



**Healthier Washington Medicaid Transformation  
Accountable Communities of Health**

**SWACH Semi-annual report**

***Reporting period: January 1, 2019 – June 30, 2019***

***SAR 3.0***

**Release date: January 31, 2019**

## Table of contents

Table of contents.....	2
Semi-annual report information and submission instructions.....	3
ACH contact information.....	7
Section 1. ACH organizational updates.....	8
Attestations.....	8
Attachments.....	9
Documentation.....	9
Section 2. Project implementation status update.....	13
Attachments.....	13
Documentation.....	16
Narrative responses.....	16
Attestations.....	20
Section 3. Pay-for-Reporting (P4R) metrics.....	21
Documentation.....	21

## Semi-annual report information and submission instructions

### ***Purpose and objectives of ACH semi-annual reporting***

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

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

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

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

### ***Reporting requirements***

The semi-annual report for this period (January 1, 2019 to June 30, 2019) includes three sections as outlined in the table below.

Semi-annual reporting requirements (January 1, 2019 – June 30, 2019)		
Section	Item num	Sub-section components
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-14	Attachments/documentation <ul style="list-style-type: none"> <li>- Key staff position changes</li> <li>- Budget/funds flow update</li> </ul>
<b>Section 2. Project implementation status update</b>	15-17	Attachments/documentation <ul style="list-style-type: none"> <li>- Implementation work plan</li> <li>- Partnering provider roster</li> <li>- Quality improvement strategy update</li> </ul>
	18-19	Narrative responses <ul style="list-style-type: none"> <li>- General implementation update</li> <li>- Regional integrated managed care implementation update</li> </ul>
	20	Attestations
<b>Section 3. Pay-for-Reporting (P4R) metrics</b>	21	Documentation

**There is no set template for this semi annual report.** ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

### ***Achievement values***

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

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

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. The amount of Project Incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given payment period.

For DY 3, 75% of all Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of January 1 through June 30, 2019, determines achievement for half of the available P4R-associated Project Incentives. The remaining half of the P4R Project Incentives will be earned through the semi-annual report covering the period from July 1 to December 31, 2019.

ACHs will earn AVs and associated incentive payments for demonstrating fulfillment of expectations and content requirements. AVs associated with this reporting period are identified in the table below.

*Table 1. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period Jan. 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
Pierce County ACH	8	6	-	-	7	-	-	6	27
SWACH	8	6	-	-	7	-	-	6	27

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

ACHs must submit their completed semi-annual reports to the IA **no later than July 31, 2019 at 3:00p.m. PST.**

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

ACHs must submit their semi-annual reports through the WA CPAS: <https://cpaswa.mslc.com/>.

**ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 3 – July 31, 2019.”**

The folder path in the ACH’s directory is:

*Semi-Annual Reports* → *Semi-Annual Report 3 – July 31, 2019.*

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

### **File format**

ACHs must submit semi-annual reports that provide HCA and the IA an update on regional project implementation progress during the reporting period. Reports should respond to all required items in this guidance document. ACHs are encouraged to be concise in narrative responses.

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

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

- *Main Report or Full PDF:* ACH Name.SAR3 Report. 7.31.19
- *Attachments:* ACH Name.SAR3 Attachment X. 7.31.19

***Upon submission, all submitted materials will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).<sup>1</sup>***

### ***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, 2019 – June 30, 2019.

ACH semi-annual report 3 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe

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

<b>ACH semi-annual report 3 – submission and assessment timeline</b>			
1.	Distribute semi-annual report template and workbook for reporting period January 1 – June 30, 2019 to ACHs	HCA	February 2019
2.	Submit semi-annual report	ACHs	July 31, 2019
3.	Conduct assessment of reports	IA	Aug 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 26-31, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 27- Sept 15, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Aug 28-Sept 30, 2019
7.	Issue findings to HCA for approval	IA	September 2019

**Contact information**

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

## ACH contact information

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

<b>ACH name:</b>	SW Washington Accountable Community of Health (SWACH)
<b>Primary contact name</b> <b>Phone number</b> <b>E-mail address</b>	Barbe West 503-515-8252 <a href="mailto:Barbe.West@southwestach.org">Barbe.West@southwestach.org</a>
<b>Secondary contact name</b> <b>Phone number</b> <b>E-mail address</b>	Susan Crandall 503-515-6958 <a href="mailto:Susan.Crandall@southwestach.org">Susan.Crandall@southwestach.org</a>

## Section 1. ACH organizational updates

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

### Attestations

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

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

<sup>2</sup> <https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26>

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

## Attachments

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

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

***If applicable, attach or insert current organizational chart.***

### 10. Budget/funds flow.

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

## Documentation

The ACH should provide documentation that addresses the following:

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

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. Moreover, SWACH's team has engaged with the Cowlitz Tribe through the Equity Collaborative in the region. Cowlitz will participate in the yearlong initiative and will also receive additional incentive dollars to complete specific milestones in the collaborative.

The SWACH executive director has been engaged with the Yakama Nation Tribe during this

reporting period to address opportunities to develop a Clinical Transformation Plan, which would include the social determinants of health and behavioral health/physical health integration. An agreement was established between SWACH and Greater Columbia ACH to work in partnership with the Yakama Nation Tribe in order to improve efficiency for the Tribe. Two meetings were held with tribal representatives to understand the issues with continuity between behavioral and physical health and with departments that are accountable for social determinants. A high priority for the Tribe is the establishment of an electronic communication system between departments/entities that will result in improved coordination of care and service. SWACH and Greater Columbia ACH will combine financial resources to support the Yakama Nation Tribe.

