Medicaid Transformation

Accountable Communities of Health

SWACH Semi-annual Report

SAR 6.0

Reporting Period:

July 1, 2020 – December 31, 2020

DY4 Q3-Q4

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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Achievement values

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

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

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

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Description of scale & sustain Transformation activities	4	6	4	4	4	6	8	6	4
Description of continuous quality improvement methods to refine/revise Transformation activities	4	6	4	4	4	6	8	6	4
Demonstrate facilitation of ongoing supports for continuation and expansion	4	6	4	4	4	6	8	6	4
Demonstrate sustainability of Transformation activities	4	6	4	4	4	6	8	6	4
Completion of semi-annual report	4	6	4	4	4	6	8	6	4
Completion/maintenance of partnering provider roster	4	6	4	4	4	6	8	6	4
Engagement/support of Independent External Evaluator (IEE) activities	4	6	4	4	4	6	8	6	4

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Completion of all P4R metrics (Project 2A, 3A only)	2	2	2	2	2	2	2	2	2
Total AVs Available	30	44	30	30	30	44	58	44	30

Table 2. Potential P4R AVs for Project Incentives, July 1 – December 31, 2020

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	8	7	-	-	8	-	-	7	30
Cascade Pacific Action Alliance	8	7	7	-	8	7	-	7	44
Elevate Health	8	7	-	-	8	-	-	7	30
Greater Columbia ACH	8	-	7	-	8	-	-	7	30
HealthierHere	8	-	7	-	8	-	-	7	30
North Central ACH	8	7	7	7	8	-	-	7	44
North Sound ACH	8	7	7	7	8	7	7	7	58
Olympic Community of Health	8	-	-	7	8	7	7	7	44
SWACH	8	7	-	-	8	-	-	7	30

Reporting requirements

The semi-annual report for this period (July 1 – December 31, 2020) includes three sections as outlined in the table below.

Semi-annual reporting requirements (July 1 – December 31, 2020)		
Section	**Item num**	**Sub-section components**
Section 1. ACH organizational updates	1-8	Attestations
	9-11	Documentation - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	12-13	Attachments - Implementation work plan - Partnering provider roster
	14	Documentation - Quality improvement strategy update
	15-17	Narrative responses - General implementation update - Regional integrated managed care implementation update - Scale and sustain update
	18	Attestations

Section 3. Value-based Payment	19-21	Narrative responses
Section 4. Pay-for-Reporting (P4R) metrics	22	Documentation

There is no set template for the semi annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

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

File format

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

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

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

Semi-annual report submission instructions

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

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

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

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

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 6 – February 1, 2021.

[1] https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents

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

Semi-annual report submission and assessment timeline

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

ACH semi-annual report 6 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2020 to ACHs	IA	August 2020
2.	Submit semi-annual report	ACHs	February 1, 2021
3.	Conduct assessment of reports	IA	February 2, 2021 – February 25, 2021
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	February 25 – March 2 ,2021
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	February 26 – March 12, 2021
6.	If needed, review additional information within 15 calendar days of receipt	IA	February 27 – March 29, 2021
7.	Issue findings to HCA for approval	IA	April 2021

Contact information

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

ACH contact information

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

ACH name:	Southwest Washington ACH
Primary contact name **Phone number** **E-mail address**	Barbe West 360-515-8252 Barbe.west@southwestach.org
Secondary contact name **Phone number** **E-mail address**	Jason Burton 360-628-3919 Jason.Burton@southwestach.org

Section 1. ACH organizational updates

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

Attestations

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

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: • Primary care providers • Behavioral health providers • Health plans, hospitals or health systems • Local public health jurisdictions • Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region • Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH's decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits.[2]	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	X	

[2] https://wahca.box.com/s/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.

Documentation

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

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

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

    If applicable, include current organizational chart.

    See attachment SWACH.SAR6.ORGANIZATION CHART. 2.01.21

The Transitional Support Manager position was a temporary project position and was planned for elimination in Fall 2020. With expansion of the Community Health Connect Program, which includes COVID-19 care coordination, a manager position was added to oversee the development and expansion of this program. The Finance & Human Resources Director resigned in November 2020. The finance and human resource functions will be assessed before reposting this position. During this review, the Controller will be serve as Interim Finance Director and continue to manage the personnel functions.

