



Healthier Washington Medicaid Transformation  
Accountable Communities of Health  
**SWACH** Semi-annual Report

**SAR 4.0**

Reporting Period: July 1, 2019 – December 31, 2019

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## 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 (July 1, 2019 to December 31, 2019) includes four sections as outlined in the table below.

Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)		
Section	Item num	Sub-section components
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-13	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>	14-16	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>
	17-19	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. Value-based payment</b>	21-23	Narrative responses
<b>Section 4. Pay-for-Reporting (P4R) metrics</b>	24	Documentation

**There is no set template for the semiannual 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).
3. Reporting on Value Based Payment (VBP) milestones (Pay-for-Reporting, or P4R).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. 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 payment period.

For DY 3, 75% of Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of July 1 through December 31, 2019 determines achievement for half of the available P4R-associated Project Incentives.

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 Project for Project Incentives, Period July 1, 2019 – December 31, 2019*

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23
North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Pierce County ACH	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

Table 2 provides the AVs associated with VBP Incentives for this annual reporting period.

Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
<b>Potential AVs</b>	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

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

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2020 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 4 – January 31, 2020.”**

The folder path in the ACH’s directory is:

*Semi-Annual Reports → Semi-Annual Report 4 – January 31, 2020.*

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 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.SAR4 Report. 1.31.20
- *Attachments:* ACH Name.SAR4 Attachment X. 1.31.20

**Upon submission, all submitted materials (except for the P4R metrics reporting workbook) 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 July 1, 2019 – December 31, 2019.

<b>ACH semi-annual report 4 – submission and assessment timeline</b>			
<b>No.</b>	<b>Activity</b>	<b>Responsible party</b>	<b>Anticipated timeframe</b>
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2019 to ACHs	IA	August 2019
2.	Submit semi-annual report	ACHs	January 31, 2020
3.	Conduct assessment of reports	IA	Feb 1-25, 2020
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2020
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2020
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2020
7.	Issue findings to HCA for approval	IA	April 2020

***Contact information***

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

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

## 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.

<b>ACH name:</b>	Southwest Washington ACH
<b>Primary contact name</b>	Barbe West
<b>Phone number</b>	360-515-8252
<b>E-mail address</b>	<a href="mailto:Barbe.west@southwestach.org">Barbe.west@southwestach.org</a>
<b>Secondary contact name</b>	Susan Crandall
<b>Phone number</b>	360-515-6958
<b>E-mail address</b>	<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
<b>1.</b> 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	
<b>2.</b> The ACH has an Executive Director.	X	
<b>3.</b> 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	
<b>4.</b> At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
<b>5.</b> Meetings of the ACH's decision-making body are open to the public.	X	
<b>6.</b> 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	
<b>7.</b> The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
<b>8.</b> 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.***

- See SWACH.SAR4. Attachment Organization Chart.1.31.20

## 10. Budget/funds flow.

a) 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. 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).

## 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 affirmed with the Yakama Nation Tribe that the ACH is supportive of the Heritage University BHA education program for Yakama Nation. BHA alternative and specialized training alternatives were being considered. The goal is to enroll 4 Yakama students in the AK BHA education program in Fall 2020. Efforts will continue to create a timeline and infrastructure to stand up a Heritage University BHA program in Yakama.

SWACH has engaged Cowlitz Tribe in conversations pertaining to HealthConnect Hub expansion.

## 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.

<b>Earned Design Funds</b>	<b>Design Fund Expenditures</b>	<b>Remaining Design Fund Balance</b>	<b>Percent remaining</b>
\$6,000,000	\$3,080,231	\$2,919,769	49%
The Design Funds will continue to be utilized to support SWACH Staff and appropriate consultants who will be working with clinical and community-based partners to implement work plans as defined in the Binding Agreements. The 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.			
<b>Use Categories</b>	<b>Design Fund Expenditures</b>	<b>Expenditures details (narrative)</b>	
Administration	\$1,271,766	Administrative operating expenses of SWACH (salaries, facilities, etc.)	
Community Health Fund	\$0	N/A	
Health Systems and Community Capacity Building	\$548,940	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	\$943,080	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	
Shared Domain 1 Incentives	\$0	N/A	
Other:	\$0	N/A	
<b>Total</b>	<b>\$3,080,231</b>		

**13. 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.

- a) Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- b) ACHs may use the table below or an alternative format as long as the required information is captured.
- c) Description of use should be specific but concise.
- d) List of use and expenditures should reflect a cumulative accounting of all incentives distributed or projected to support behavioral health providers transitioning to integrated managed care. It is not limited to the reporting period.