## 12. Design Funds.

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

Earned Design Funds	Design Fund Expenditures	Remaining Design Fund Balance	Percent remaining
\$6,000,000	\$3,080,231	\$2,919,769	49%
Use Categories	Design Fund Expenditures	Expenditures details (narrative)	
Administration	\$1,271,721	Administrative operating expenses of SWACH (salaries, facilities, etc.)	
Community Health Fund	\$0	N/A	
Health Systems and Community Capacity Building	\$546,755	Pathways Hub development and education; community integration	
Integration Incentives	\$0	N/A	
Project Management	\$313,995	Development of process for Work Plan and Contracting submission, including measurement and reporting process	
Provider Engagement, Participation & Implementation	\$945,310	Development of payments to partners for engagement and participation in work groups	
Provider Performance and Quality Incentives	\$2,450	Transformation plan development	
Reserve/Contingency Fund	\$0	N/A	
Other:	\$0	N/A	
<b>Total</b>	<b>\$3,080,231</b>		
Design Funds will continue to be utilized to support SWACH staff and consultants who will be working with clinical and community-based partners to implement/support work plans as defined in the Binding Agreements. Design funds will also be used to support the administrative operations of SWACH (rent, IT, etc.). Design funds are also set aside for contingency planning.			

**13. Funds flow.** If the ACH has made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission, attach:

- The ACH’s current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.
- Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.

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

- Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- ACHs may use the table below or an alternative format as long as the required information is captured.
- Description of use should be a brief line item (not narrative).

Description of Use	Expenditures (\$)	
	Actual	Projected
HIE/HIT and Clinical Assessments	\$612,500	
1) Investments into provider organizations to support evidence based clinical integration models	\$709,027	\$3,510,973
2) Investments into provider organizations to support workforce development for integrated care teams		
3) Investments to support shared learning and science of improvement across networks of care		
4) Investments for practice transformation personnel and/or training		
5) Partnership investments to support community and clinical linkages		
6) Investments to support the advancement of using equity as a lens to support continuous quality improvements		
7) Investments to support IT investments related to new clinical and administrative process.		



## Section 2. Project implementation status update

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.

### Attachments

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

#### 15. Implementation work plan

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

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

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

---

<sup>3</sup> Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

“Work Step” column and the “Timing” column. This column should reflect the status assigned to the work step.

- The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to bet started.
- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

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

## 16. Partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.<sup>4</sup> ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:<sup>5</sup>

- *Health systems and community capacity building*
- *Financial sustainability through participation in value-based payment*
- *Bidirectional integration of physical and behavioral health*
- *Community-based whole person care*
- *Improve health equity and reduce health disparities*

The partnering provider roster is a standard component of semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in Medicaid Transformation activities.

To earn the achievement value associated with this reporting component, ACHs are required to confirm and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites (“potential site list”), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites (“potential site list”) to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific “potential site list” to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
  - Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).
  - When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

### ***Submit partnering provider roster.***

---

<sup>4</sup> Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

<sup>5</sup> <https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf>

## Documentation

The ACH should provide documentation that addresses the following:

### 17. Quality improvement strategy update

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

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

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

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

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

***Attach or insert quality improvement strategy update.***

## Narrative responses.

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

### 18. General implementation update

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols:* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.
  - Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?

The attached Partnering Providers Executive Summary (*See Addendum “SWACH Partner Change Plans Overview\_SAR\_7.5.2019”*) provides a high-level overview of the 29 clinical and community partnering providers contracting with SWACH as well as the aims, programs, partnerships and collaboratives with which they are engaged to support systems transformation and adoption/adaptation of policies, procedures and/or protocols.

- SWACH requires quarterly progress reports toward identified milestones from all partnering providers. SWACH reviews reports and meets with partners to ensure continued progress towards aims and milestones.
- Contracts specify payments associated with outcomes. Full funding for partners is contingent on successful and demonstrated progress toward milestones.
- Partners engaged in Pathways HealthConnect have bi-weekly and monthly meetings with a quality improvement focus.
- SWACH supported Opioid Taskforces provide forums for project, progress and implementation updates (Clark County Opioid taskforce, Opioid Treatment Network [OTN] Workgroups, regular convening of Regional OTN collaborative)

Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.

- In addition to examples detailed in *Addendum “SWACH Partner Change Plans Overview\_SAR\_7.5.2019”*, the table below describes additional examples of partnering providers sharing policies, procedures and/or protocols.

<b>Partnering Providers</b>	<b>Shared Policies/Procedures/Protocols</b>
SeaMar CHC, Community Voices Are Born (CVAB)	SWACH supports a formal partnership between CVAB and SeaMar to embed a Hep C peer in the clinical workflow for Hep C treatment and to provide peer support to Hep C patients through and after treatment until test of cure.
Share, Clark County Public Health (CCPH)	SWACH facilitated partnership to expand harm reduction services through CCPH partnering and increasing capacity of Share’s mobile syringe exchange program.
Klickitat Valley Health (KVH), Klickitat Jail	SWACH supported Opioid Treatment Network (OTN) and related partnership between KVH and Klickitat Jail to provide Medication Assisted Treatment (MAT) for incarcerated population.
Klickitat Valley Health (KVH), Washington Gorge Action Program (WGAP)	SWACH supported OTN and Pathways HealthConnect to provide peer support and care coordination in clinical setting (hospital, ED and primary care) for Opioid Use Disorder (OUD) population.
Klickitat Valley Health (KVH), Washington Gorge Action Program (WGAP), Comprehensive Behavioral Health	SWACH supported OTN and Pathways HealthConnect collaboration to increase access to behavioral health services. Partners developed an ongoing OTN workgroup, with participation of a peer navigator from WGAP. Peer perspective informed change in protocol and development of a new system in which Comprehensive Behavioral Health providers come to the KVH setting to offer assessment and engagement with continuing behavioral health treatment.