10. **Budget/funds flow.**

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

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

    - For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[3]
    - For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[4]

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

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

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

support the region in transition to integrated managed care.

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

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

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

   iii. Description of use should be specific but concise.

Use of incentives to assist in the transition to integrated managed care		
Description of Use	**Expenditures ($)**	
	Actual	**Projected**
• Investments into provider organizations to support evidence based clinical integration models and shared learning across networks of care • Investments into provider organizations to support workforce recruitment, development and training integrated care teams • Investments to support the advancement of utilization of equity lens to support continuous quality improvements • Limited IT investments related to administrative support processes.	**$62,500**	

Section 2. Project implementation status update

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

Attachments

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

12. Implementation work plan

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

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

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

See Attachment SWACH.SAR6 Implementation Plan 2.1.21.xlsx

13. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.[5] To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH. ACHs should maintain the roster provided by HCA at the time of the SAR4 release for the remaining semi-annual reporting periods.

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

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

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

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

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

Submit updated partnering provider roster.

See attachment: SWACH SWACH.SAR6 Provider Roster 2.01.21

Documentation

The ACH should provide documentation that addresses the following:

14. Quality improvement strategy update

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

See attachment: SWACH.SAR6 Attachment QI Strategy Update. 2.01.21

Narrative responses

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

15. COVID-19

a) Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have changed (i.e., which projects remain on track, which projects or areas of focus have expanded, which capacity building efforts have emerged, etc.).

COVID-19 impact on DSRIP Activities and timelines

Reporting

- All partners completed a quarter two report and received quarter two funding.
- SWACH leadership made a change to reporting to reduce the burden on our partners. We did not require a quarter three report and all future reporting will be semi-annual. Even though reporting is semi-annual, we will continue with the previously agreed upon quarterly payments to partners.

2A Integration

- Partners were able to continue their transformation work after adjusting to the challenges of the pandemic.
- The Integrated Care Collaborative continued to meet monthly in a virtual setting.

[6] Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the "Narrative Responses" section

- The Collaborative came to end in December 2020. SWACH is conducting an evaluation on the Collaborative and using the information to inform how it can support partners moving forward.

2B Care Coordination

- The ability of the Health Connect HUB to serve individuals seeking care coordination continues to be impacted by the inability of CHWs and peers to meet people in person. HealthConnect HUB has supported the cohort in adapting to working in a virtual environment including working with changes in privacy considerations to support virtual/telephonic care coordination.
- CHW/Peers have had to pivot in their approaches supporting community members as COVID impacts access to opportunities related to resources, supports and services.
- HealthConnect HUB trainings and convenings of CHW/Peer regional cohort were impacted and could no longer take place in congregate settings. HealthConnect HUB continues to hold meetings and trainings using virtual platforms.
- COVID-19 impacted the HealthConnect HUB expansion timeline and format. Training and onboarding of additional CHWs and Peers was pushed back one month from June to July. The training was adapted to work in a virtual setting.
- SWACH was approved to lead the Care Connect Washington (CCW) program for Clark, Skamania, and Klickitat Counties. This has provided the opportunity to expand HealthConnect to serve people impacted by COVID-19. Existing Care Coordination Agencies (CCAs) were offered the opportunity to have their community-based workers (CBWs) trained to provide care coordination as part of CCW. SWACH is also engaging stakeholders and the community to expand the network of CBWs to better meet the needs of diverse communities. Our goal is to train these additional CBWs in other HealthConnect care models and continue providing care coordination post pandemic..

3A Opioid

- The Clark County Opioid Taskforce and Steering Committee continue to meet regularly virtually for shared learning, collective impact, community engagement, and advocacy.
- The Klickitat Opioid Treatment Network meeting serves and as a broad cross sector opioid collaboration and systems integration meeting.
- Clark County Opioid Treatment Network continues to integrate Medication Assisted Treatment into their network and works to improve the efficacy of the approach. For example, the Clark County OTN has implemented the CCAR model of Recovery Coach integration into the emergency department at our local hospital.
- The Skamania County SUD Taskforce is now meeting virtually to facilitate shared learning and collective impact.

3D Chronic Disease

- COVID-19 and the typically high-risk populations accessing CDSME programs required redesign of program for virtual and telephonic delivery. Adapting to the virtual environment has been successful and the programs continue to offer services.

