrative changes. The former executive director transitioned out and a new executive director was on boarded. The change in leadership necessitated a pause in strategic planning while onboarding. ***ACH Recommendation:*** OCH should continue to monitor and evaluate the new strategic plan for success and necessary adjustments.

Table 19. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	7	7	$806,088
2D: Diversions Interventions	6	6	$327,473
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$100,761
3B: Reproductive and Maternal and Child Health	6	6	$125,951
3C: Access to Oral Health Services	6	6	$75,571
3D: Chronic Disease Prevention and Control	6	6	$201,522
Total	**38**	**38**	**$1,637,366**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

Pierce County ACH dba Elevate Health of Washington

Table 20. Pierce County ACH Key Considerations

Findings for Pierce County ACH dba Elevate Health of Washington	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**

• For the Pathway HUB project, Elevate Health noted the following:
  • In DY2, Q4 implemented all 20 standard pathways for the pilot target population, and 337 clients received care coordination from a Care Coordination Agency (CCA) in 2018. This information is provided by MCO, which indicates the ACH is able to make the connection to the MCO and avoid duplication.
  • The ACH now provides payments to CCAs with 100% earnings dependent on performance in closing Pathways and earning Outcomes-based Payments (OBP). The ACH's goal is to contract with at least one MCO to facilitate sustainable payment of OBPs to the CCAs.
• For Project 3A specific to opioids, Elevate Health:
  • Is in process of standing up Community Health Action Teams (CHAT) to deter costs for high utilizing patients.
  • Has joined a national consortium of service providers and researchers, hosted by the Massachusetts Institute of Technology and Staten Island Performing Provider System (PPS), to address the opioid crisis at the national level.
  • Is establishing cross-sector partnerships to transition from a punitive response to overdose to one that promotes restorative justice and ensures individuals receive proper clinical care and medication assisted treatment to deter addiction.
• Elevate Health is contracted to support the Puyallup Tribe of Nations' implementation of the Nurse Family Partnership (NFP) program in conjunction with funding from the Tacoma Pierce County Health Department. The program matches a registered nurse with low-income mothers in early pregnancy through the child's second birthday.
• For all partners, a clinical improvement advisor is assigned to assist with project planning, management, and monitoring results.
• Elevate Health offered an example of a comprehensive integration project that includes co-developing policies, procedures, and job descriptions to ensure successful launch of their Collaborative Care Program. This includes
	• Of the 21 staff positions listed on the organization chart, several remain unfilled and there have been gaps over two performance periods, including data and operational positions. There is currently an interim CMIO and the sole program director position under OnePierce is vacant.
	HCA Recommendation: Consider opportunities for shared learning on hiring and maintaining workforce development opportunities.
	• Elevate Health noted challenges in defining measures, tracking data, and establishing cohorts of patients to track across two organizations working on integration efforts. The ACH utilized its Clinical Improvement Advisor to begin addressing the challenges until funding to hire a long-term project manager was approved to offer on-going support.
	HCA Recommendation: Continue to monitor the ACH's data analytics capabilities.
	• Pierce County went live with IMC in January 2019. The ramp up was administratively challenging for smaller providers, many of whom were concurrently implementing new EHR systems. Elevate Health assisted by conducting workgroups on future-state process changes, including regional plan for residential treatment facilities, MAT adoption, and referral processes.
	ACH Recommendation: Continue to monitor burden of transformation and IMC on providers and impacts to participation levels and progress on initiatives.
	• There are challenges for implementing the Whole-Person Care Collaborative when developing information sharing, when organizations do not use the same EHR, making the exchange of data and management of shared rosters difficult. Elevate Health is partnering with the AIMS Center to share best practices to work through issues in a shared-learning environment.
	HCA Recommendation: Continue to monitor progress in addressing data sharing capabilities.
	• The majority of MCO claims systems weren't ready to accept claims for processing 1/1/19, causing a delay in processing and reimbursement. Elevate Health collaborated with all payers in Pierce County and HCA to implement a

Findings for Pierce County ACH dba Elevate Health of Washington	
deploying screening, risk stratification methods, developing job descriptions and meetings between Boards of Governance to share policies and strategic direction. • Elevate Health hired an outside firm, the Center for Outcomes, Research & Education (CORE), to independently evaluate the Pathways model, along with other Care Continuum Network (CCN) activities.	contingency plan for providers to utilize when delays in the Service Encounter Reporting Instructions (SERI) update impacted their system builds. This plan was developed by the ACH and presented to HCA with MCO and provider support. It was subsequently widely adopted across the state. ***HCA Recommendation:*** In addition to Elevate Health monitoring progress on this issue, we recommend HCA monitor provider complaints submitted directly to HCA as well as to MCOs about claims payment delays to identify any ongoing issues or trends. • A threat noted by Elevate Health is the continued limitations on direct access to state data to support a more informed view of the clients in the region. The ACH is developing a regional data-driven population health strategy built on community and provider-led data sharing. This will allow "smart targeting" for interventions and investments. ***HCA Recommendation:*** Consider working with MCOs and ACHs to create enhanced data sharing capabilities.

Table 21. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

Pierce County ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$2,381,623
2B: Community-based Care Coordination	6	6	$1,637,366
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$297,703
3D: Chronic Disease Prevention and Control	6	6	$595,406
Total	**27**	**27**	**$4,912,098**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach

SWACH

Table 22. SWACH Key Considerations

Findings for SWACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• SWACH documents examples of partnering providers sharing policies, procedures and/or protocols (examples listed for each contracted provider). One of the more significant examples: "SWACH contracted with four agencies to serve as Care Coordinating Agencies (CCAs) in the implementation of Pathways HealthConnect across the SWACH region. Through shared learning, agencies develop and update policies and procedures, and are engaged in continuous quality improvement and ongoing tests of change."	• SWACH had turnover in three staff positions during the reporting period. ***HCA Recommendation:*** Consider opportunities for shared learning on hiring and maintaining workforce development opportunities. • No funds have been distributed to tribal providers; however, the SAR narrative notes that, "SWACH has been working with the Cowlitz Tribe during and before the reporting period to develop a Clinical Transformation Plan, scope of work, budget and contract that would facilitate Cowlitz's implementation work in 2019-20. SWACH has met on a regular basis with tribal leaders, clinical leaders, and administrators for the Cowlitz Tribe. These meetings led to the completion of a scope of work, budget and contract during the reporting period." SWACH also notes activities with the Yakama Nation Tribe and indicates that "SWACH and Greater Columbia ACH will combine financial resources to support the Yakama Nation Tribe." ***Recommendation:*** HCA should continue to monitor distribution of funds to Tribal providers to ensure the ACH is leveraging all opportunities to engage such providers.

Table 23. Achievement Values and Earned Incentives for Reporting Period January 1, 2019 – June 30, 2019

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	8	8	$1,389,280
2B: Community-based Care Coordination	6	6	$955,130
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	7	7	$173,660
3D: Chronic Disease Prevention and Control	6	6	$347,320
Total	**27**	**27**	**$2,865,390**

Note: Shared Domain 1 Investments were omitted pending a decision on funding approach