PeaceHealth, Lifeline	SWACH supported collaboration to develop a medication first rapid response treatment clinic for OUD.
PeaceHealth, Lifeline	A SWACH supported OTN developed formal partnership between PeaceHealth and Lifeline to induct persons with OUD in hospital and ED settings and connect to low barrier and continuing treatment services post-discharge.
Community Voices are Born (CVAB), SeaMar CHC, Skamania County Community Health (SCCH), Washington Gorge Action Programs (WGAP), SWACH	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.
Community Voices are Born (CVAB), SeaMar CHC, Skamania County Community Health (SCCH), Washington Gorge Action Programs (WGAP), PeaceHealth, Lifeline, NorthShore, Klickitat Valley Health (KVH), SWACH, Skyline Hospital, YWCA, Veterans Assistance Center	SWACH Pathways HealthConnect has supported development of referral procedures and protocols between agencies to refer community members to SWACH for care coordination and the Pathways HealthConnect CCAs. The network of referral agencies will continue to grow with the Pathways HealthConnect program.
Klickitat Valley Health Family Medicine, Legacy Salmon Creek, Northshore, PeaceHealth, Providence, SeaMar CHC	SWACH supported partners registering and receiving WSMA Opioid reports.
WSU Extension, SWACH, Community Voices are Born (CVAB), SeaMar CHC, Skamania County Community Health (SCCH), Washington Gorge Action Programs (WGAP), SWACH	SWACH supported development of networked, consistent programming of Chronic Disease and Self-Management Education (CDSME) programing. WSU Extension to serve as the regional coordinator and license administrator for CDSME as well as CDSME program delivery. All partners will deliver regular and scheduled CDSME programming.
Vancouver Clinic, PeaceHealth, SeaMar CHC, Klickitat Valley Health, Sound Physicians, Choice Wellness Centers, Community Services NW, Emergency Medicine Associates, Legacy Medical Group, Multnomah County Jail, Pacific Medical Centers, Providence Medical Group	SWACH has provided leadership in the regional opioid response and partnered with PeaceHealth provider champions to coordinate and deliver six Medication Assisted Treatment (MAT) Waiver trainings to providers across the region. SWACH has developed video training tools (e.g. Practical Application of Suboxone in a Clinical Setting) with local champions to advance the sharing of best practices, protocols etc. in working with opioid affected population.

Describe any challenges faced by partnering providers in the adoption of policies, procedures and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?

- SWACH works with providers to develop and cultivate partnership relationships grounded in dynamics of shared learning, collaborative and collective impact,

- and continuous tests of change to achieve and share best practices for system transformation.
- SWACH works with partners to overcome challenges to adoption through a range of strategies. SWACH support for these partners includes direct formal and informal consultation, technical support, quality improvement collaboratives, shared learning and collective impact collaboratives, and a framework of regular review and follow up of partner progress reports.
  - Some examples:
    - Development of WA Portal for partners and SWACH to support cross-setting communication, collaboration and shared learning
    - QI framework and technical assistance for development of Medication Assisted Treatment Rapid Response Clinic
    - QI framework and technical assistance for development of the Hep C Cures project of integrating peers into clinical settings
    - SWACH facilitated cross-sector Opioid Collective Impact Taskforces
    - SWACH facilitated multi-partner Equity Collaborative
    - SWACH facilitated multi-partner Clinical Integration Learning Collaborative

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

The following challenges or risks are potentially viable in certain projects:

1. A specific transformation project requires two major healthcare partners to work in collaboration to improve health outcomes for Medicaid members. These two partners have had ongoing differences for years, and yet, the majority of the Medicaid population in Clark County is in these two organizations. Being sensitive to this longstanding history is imperative as the transformation work progresses. A full time project manager from SWACH has been assigned to this project to facilitate and oversee the work. The SWACH Executive Director is also involved with oversight of this effort.
2. In another transformation project, success will require the integration of an FQHC with a behavioral health organization. Currently, the FQHC does not “reside” in the SWACH geographic area. Regular communication with the FQHC and SWACH leadership is imperative in order to address “potential negative impacts”.

## **19. Regional integrated managed care implementation update**

- **For 2019 adopters**, list the date in which the ACH region implemented, or will implement, integrated managed care.

In Southwest Washington, Clark and Skamania counties implemented integrated managed care on April 1, 2016. In Klickitat County, integrated managed care was implemented on January 1, 2019.

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

SWACH set up an IMC Core Group in early 2018 to provide an opportunity for all stakeholders to convene on a regular basis to support the implementation of IMC. The core group met every other month until January 2019. Afterward, SWACH supported the region’s transition through one-on-one meetings and generally facilitated connections, convened stakeholders as needed and developed a contracting structure with the behavioral health provider in the region to support their transition.

Overall, the transition in Klickitat County has gone well, with some expected concerns. The concerns that were identified are related to administrative and business changes. For example, the conversion of crisis services to the ASO led to some challenges with data submission to the ASO and developing a better understanding of the credentialing process for the ASO. Similarly, the transition with submitting fee for service claims to MCO partners influenced changes in business practices and administrative workflows. There has been challenges with residential treatment authorizations as this change has created loss of administrative time. SWACH and the region continue to work through the transition by addressing both infrastructure and operational challenges. SWACH has served in several supportive roles, including as a connector and conveyer when needed. Connecting partners with the payers or connecting partners with other partners for peer-to-peer learning has been helpful. To help address the structural changes needed, SWACH developed an exclusive contract with the behavioral health provider to invest in administrative and infrastructure needs. SWACH has committed all the behavioral health integration incentive dollars to the behavioral health provider. SWACH will continue to do so for Phase 2 incentive dollars.