Equity Collaborative

- The Equity Collaborative continued to meet monthly in a virtual setting,
- Partners are continuing to move this work forward despite the pandemic.
- SWACH extended the collaborative timeline by 3 months and will end March 2021

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

Amplifying Voices Initiative: Elevate community voices to allow cross-sector partners to better respond to the needs of the community.

- Problem statement: Currently, cross-sector partners in SW Washington do not have a mechanism across systems with community members as partners related to COVID-19 information, resources, understand challenges, key learnings, how information is received and shared to influence policy and organizational system change.
    - SWACH is in the promotion, testing and information gathering stages of its Amplifying Voices Initiative (AVI) which will provide a forum to elevate community voice and share information across the region related to COVID-19.
    - SWACH will collect information to 1) Understand regional needs, barriers and challenges, 2) Understand how responses to COVID-19 have magnified discrimination, racism, and/or stigma, 3) Identify priorities to achieve policy and organizational change, 4) Identify regional trainings needs, and 5) Provide feedback for collective impact response.
    - As a result of this process, SWACH will be positioned to provide shared learning opportunities to collectively solve problems, influence policy and system change and support health partners at local, regional and state levels related to COVID-19.
    - Stakeholder feedback includes more real-time raw data rather than summary data. SWACH is working to incorporate this feedback.

2A Integration: Provided ongoing forum for partners to discuss and receive technical assistance to assist with integration challenges that arose from COVID-19 protocols.

- Problem Statement: COVID-19 created a need to provide services via telehealth which many partners were not already providing.
    - SWACH continued to hold regularly scheduled monthly webinars for its partners in the Integrated Care Collaborative.
    - The webinars were optional and provided content on how to provide integrated patient/client-centered care in a virtual environment.
    - Our integration experts also provided technical assistance to partners as needed to help them walk through setting up their telehealth services in response to COVID-19.
    - We have also helped our partners in thinking through how to utilize and optimize telehealth sustainability, beyond COVID-19.

DSRIP activities related to Community Care Coordination and Chronic Disease Management focus areas enabled SWACH's HealthConnect Hub and partners to respond to and navigate the COVID-19 pandemic through four significant bodies of work:

- SWACH HealthConnect - Public Health partnership
- SWACH HealthConnect - DOH partnership
- SWACH HealthConnect - Clark County's Quarantine and Isolation (Q&I) Hotel partnership
- Enhanced COVID Response through HealthConnect Hub Infrastructure and Systems

SWACH HealthConnect - Public Health partnership for COVID referrals to community care coordination - October- December 2020

HealthConnect partnership established with Clark County Public Health (CCPH) case investigation, contract tracing systems and wraparound service systems.

- CCPH received log-in to HealthConnect and referred COVID impacted clients to community care coordination for whole person care.
- HealthConnect processed 27 referrals from CCPH, 15 enrolled in Pathways care coordination.
- Foundational systems and processes established for collaboration between community care coordination infrastructure and public health.

SWACH HealthConnect partnership with DOH Care Connect / COVID Care program - October - December 2020

SWACH planned and partnered with DOH to provide immediate and long term supports to those experiencing COVID and needing to isolate and quarantine in the home.

- SWACH collaboration and planning with LHJ's of the three SWACH counties: Klickitat, Skamania, and Clark.
- Care Connect program leveraged HealthConnect Hub regional infrastructure of 40+ community-based care coordinators and 11 partner agencies.
- HealthConnect mobilized a CARE *(Culturally Appropriate Response Effort)* Cohort - trained cohort of culturally diverse CHW's and community paramedics- to connect to COVID impacted/vulnerable/marginalized populations through the DOH Care Connect program.
    - CARE Cohort connects COVID positive individuals and families to immediate resources they need to Q&I.
    - Care Cohort connects COVID positive individuals and families after Q&I to long-term HealthConnect community care coordination programs for whole person care.

HealthConnect Partnership with Clark County's Quarantine and Isolation (Q&I) Hotel - May-December 2020

Systems and Process Improvement connecting COVID Response to Community Care Coordination:

- HealthConnect partnership with Clark County Public Health, the Department of Community Services, and a network of clinical and community-based partners.
- HealthConnect deployed community health worker capacity to provide direct and ongoing engagement, support, and connection to services for unhoused individuals at the Q&I hotel.
- Process improvement with community and clinical organization networks referring to the Q&I hotel to ensure upstream release of information and consent for HealthConnect community care coordination support.
- Immediate supports for Q&I Hotel guests through HealthConnect CHW support included food assistance, health insurance support, housing assistance, medical transportation, hygiene and PPE, others.
- Outreach and engagement of 100+ "guests" at the Q&I Hotel to connect to CHW support.
- Support and referral of "guests" to comprehensive whole person health risk assessments and longer term, whole person community care coordination support (Pathways).