- For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.
- For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the ACH has identified as it pertains to integrated managed care. What steps has the ACH taken to address these needs?

### Attestations.

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

	Yes	No
20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:	XX	

	Yes	No
<ul style="list-style-type: none"> <li>• Identification of partnering provider candidates for key informant interviews.</li> </ul>	XX	
<ul style="list-style-type: none"> <li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li> </ul>	XX	
<ul style="list-style-type: none"> <li>• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.</li> </ul>	XX	

If the ACH checked “No” in item 20 above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

## Section 3. Pay-for-Reporting (P4R) metrics

### Documentation.

#### 21. P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.<sup>6</sup> Twice per year, ACHs will request partnering providers respond to a set of questions. ACHs will gather the responses and report them to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

*Related resources and guidance:*

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets.](#)<sup>7</sup>
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under *ACH pay for reporting metrics.*<sup>8</sup>
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.
- It is HCA’s expectation that ACHs will facilitate participation of practice/clinic sites and CBOs, and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to summarize the number of potential sites and actual respondents by provider type for each

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

<sup>7</sup> <https://www.hca.wa.gov/assets/how-to-read-p4p-metric-specifications.pdf>

<sup>8</sup> <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics>

reporting period.

*Instructions:*

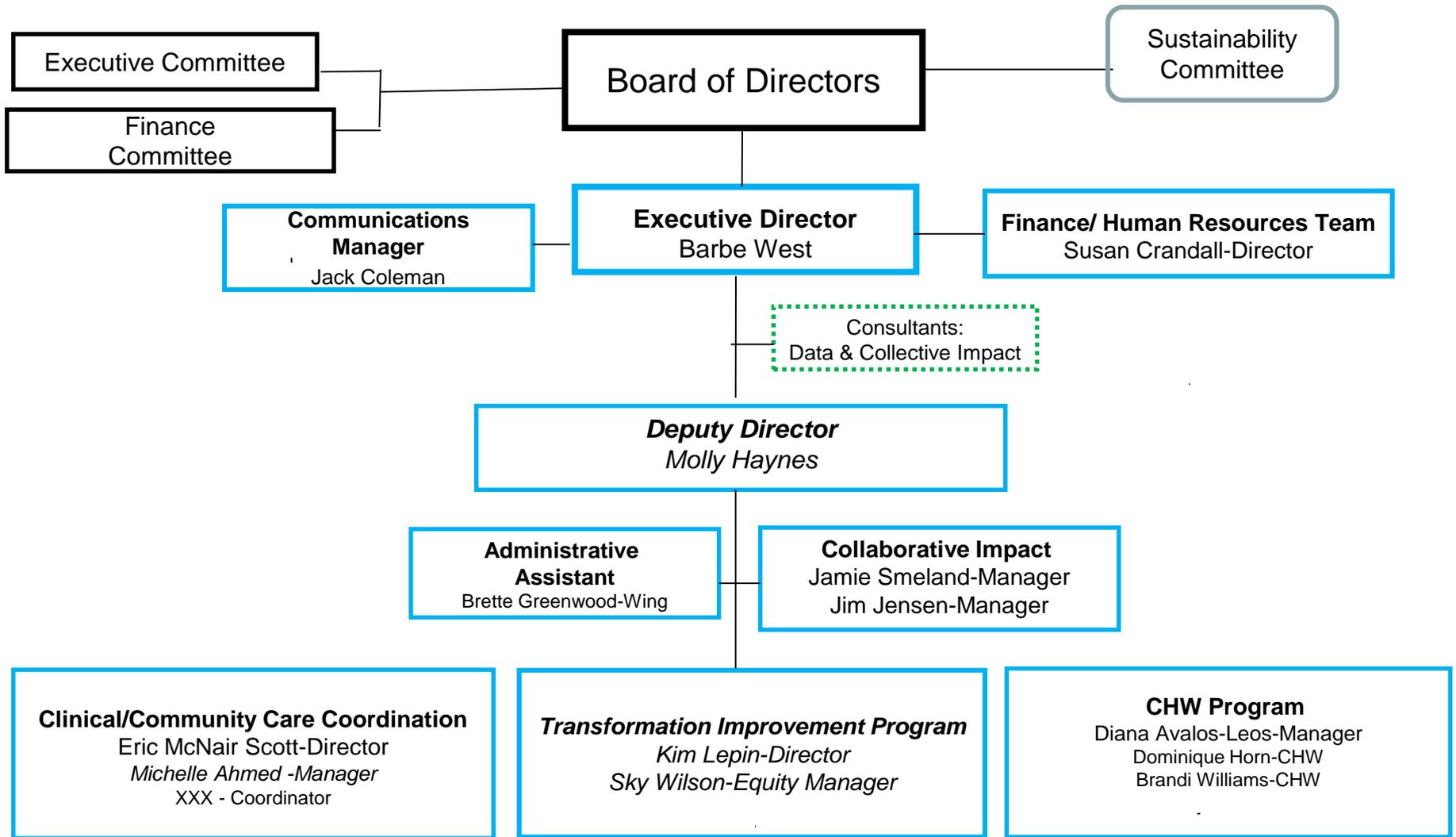
- Submit line-level P4R metric responses collected from partnering provider sites. Include partnering provider organization name and site name for each respondent.
- Provide a count of partnering provider sites participating in Project 2A and 3A, and a count of P4R metric respondents, stratified by provider type (practice/clinic site and community based organization).

*Format:*

- ACHs have the option to submit P4R metric information using the workbook provided by the state or via an alternative format (as long as all data fields are represented and consistent with the P4R metric required data fields list).

***Submit P4R metric information.***

# SWACH



## Partnering Providers Executive Summary

*SWACH has signed contracts with 16 Clinical Partners and is finalizing contracts with 4 others. 20 of the Clinical Partners are developing care models and/or care pathways to integrate physical health and behavioral health.*

- |   |                                       |
|---|---------------------------------------|
| 1. Kaiser                               | 11. Children's Center                 |
| 2. Peace Health                         | 12. Children's Home Society           |
| 3. Klickitat Valley Health              | 13. Columbia River Mental Health      |
| 4. North Shore Medical Group            | 14. Family Solutions                  |
| 5. Legacy                               | 15. Lutheran Community Services       |
| 6. Rose Medical                         | 16. Lifeline Connections              |
| 7. Sea Mar/Community Services Northwest | 17. Providence                        |
| 8. Skyline                              | 18. Skamania County Behavioral Health |
| 9. Child and Adolescent Clinic          | 19. Cowlitz Tribe                     |
| 10. Comprehensive                       | 20. Yakama Nation                     |

*SWACH has signed contracts with 6 Community Serving Organizations and is finalizing contracts with one other. All 7 Community Serving Organizations will be partnering, in some capacity, with a clinical partner.*

- |  |  |
|--|--|
| 1. Area Agency on Aging and Disability of Southwest Washington | 5. Vancouver Housing Authority           |
| 2. Clark Fire and Rescue                                       | 6. White Salmon Ed Foundation            |
| 3. Council for the Homeless                                    | 7. Washington State University Extension |
| 4. SHARE   |  |

*SWACH has completed contracts with 4 Community Care Agencies (Pathways)*

- |                              |                                      |
|------------------------------|--------------------------------------|
| 1. Sea Mar                   | 3. Washington Gorge Action Program   |
| 2. Community Voices Are Born | 4. Skamania County Behavioral Health |

*SWACH will support 13 organizations in the Equity Collaborative. SWACH and Cascade Pacific Action Alliance will also participate.*

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| 1. Children's Center            | 9. Lutheran Community               |
| 2. Children's Home Society      | 10. Providence                      |
| 3. Columbia River Mental Health | 11. Share                           |
| 4. Council for the Homeless     | 12. Skyline                         |
| 5. Cowlitz Tribe                | 13. Community Services Northwest    |
| 6. Family Solutions             | 14. SWACH                           |
| 7. Kaiser                       | 15. Cascade Pacific Action Alliance |
| 8. Klickitat Valley Health      |                                     |

*SWACH is supporting 15 organizations in the Clinical Integration Learning Collaborative (Behavioral Health and Primary Care Integration).*

- |                                  |                                       |
|----------------------------------|---------------------------------------|
| 1. Klickitat Valley Health       | 9. Children's Home Society            |
| 2. Legacy                        | 10. Columbia River Mental Health      |
| 3. Rose Medical                  | 11. Family Solutions                  |
| 4. Sea Mar/Community Services NW | 12. Lutheran Community Services       |
| 5. Skyline                       | 13. Lifeline Connections              |
| 6. Child and Adolescent Clinic   | 14. Skamania County Behavioral Health |
| 7. Comprehensive                 | 15. Cowlitz Tribe                     |
| 8. Children's Center             |                                       |



The intent for providing this information is to share our partnering providers high level AIM statements related to our Whole Person Care and Community Clinical Linkages strategies. Providers are in the process of submitting final scopes of work to SWACH and the information is subject to change. Within the scope of work document, providers were asked to identify key milestones, activities and evidence of progress towards achieving their AIM statements.

Partner Organization	Whole Person Care-AIM	Community Clinical Linkages-AIM	Other	Partnerships/ Collaborations	Clinical Integration Learning Collaborative
<b>Area Agency on Aging and Disability of Southwest Washington (AAADSW)</b>	Improve coordination of care between healthcare and social services, enhance access to care for patients and family caregivers. A warm hand off is a critical link. An Aging and Disability Resource Specialist available in person at the point of care can provide a person-centered consultation and screen for community resources. This pilot promotes a learning collaborative whereby healthcare learns more about AAADSW's capacity to resolve social determinants of health and long-term care needs; AAADSW learns more about			Peace Health and potential partnership with Providence Medical Group	

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



	healthcare culture; resulting in building a stronger safety net for patients and family caregivers.				
<b>Clark County Fire and Rescue (CCFR)</b>	Clark County Fire and Rescue CARES Program aims to increase the availability of social and educational services to assist its citizens in obtaining healthcare and other resources that will result in increased safety and health of the community as a whole.	Clark County Fire and Rescue Opioid Harm Reduction Program aims to reduce preventable deaths from opioid overdoses and increase referrals and admissions to addiction treatment programs for residents living in its service area.		Collaborate with Clark College and Eastern Washington University School of Social Work	
<b>Child and Adolescent Clinic</b>	Provide access to comprehensive, integrated care for children with behavioral health conditions. We will implement integration elements of the PCMH model to deliver integrated care.	Collaborate with schools and child serving agencies, as evidenced by formal agreements, shared goals and strategies with these agencies to co-manage our mutual patients/students/clients.		Partnership with Children's Home Society	Yes
<b>Children's Center*</b>	Integrate medical care coordinator, develop policies and procedures to better identify medical conditions and co-manage patients between primary care and behavioral health.	Improve identification of Substance Use Disorder treatment needs and develop protocols and procedures for referrals between Substance Use Disorder providers and Children's Center.	<p>Focus on:</p> <ul style="list-style-type: none"> <li>• Training</li> <li>• Retention</li> <li>• Recruitment</li> <li>• Integration Specialist</li> <li>• PreManage</li> </ul> <p>Participate in Equity Collaborative</p>	<p>Potential collaboration with Legacy Salmon Creek-pediatrics</p> <p>Potential collaboration with Rose Medical Group-pediatrics</p>	Yes