Enhanced COVID Response through HealthConnect Hub Infrastructure and Systems - March-December 2020

Trained and mobilized the regional cohort of HealthConnect community-based care coordinators to support community members impacted by COVID.

- Monthly convenings for training, shared best practices, process improvement.
- Training and support on CDC/DOH approved information and guidance for community member education and infection control best practices.
- Partnership and collaboration with community partners/resources to connect with and train HealthConnect's community care coordinator cohort on access and adjustments to services during COVID: Crisis services, transportation, food security, behavioral health, physical health, self-care, flu vaccinations.

HealthConnect Partner Agencies: Community-Based Care Coordinators Cohort	
Sector	**Agency**
Housing	• Vancouver Housing Authority • Outsiders Inn • Share • Council for the Homeless • Washington Gorge Action Program
Physical and Behavioral Health	• SeaMar CHC • Skamania County Community Health • Lifeline Connections
Community Paramedicine	• Clark Cowlitz Fire and Rescue
Home and Community Based Services	• Area Agency on Aging and Disabilities of Southwest Washington
Education	• White Salmon School District

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

SWACH has been collating and distributing COVID-19 related information and resources to its clinical partners, including our Tribal partners. Cowlitz Tribal Nation has provided feedback that these resources have been useful and continue to be included in our communications. Additionally, Tribal partners are eligible to apply for SWACH's COVID-19 Emergency Response funding. However, they have not applied for emergency funding.

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

Reporting & Payments

- To reduce reporting burden, SWACH moved from quarterly reporting to bi-annual reporting. Funds are still disbursed quarterly per partner contracts.
- Reporting is no longer optional; all partners (clinical and community serving) are required to complete the bi-annual report and will follow the SAR reporting timeline (January-June and July-December).

Contracts

- 18 clinical contracts came to an end December 31, 2020. As part of their final report, partners were asked to provide narrative around their sustainability plans for each project area. In early 2021, SWACH will use this information to assess how to best support these partners moving forward.

COVID-19 Emergency Funding Payment Strategy

- Contracted partners are eligible for one-time funding to support their COVID-19 response efforts. Up to $300,000 of SWACH funding was allocated for this response. This started at the end of March and funding has been awarded to 14 partners for a total of $213,533 as of December 31, 2020.

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

While a few partners have started to regain patient/client volume and revenue compared to our last SAR report, over half of our partners are still reporting a decrease in patient/client volume and loss of revenue. One behavioral health organization reported a decrease in referrals and overall number of patients in their WISE program. For some, in addition to patient/client volume decreasing, the time requires for each visit has increased due to full PPE and the need to keep families separate from each other. Health systems continue to face losses in revenue due to government mandates to pause procedures and elective surgeries. Dental service revenue also continues to decline. Telehealth and teletherapy are not also a solution to decreased visits. Virtual visits do not easily translate to children and youth, especially young children. Their attention spans are short, and they are spending numerous hours in front of a screen for school daily. Additionally, youth are not as comfortable with telehealth and often do not feel safe or comfortable doing services remotely as there is not always privacy in many homes. Generally, many clients disengaged from care due to a dissatisfaction or discomfort with phone and e-

therapy. It is also important to note that our housing partners are experiencing lower rent collections and the demand for housing greatly outstrips the supply of housing.

The most common mitigation strategies included adapting and developing new services, strengthening relationships with existing partnerships, and developing new partnerships. Examples of new services include: COVID-19 testing and vaccination, SUD telehealth groups, creating digital and printed education resources and transportation and grocery delivery for seniors. Cowlitz Tribe adapted existing group curriculum as well as the development of new curriculum specific to remote services. Partners also extended hours of service, sometimes doubling or tripling staffing.

Many reported a stronger relationship between behavioral health and physical health providers and new or strengthen relationships with SWACH and the Department of Health. It was noted that moving to remote meeting formats, the participation in local, regional, and state boards and committees has become more accessible. New partnership across health systems have developed to better coordinate care and inpatient resources. In our rural counties, health systems have strengthened their partnerships with local schools and service agencies and Crisis Collaborative was developed.