		Develop formal and informal agreements with frequently utilized Social Determinates of Health resources and develop referral and feedback processes.		Pediatric-Transform Clinical Practice Initiative Behavioral Health Champion is at Children's Center-collaboration with initiative and Child and Adolescent Clinic	
<b>Children's Home Society* (CHS)</b>	Implement plan to move along the Substance Abuse and Mental Health Administration six levels of integration and to embed a Children's Home Society Child and Family Therapist with Child and Adolescent Clinic Salmon Creek Pediatric Primary Care Clinic.	Transform our practice of routine screening and information sharing to provide more effective coordination of services to our clients and become a stronger community partner. This will improve access to those we serve to necessary services outside of Children's Home Society and improve health equity in the region.	Participate in Equity Collaborative	Partnership with Child and Adolescent Clinic	Yes
<b>Columbia River* (CRMH)</b>	The adoption of universal screening tools and creation of a position to coordinate staff interactions between the two agencies will greatly enhance the abilities of both organizations to implement whole person care and expand progress made at the	n/a	Participate in Equity Collaborative	Collaboration with Rose Medical Group  Potential partnership with Cowlitz Family Health Center a Federally Qualified Health Center	Yes



	<p>Battle Ground clinic to Rose’s Devine clinic.</p> <p>Columbia River Mental Health intends to create a comprehensive healthcare provider to serve communities across southwest Washington. Upon completion of a merger with Cowlitz Family Health and associated program integrations, the combined organization will be empowered to integrate electronic client records, coordinate health care delivery, and address the social determinants of health.</p>				
<p><b>Comprehensive</b></p>	<p>Improve utilization of care and coordination of care using a team-based approach reducing unnecessary Emergency Department visits. We will formalize agreements with community partners and develop policies and procedures to support integration.</p>	<p>Formulating relationships with criminal justice partners (County Jail) for sharing data, co-management, and developing shared goals</p> <p>Comprehensive Healthcare is committed to a sustainable model for behavioral health integration within schools (White</p>	<p>Focus on recruitment and retention</p> <p>Integrated Managed Care Transition:</p> <ul style="list-style-type: none"> <li>• PreManage implemented in clinics</li> <li>• Medicaid Billing reports consolidated and streamlined.</li> <li>• Outcomes Data Collection &amp; Reporting capabilities expanded.</li> </ul>	<p>Potential partnerships and collaboration with:</p> <ul style="list-style-type: none"> <li>• Skyline</li> <li>• Klickitat Valley Health</li> <li>• School Districts</li> <li>• Sheriff’s Office</li> </ul>	

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



		Salmon and Goldendale). Development of Memorandum of Understanding to better coordinate care, provide quick response to mental health needs and information sharing are planned with our partner schools.	<ul style="list-style-type: none"> <li>• Consultation to assist with manage care contracts.</li> <li>• Marketing and public relations campaign</li> <li>• Hardware upgrades to meet the demands of new electronic health record.</li> <li>• Clinic Infrastructure Rewire to meet current network needs.</li> <li>• Transport and Security from Law Enforcement</li> </ul>		
<b>Council for the Homeless* (CFTH)</b>	Create new connections between Council for the Homeless and clinical partners. Change the relationship with clinical partners by providing training and identifying where to be more integrated or engaged to help address housing challenges. Clinical partners would gain a better understanding of the homelessness system and opportunities to address individual and systemic-level need. Council for the Homeless would gain a better understanding of the clinical partner realities and integrate more effectively.		Participate in Equity Collaborative	Partner in the Comprehensive Community Centered Care Partnership (C4P) with Sea Mar, Vancouver Housing Authority and Peace Health  Collaboration with various clinical partners.	



<b>Cowlitz Tribe*</b>	Pending  **Integrate the mental health and Substance Use Disorder programs into a co-occurring program.	Pending	Participate in Equity Collaborative		Yes
<b>Family Solutions*</b>	Provide physical health care services on-site at our main location, integrating primary care services within a care team.  Planning on partnering or providing Substance Use Disorder services to youth.	Increase and enhance partnerships with community partners through policy, protocol and formal agreements. Increase school-based service programs, focusing on early intervention services and suicide prevention and education.	<ul style="list-style-type: none"> <li>• PreManage</li> <li>• Participate in Equity Collaborative</li> </ul>	Potential collaboration or partnership with Substance Use Disorder provider  Partnership with Psychiatrically Sensitive Care Integration (PSCI)	Yes
<b>Kaiser*</b>	Pending	Pending	Participate in Equity Collaborative		Yes
<b>Klickitat Valley Health* (KVH)</b>	We want to improve access to care by increasing the hours and days that primary care and specialty care are available at our clinic, improve access to pharmacy by utilizing the hospital pharmacy license to dispense to patients under our care, and improve access to behavioral health services by offering these services in our primary care clinic.	In an effort to maximize our resources we are going to intentionally collaborate with other community groups to address the greatest needs identified by KVH and our community partners. We will raise community awareness of resources that are available by facilitating meetings, sharing resource	Participate in Equity Collaborative	<ul style="list-style-type: none"> <li>• Potential collaboration with Comprehensive</li> <li>• Partnership with Sheriff's Office</li> <li>• Lead regional coalition development</li> </ul>	Yes