Three specific risks/issues emerged during the reporting period related to Community Care Coordination and Chronic Disease Management focus areas.

- Compounding impacts of COVID-19 severely affect housing security.
- Workforce Development Opportunity for CHWs/Peers derailed by COVID
- Disruption to HealthConnect Hub community engagement and partnerships through technology platform proliferation

Mitigation strategies were implemented for these risks as described below.

Risk: Compounding impacts of COVID-19 severely affect housing security.

Mitigation: SWACH expanded contracted partnerships with housing agencies trained and integrated in the HealthConnect Hub as Care Coordination Agencies.

- Alignment with housing agencies benefits people experiencing COVID impacted housing insecurity by addressing interconnected COVID related issues impacted such as employment, food security, behavioral health issues and others.
- HealthConnect trained staff from housing agencies provide whole person care coordination in addition to housing services through whole person focused care coordination programs such as Pathways.

HealthConnect Contracted Housing Agency Partners
o *Washington Gorge Action Program* HealthConnect training of 15 staff
o *Council for the Homeless*- HealthConnect training and integration of 5 staff
o *Share*- HealthConnect training and integration of 10 staff
o *Vancouver Housing Authority*- HealthConnect training and integration of 3 staff
o *Outsiders Inn*- HealthConnect training and integration of 4 staff

Risk: Workforce Development Opportunity for CHWs/Peers derailed by COVID

Mitigation: Pivot to virtual delivery of training to support CHWs and Peers as essential workforce to the COVID response.

- HealthConnect developed and delivered an open-to-community workforce development opportunity, "Common Principles and Practices of CHWs and Peers", a virtual continuing education opportunity.
- CHWs and peers reaffirmed as trusted community members who come alongside vulnerable and COVID impacted populations for support and connection to whole person health.
- Attended by 30+ regional CHWS/Peers.

Date	Topic	Date	Topic
Oct 27	CHW / Peers Profession	Nov 10	Social Determinants of Health
Oct 29	CHW / Peers Profession	Nov 12	Cross-Cultural Skills
Nov 3	Intro to Popular Education	Nov 17	Community Organizing and Community Engagement
Nov 5	Trauma Informed Care	Nov 19	Self-Care, Ethics and Boundaries (healing and resiliency)

Risk: Disruption to HealthConnect Hub community engagement and partnerships through technology platform proliferation

- The UniteUs technology platform, a closed loop resource directory system, offers functionality and community impact implications separate and distinct from community-based care coordination infrastructure supported by the CCS technology system.

- Deployment of the UniteUs technology platform a potential disruption risk to HealthConnect networked Hub infrastructure of partners, community-based workforce, and CCS technology platform.

Mitigation: Partnership created with Kaiser Permanente towards systems alignment and community engagement collaboration

- Regular discussion between SWACH, CPAA and Kaiser Permanente surfaced concerns of the impact on community and clinical partners
- SWACH and Kaiser Permanente formally partnered in a collaborative effort to strengthen community-based care coordination infrastructure
- Partnership to identify opportunities and development of workplans that support alignment, connectivity, and synergy between UniteUs deployment and HealthConnect Infrastructure
- Partnership to support and inform state level efforts for interoperability between UniteUs and CCS.

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

SWACH, in partnership with Clark County Public Health, Klickitat County Public Health and Skamania County Community Health, received DOH approval to implement a COVID Response program, Care Connect Washington. The program offers support to those experiencing COVID and needing to isolate and quarantine in the home, and integrates with existing HealthConnect Hub infrastructure and community care coordination partners.

While the program did not officially launch until January 11, 2021, a significant amount of planning and procurement took place in the final quarter of 2020 to ensure a successful launch. Planning included transitioning most of SWACH's staff to work outside of their traditional roles in an "all hands on deck" approach. This included project management, procurement, communications, and stakeholder engagement, to name a few. SWACH staff worked with DOH staff to order food and care kits and establish processes for referrals and grocery ordering. Partnering with DOH and our existing care coordinating agencies allowed 17 community health workers and supervisors to receive training in the new care model prior to launch.