		lists, and identifying areas where we can collaborate.			
<b>Legacy Health</b>	Implement whole person care for our patients by integrating behavioral health support, team based chronic disease management and decreasing opioid prescribing. improving continuity of care for our patients by connecting and collaborating with our community partners with additional nurse case manager support.	Develop a collaborative relationship with Children's Center.		Collaboration with Children's Center	Yes
<b>Lifeline</b>	Three primary gaps we identify is access to Primary Care services in a Behavioral Health setting, financial incentives to provide acute Substance Use Disorder care are misaligned with treating Substance Use Disorder as a chronic health condition, and care management services often do not address the whole person's needs.  Our strategies are expanding care management program, utilize pathways type model.	Peer connection and support that is relatable and able to motivate change in a way that the Case Management cannot do.		Opioid Treatment Network collaborators	Yes



	<p>Second piece is access to primary care in Behavioral Health settings by bringing in an evidenced based co-located integrated care model.</p> <p>Third is to develop the business case for cost and risk sharing models with health plans for this high-risk population that would be better supported through a chronic care treatment approach.</p>				
<b>Lutheran Community*</b>	<p>The goal of the Vancouver mental health program is to improve coordination of care with other social service organizations in the community. The program will coordinate care with Substance Use Disorder programs, Primary Care Physician's, and psychiatric hospitals to ensure that integrated services are provided for individuals living in the Clark County area</p>	<p>The goal of the Vancouver Mental Health Program is to extend culturally specific mental health services within the Russian speaking community. We will engage in a strategy that breaks down barriers to accessing mental health services for Russian speaking individuals living in the SW Washington communities.</p>	Participate in Equity Collaborative		Yes
<b>North Shore Medical</b>	<p>These projects will transition the organization from purely medical, to</p>	<p>Improve awareness of safe medication storage and disposal. To address this</p>	<p>Enhance and supplement staff and provider training regarding the biological bases of substance</p>	<p>Collaboration with White Salmon School District</p>	Yes



	an evidence based integrated medical/ behavioral health practice, delivering services at both medical (clinic) and non-medical (school) settings.	problem, we will be launching an advertising & marketing campaign for our patients. The materials will be in English & Spanish.	use disorder and lifelong impacts of trauma.  PreManage Implementation		
<b>PeaceHealth</b>	PeaceHealth will collaborate with SeaMar/Community Services Northwest, the Housing and Health Innovation Partnership, and SWACH Comprehensive Community Centered Care Partnership (C4P) to:  improve access to, and delivery of, whole person care for people who need respite care, people in supportive housing programs, and people who are utilizing the emergency department, and inpatient services, but could receive better care in a different setting. The collaboration will develop and implement multi-disciplinary clinical-community teams; use of the Community HUB for Care Traffic Control; and share risk through shared resources; contracts with			Community Centered Care Partnership (C4P) is a collaborative effort between SeaMar, PeaceHealth, Vancouver Housing Authority and Council for the Homeless  Secondary collaborative with PeaceHealth Medical Group & Rose Village CHWs	Yes



	payers; and other braided funding.				
<b>Providence*</b>	Assess and treat patients as a whole person, including identifying their physical health, mental health and social determinant needs.	Pilot a Community Resource Desk to connect patients to resources in the community to address Social Determinates of Health-based on a model implemented in Oregon.	Participate in Equity Collaborative	<p>Potential partnership with Area Agency on Aging and Disabilities of Southwest Washington for a Community Resource Desk.</p> <p>Potential collaboration with Washington State University Extension to offer Diabetes Management program in an underserved area</p>	Yes
<b>Rose Medical</b>	The specific outcomes we want to accomplish through this project are: 1) having an in-house Behavioral Health specialist in collaboration with Columbia River Mental Health Services (CRMH) and Lifeline Connections, 2) developing a system to allow primary care providers	This project will enhance our capacity to address the “Social Determinants of Health” such as transportation, housing, and food. We will have formal agreements with two to three community-based organizations that our patients used most frequently. Through our		Collaboration with Columbia River Mental Health	Yes



	<p>and the Behavioral Health specialist to share important and relevant information of their patients,          3) having the ability to deliver timely access to integrated, population-based, preventive behavioral health services such as prevention and early intervention for common behavioral health issues</p>	<p>formal agreements, we will develop a system to standardize our reciprocal referrals to ensure our shared clients have their needs met as designed.</p>			
<p><b>SeaMar</b></p>	<p>SeaMar/Community Services Northwest will collaborate with PeaceHealth, the Housing and Health Innovation Partnership, and SWACH Comprehensive Community Centered Care Partnership (C4P) to:</p> <p>Improve access to, and delivery of, whole person care for people who need respite care, people in supportive housing programs, and people who are utilizing the emergency department, but could receive better care in a different setting. The collaboration will develop and implement multi-disciplinary</p>		<p>Participate in Equity Collaborative (Community Services NW only)</p>	<p>Comprehensive Community Centered Care Partnership (C4P) is a collaborative effort between SeaMar, PeaceHealth, Vancouver Housing Authority and Council for the Homeless</p>	<p>Yes</p>