Another critical aspect of the planning was understanding who in our community is being impacted by COVID and who of those people is likely to have the most difficult time with isolation and quarantine. Building connection and trust with communities that are most impacted by health inequities is critical to limiting the spread of the virus as well as improving the likelihood that residents will be open to receiving the vaccine. Ensuring we are able to reach those residents through partnerships with trusted community organizations is an ongoing effort. Our goal is to add culturally specific care coordinating agencies and increase the diversity of the community-based workforce to meet the cultural and linguistic needs of the population.

We are excited about the opportunity to offer long term supports for those in need through our Pathways program. One challenge in accomplishing this vision is ensuring adequate capacity within our care coordinating agencies. We are actively working to ensure there are enough

CHWs trained in both Care Connect and Pathways to meet the need in the community.

16. Scale and sustain update

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

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

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

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

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

In 2020, an RFP was sent to potential community partners asking for proposals for integrated services across clinical and social determinants structures. Project proposals were reviewed and awarded funding in February 2020. For the project recipients, funding will continue to be provided in 2022. The amount of funding that has been obligated is : $1,162,735.

The types of entities receiving the awards included:

- K-Link Collaboration of rural community providers representing hospitals, primary care, behavioral health, care coordination, public health, law enforcement and education. This project is addressing the delivery of care and services, coordinating care across sectors and organizations, and the inequitable availability of health care and social services for some of our most systemically underserved populations.
- Collaboartion of housing and care services representing homeless and housing services, and clinical support, including an FQHC. This project is strengthening the homeless crisis system in order to reduce homelessness and determine appropriate housing resources for a variety of clients.

SWACH has forecast the retention of a limited amount of P4P incentive funding for administrative support in 2022 and 2023. This will provide for transition from Medicaid Transformation Project coordination to planning and implementation of future strategies which began in 2020 and will continue into 2022 and 2023.

b) Assessment of DSRIP sustainability:

i. Describe activities and/or conversations, if any, your ACH has supported with partners related to sustainability priorities and mechanisms. For example, have there been activities or conversations around defining sustainability, evaluating results, or

establishing criteria to determine what DSRIP activities would continue post-DSRIP funding?

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

iii. Describe activities and/or conversations, if any, your ACH has supported during this reporting period with partners and other stakeholders regarding the continuation and/or scaling of specific DSRIP project toolkit evidence-based models and/or pilots (e.g. Community Based Care Coordination, CoCM). If you have not supported related activities and/or conversations during the reporting period, please explain why.

Nearly all SWACH's clinical partner contracts ended in December 2020. Over the last several months, the Integrated Care Collaborative provided training and resources around business modeling to help partners sustain their work around behavioral health and physical health integration. Participants expressed the value the Collaborative has provided in advancing their integration work and the desire to have opportunities to continue the Collaborative or another shared learning structure in the future. SWACH will explore the feasibility of this in the spring/summer of 2021.

SWACH partners were encouraged to plan for sustaining their DSRIP projects when initially developing their scopes of work for the these projects. For partners with contracts ending, we included questions in our partner reporting around sustainability priorities and mechanism. This is discussed further in the question below.

The SWACH Board of Trustees, which include partners, appointed a Sustainability Leadership Work Group in early 2020 to develop a Sustainability Plan for the organization. The Work Group includes Board members and representation from MCOs, Housing, Equity, Rural, Physical and Mental Health. The first phase of their work (reviewing SWACH history, MTP program, current Strategic Framework and all evaluation information collected over past 4 years) is complete. In addition, a partner survey was completed and information from this survey will be factored into addressing sustainability. Although it is preliminary, it appears that Care Coordination (HealthConnect) and Collective Impact Services will be strong components of future Sustainability. In this same time period, SWACH staff have initiated planning for additional funding streams post DSRIP, i.e., grants, billing for care coordination services, etc. Current contracted partners have been requested to address plans for MTP project sustainability within their current structures in their fourth quarter reports, which will be submitted to SWACH in January 2021.

For partners with contracts ending in December 2020, we included sustainability questions in our July-December 2020 semi-annual partner report. Partners were asked the same set of sustainability questions for each of their project areas (see questions below). SWACH intends to use partner responses to inform how we can best support partners in the continuation of DSRIP funded activities as part of our Equity & Collaborative Impact infrastructure.

Project Sustainability Questions

[Sustainability questions will only appear for those with contracts ending in 2020]

*From 2019-2020, what additional resources did you leverage outside of SWACH funding?

	Select all that apply	Please describe:
Workforce or staff time	☐	
Funding from other sources	☐	
Equipment and supplies	☐	
Facilities	☐	
Other	☐	
N/A	☐	

*Do you plan to sustain this work beyond December, 2020? *[If response is "yes", next 3 questions will populate. If no, will skip to next question set]*

☐ Yes

☐ No

*What resources will you leverage after December, 2020?

	Select all that apply	Please describe:
Workforce or staff time	☐	
Funding from other sources	☐	
Equipment and supplies	☐	
Facilities	☐	
Other	☐	
N/A	☐	

*Which of the following have you completed for this work?

	Select all that apply	Please describe:
Developed plans to continue this work	☐	
Developed plans to build out and expand interventions to additional sites, populations, locations	☐	
Secured/committed resources to sustaining this work beyond December, 2020. For example:	☐	

workforce, equipment, facilities, technology, other.		
Demonstrated cost savings	☒	
Changes in policies and/or systems (internal and/or external)	☐	

*How can SWACH continue to provide support to sustain this work?

	Select all that apply	Please describe:
Convening groups for collaborative problem solving	☐	
Facilitating opportunities for shared learning	☐	
Community Engagement technical assistance	☐	
HealthConnect HUB technical assistance	☐	
Other technical assistance	☐	
Policy advocacy	☐	
Other	☐	
N/A	☐	

17. Regional integrated managed care implementation update

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

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

During July-December 2020, mid adopter region (Klickitat County) care providers were met with COVID-19 pandemic. This resulted in shifting providers and caregivers to address the outbreak, reduce some routine services and seek additional temporary staffing. SWACH extended the quarterly reporting period for the partners by one quarter and yet, provided the quarterly payment without a report. In addition, SWACH established a financial fund to assist caregivers in system/workforce adjustments. Requests were approved for telehealth services (phones, computers, staff recruitment services for temporary workers, etc.) In the monthly

meetings with MCOs, organizations shared actions they were taking to support providers in order to reduce duplication between MCOs and SWACH.

Our partners have described several challenges with implementing IMC. Challenges include:

- COVID-19 pandemic has paused collaborative efforts between physical health and behavioral health providers.
- Lack of access to data for services provided outside of the partner organization. It would be helpful to have clear and consistent communication around the types of services that are available for members across the different plans.
- Inconsistent payment levels with new MCOs entering the region that don't want to pay IMC rates v. Medicaid rates.
- Difficulties with billing, such as outstanding claims that have not been paid with no explanation. Limited MCO staff resources for addressing these inquires.
- Particularly for rural organizations, they face a variety in differences in terms of what payers require of them. Such as, one payer requires prior authorization for some services when another does not.
- Tracking outcomes and sharing patient information between primary care and behavioral health care providers.
- Five years is not a long span of time for transformation on the scale envisioned by various IMC and Medicaid Transformation initiatives in Washington.
- American Indians and Alaska Natives are opted out of the managed care system automatically and have not always been informed about the potential implications of this. Our tribal partners experience challenges when trying to assist clients with accessing resources.

SWACH holds regular meetings with the MCOs in our region. The feedback above will be shared with the MCOs to determine how we can collaborate to address these challenges.

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

The primary issue for the mid-adopter region is the lack of trained and available behavioral health staff, including psychiatrists, psychologists, and social workers). During this six month period, the executive director, with a behavioral health partner, addressed the licensing/rulemaking issue regarding behavioral health students and their inability to provide direct billable clinical services due to a regulation conflict between Department of Health (DOH) and the Health Care Authority (HCA). SWACH executive director, in partnership with major behavioral health clinic, addressed the conflicting direction with DOH and HCA regarding billable services for behavioral health students working in the behavioral health industry. As a

result of these meetings, there was a revision to contract language so that a behavioral health student could work as an intern in behavioral health clinics.

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

Clinical integration continues to be monitored through the Integrated Care Collaborative which is composed of behavioral health and primary care representation. The Collaborative ended their SWACH funded collective impact work in December 2020. Organizations within the Collaborative have reached agreement to sustain a Collaborative structured model as a way to connect regularly on learnings and resulting changes in organization.