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



	clinical-community teams; use of the Community CareConnect for Care Traffic Control; and share risk through shared resources; contracts with payers; and other braided funding				
Share*	Share will partner with local hospitals to increase access to immediate shelter for people experiencing homelessness and exiting from hospital settings. Share will also explore opportunities to expand syringe exchange services.	In Southwest Washington people injecting illegal drugs have limited access to safe disposal, clean needles and needed harm reduction information. To address this concern Share is seeking to provide these services at more sites across the community.	Participate in Equity Collaborative		
Skamania County Community Health	Implement primary care services at the behavioral health site of care	Ongoing community listening sessions to provide guidance for future service development	Implement PreManage	Skyline Family Practice	Yes
Skyline*	Specific projects/milestones include improving access to behavioral health in a multi-care setting and improved coordination between oral health providers, vision providers, nutrition services and transportation services.	The goal is to screen for and identify Social Determinates of Health issues in the family medicine clinic, determine the key Social Determinates of Health issues within Skyline's	The goal is to implement cultural systemic change by incorporating Trauma Informed Care practices throughout the entire Skyline organization.  Participate in Equity Collaborative	Collaboration with Skamania County Behavioral Health	Yes



	<p>Skyline’s projects and milestones will prepare the organization to negotiate value-based contracts and develop tools to impact cost and quality of care.</p>	<p>Medicaid patients, and share findings with other key community partners to guide a joint needs assessment.</p> <p>Engage with schools in Skyline’s service area to determine healthcare and Social Determinates of Health needs of students. Jointly collect input and share collective data with the schools. If appropriate and feasible implement programs to address the needs identified.</p>			
<p><b>Vancouver Housing Authority</b></p>	<p>The Housing and Health Innovation Partnership will collaborate with PeaceHealth, the Housing and Health Innovation Partnership, and SWACH Comprehensive Community Centered Care Partnership (C4P) to:</p> <p>Improve access to, and delivery of, whole person care for people who need</p>				

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



	<p>respite care, people in supportive housing programs, and people who are utilizing the emergency department, but could receive better care in a different setting. The collaboration will develop and implement multi-disciplinary clinical-community teams; use of the Community CareConnect for Care Traffic Control; and share risk through shared resources; contracts with payers; and other braided funding</p>				
<p><b>Woodland Action Center</b></p>	<p>Pending</p>	<p>Pending</p>	<p>Pending</p>		
<p><b>White Salmon Education Foundation</b></p>	<p>We intend to create opportunities to empower students, teachers, and families to be aware of and take part in integrating the services that are provided in the school, as well as educate teachers on the care pathways and processes, in addition to providing them professional development opportunities to learn and expand their knowledge base</p>			<p>Collaboration with:</p> <ul style="list-style-type: none"> <li>• North Shore Medical Group</li> <li>• Comprehensive Skyline Clinic</li> <li>• Public Health</li> </ul> <p>Partnership with:</p> <ul style="list-style-type: none"> <li>• White Salmon School District</li> </ul>	

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



	regarding mental health, Substance Use Disorder risks and early intervention. Furthermore, we will work with community partners to provide effective, age-appropriate, and culturally competent services when and where students need it.				
<b>WSU Extension</b>	WSU Extension Clark County will improve access to community-based interventions, such as the Diabetes Prevention Program and the Chronic Diseases Self-Management program by establishing screening and referral systems between medical providers and community-based organizations. Additionally, we will support increasing the capacity for organizations in the area to provide Diabetes Prevention Program (DPP) and Chronic Disease Self-Management (CDSM) thru training and administrative support.			Partner with at least 1 Medicaid clinic/medical provide	
<b>Yakama Nation</b>	Improve coordination of care and services for members of Yakama Nation	Potential collaboration between all behavioral health providers and all			

\* Indicates the provider organization is participating in the Equity Learning Collaborative and will receive an additional \$20,000 for participation and achieving milestones.



	Tribe. Coordination would include developing IT linkage between behavioral health, physical health and social service agencies within the Tribe.	agencies addressing social determinants of health. Will not be involved in learning collaborative at this time.			
--	--	---	--	--	--



## Southwest Washington Accountable Community of Health

### ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority<sup>1</sup>

Funds Earned by ACH During Reporting Period <sup>2</sup>		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	3,738,014.00
2B: Community-Based Care Coordination	\$	2,569,886.00
2C: Transitional Care	\$	-
2D: Diversion Interventions	\$	-
3A: Addressing the Opioid Use Public Health Crisis	\$	467,252.00
3B: Reproductive and Maternal/Child Health	\$	-
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	934,503.00
Integration Incentives	\$	126,382.00
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus Pool/High Performance Pool	\$	-
<b>Total Funds Earned</b>	<b>\$</b>	<b>8,136,037.00</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
Administration	\$	257,144.72
Community Health Fund	\$	-
Health Systems and Community Capacity Building	\$	738,457.92
Integration Incentives	\$	-
Project Management	\$	21,435.20
Provider Engagement, Participation and Implementation	\$	155,586.57
Provider Performance and Quality Incentives	\$	1,579,198.60
Reserve / Contingency Fund	\$	-
Shared Domain 1 Incentives	\$	1,278,659.00
<b>Total</b>	<b>\$</b>	<b>4,030,482.01</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
ACH	\$	856,146.58
Non-Traditional Provider	\$	357,643.13
Traditional Medicaid Provider	\$	1,538,033.30
Tribal Provider (Tribe)	\$	-
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	1,278,659.00
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>4,030,482.01</b>

<b>Total Funds Earned During Reporting Period</b>	<b>\$</b>	<b>8,136,037.00</b>
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>4,030,482.01</b>

<sup>1</sup> 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 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019.

<sup>2</sup> For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.
- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

<sup>3</sup> Definitions for [Use Categories and Provider Types](#)