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
18. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to: • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.	X	

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

Section 3. Value-based Payment

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

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

Narrative responses

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

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

SWACH has facilitated the Integrated Care Collaborative for a cross-section of providers (physical and behavioral health) to address issues they have experienced with integrating services and the impact on value based payments. Because many of these providers work with multiple payers and each payer has a different VBP structure, it creates an administrative challenge in responding to each MCO's VBP program. Providers have to weigh the value of addressing the administrative variation by MCO or providing direct care to their patients/clients. Major health care systems have the capability to address VBP due to their size, but even with their size, they are frustrated with the variation in MCO VBP programs and the limited financial reimbursement from each MCO> In addition, there is significant delay in receiving current data from each MCO.

Our partners have described several barriers regarding implementing value-based care. These barriers include:

- Staff capacity to manager patient rosters and patient population lists.
- COVID-19 pandemic has halted or slowed implementation.
- Smaller behavioral health programs, particularly those experiencing high turnover, have a significant barrier in making the case to move forward with implementation.
- Value based care options offered by the payers are minimal.
- Some of the metrics in VBC contracts will be very difficult for us to meet.

SWACH holds regular meetings with the MCOs in our region. The feedback above will be shared with the MCOs to determine how we can collaborate to address these barriers.

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

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

Due to COVID-19, SWACH did not initiate meetings with small clinical providers (less than 25 FTEs) regarding VBP. Prior to COVID-19, SWACH was aware that small provider groups had been approached by some MCOs and were unable to determine the value of moving to VBP contracts due to their size. It appears that MCO's desire to apply contract requirements with small providers that are identical to large provider groups; there may not be alignment in these contracts. In addition, smaller providers and behavioral health providers may not have the interoperable data systems and patient volume by payer to take on clinical risk.

SWACH meets on a regular basis with each MCO in the Southwest Region and one of the topics is Value Based Payments and approaches to work collaboratively to improve VBP contracts. There has been significant variation in MCO approaches with provider groups. It is not clear what the role of ACH's should be in the implementation of VBP structures with providers.

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

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

Compared to 2019 VBP Survey, SWACH initiated additional communication with SWACH clinical partners to encourage their participation in the annual VBP Survey. Two written requests were made to the Partners. In addition, at the monthly Regional Health Improvement Council meeting, partners were encouraged to complete the VBP Survey. Incentives were not offered.

b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

The 2020 Paying for Value Survey Results were received in January 2021. SWACH plans to review the survey results with each MCO during the monthly meeting and address potential action steps that could be done collaboratively. These meetings will begin in February 2021 (dependent on impact of COVID-19) during this same period of time. SWACH has requested combined MCO meetings quarterly in 2021 and will ask if VBP discussions are appropriate for these combined meetings or if this is a "competitive" issue for the MCOs.

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

Documentation

22.P4R Metrics

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

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.[7] Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

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

Instructions:

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

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

Format:

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

Optional: The ACH may submit P4R metric information.

See attachment SWACH.SAR6 Attachement P4R Metric Reporting 2.01.21

[7] https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121

SWACH

July 1, 2020 - December 31, 2020

Cumulative snapshot

Funds Earned	$	44,521,785.74
Funds Distributed	$	27,534,695.84
Funds available	$	16,987,089.90

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A	$ -	$ 825,333.00	$ 825,333.00
Project 2B	$ -	$ 567,417.00	$ 567,417.00
Project 3A	$ -	$ 103,167.00	$ 103,167.00
Project 3D	$ -	$ 206,333.00	$ 206,333.00
VBP	$ -	$ -	$ -
Total	$ -	$ 1,702,250.00	$ 1,702,250.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	$ 1,481.36	$ -	$ 1,481.36

Table 3: incentive funds distributed, by use category

	Q3	Q4	Total
Adminstration	$ 672,944.72	$ -	$ 672,944.72
Community health fund	$ -	$ -	$ -
Health systems and	$ 1,207,679.43	$ 250,160.02	$ 1,457,839.45
Integration incentives	$ 126,382.00	$ -	$ 126,382.00
Project management	$ 21,435.20	$ -	$ 21,435.20
Provider engagement, participation, and implementation	$ 145,586.57	$ -	$ 145,586.57
Provider performance	$ 2,077,638.00	$ 1,793,200.00	$ 3,870,838.00
Reserve/contigency fund	$ -	$ -	$ -
Total	$ 4,251,665.92	$ 2,043,360.02	$ 6,295,025.94

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