<b>Use of incentives to assist Medicaid behavioral health providers</b>		
<b>Description of Use</b>	<b>Expenditures (\$)</b>	
	<b>Actual</b>	<b>Projected</b>
HIE/HIT and Clinical Assessments	<b>\$655,000</b>	
Behavioral Health Integration support including:	<b>\$2,735,735</b>	<b>\$5,230,911</b>
<ul style="list-style-type: none"> <li>• Investments into provider organizations to support evidence based clinical integration models</li> <li>• Investments into provider organizations to support workforce development for integrated care teams</li> <li>• Investments to support shared learning and science of improvement across networks of care</li> <li>• Investments for practice transformation personnel and/or training</li> <li>• Partnership investments to support community and clinical linkages</li> <li>• Investments to support the advancement of using equity as a lens to support continuous quality improvements</li> <li>• Investments to support IT investments related to new clinical and administrative process.</li> </ul>		

## Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report. 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:

#### 14. 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>

- a) 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:
  - i. Work steps and their status.
    1. 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.
    2. 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 be started.
  - b) If the ACH has made minor changes for any work step from their originally submitted

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

work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.

- c) If the ACH has made substantial changes to the work plan format since the last 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.***

## **15. Partnering provider roster.**

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.<sup>4</sup> 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.

See SWACH.SAR4. Attachement Partnering Provider Roster.1.30.20

### **Instructions:**

- a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database and apply consistent formatting for ease of maintenance for future reporting periods.
- b) By **October 15**, HCA will provide ACHs a clean version of the ACH's partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.
  - i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.
- c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
  - i. Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an "X" in the appropriate project column(s).
  - ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.
- d) Update partnering provider site information as needed over each reporting period.

## **Documentation**

The ACH should provide documentation that addresses the following:

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<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 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).

## 16. 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.***

- See SWACH.SAR4 Attachment Updated QI Strategy.1.31.20
- See SWACH.SAR4 Attachment Partner Reporting Quality Review Debrief.1.31.20

## Narrative responses

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

### 17. General implementation update

- a) *Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities.
  - i. Across the project portfolio, provide three examples of *each* of the following:
    1. Trainings and technical assistance resources provided to or secured by partnering providers or members of care teams necessary to follow required guidelines and to perform their roles in an approach in a culturally competent manner. Be specific when describing the project(s), partnering provider(s), the guidelines or evidence-based approaches, specific needs that the training and/or technical assistance addresses and describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner. Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are

anticipated to be addressed in the future.

**Example 1) Equity Collaborative:**

SWACH has identified health equity as a critical part of the region's overall vision, strategy and work. Health equity means that all people have access to a healthy environment, community, and relationship with local institutions and service providers. SWACH is furthering equity work by supporting partners in the SWACH Equity Learning Collaborative, where partners receive peer and expert support in completing an equity assessment and equity plan. SWACH convenes a cohort of 14 organizations, including clinical providers and community serving organizations, on a monthly basis. Each participating organization selected two representatives to be accountable for Collaborative work. These representatives attend monthly meeting to receive training in diversity, equity and inclusion terminology and concepts. Additionally, participants receive technical support to select an equity assessment tool, develop a strategy for their assessment process, analyze assessment results, create an aim statement to focus their change tactics, and finally, to evaluate their tests of change. While SWACH provides this technical support and training, the structure of the Collaborative creates a peer learning environment in which partners share experiences, resources, and strategies for doing organizational Diveristy Equity and Inclusion (DEI) work. The Equity Collaborative also utilizes the SWACH Learning Community portal to share resources, continue dialogue, and work out logistical issues between our monthly meetings.

At this point all participating partners have completed their organizational equity assessment and are in the process of drafting an aim statement for their organization. These statements will guide their strategies for, and tests of, change in 2020. To this end, we have created a structure for the Collaborative that employs a Quality Improvement strategy. Participating organizations will identify a series of change tactics to test in 2020, and share their results, successes and challenges with the group. Additionally, SWACH will continue to provide training in content areas partners identify as significant to their equity work (e.g. trauma-informed care, stigma reduction).

In order to support partners' ability to take on this body of work, SWACH is funding each organization's participation.

**List of partnering provider(s):**

Children's Center, Children's Home Society, Columbia River Mental Health, Community Services Northwest, CORE, Council for the Homeless, Family Solutions, Kaiser Permanente, Klickitat Valley Health, Lutheran Community Services, Providence, Share, Skyline Hospital and Cascade Pacific Action Alliance (ACH adjacent to SWACH).

**The guidelines or evidence-based approaches:**

In 2019 the primary outcome for participating organizations has been the completion of an organizational equity assessment. The guidelines and approaches for this work are, to a large extent, outlined in the tools themselves. Examples of these assessments include the following: the Meyer Memorial Trust Diversity, Equity and Inclusion Spectrum Tool; The Coalition of Communities of Color's Protocol for Culturally Responsive Organizations; Coalition of Communities of Color Tool for Organizational Self-Assessment Related to Racial Equity; Dancing on Live Embers; and the Bay Area Regional Health Inequities Initiative Local Health Department Organizational Self-Assessment for Addressing Health Inequities. In 2020, as participants in the Collaborative turn toward implementation, organizations are creating aim

statements based on their assessment results and creating plans for systems change. For this stage, the collaborative is using a Quality Improvement approach to change. Participating members are using a change package to guide their aim statements, change tactics, and will use QI practices to measure and document their process.

**Specific needs that the training and/or technical assistance addresses:**

The Equity Collaborative provides training on DEI terminology and concepts, and technical assistance to the organization's assessment process. While all participating organizations expressed that they value health equity, and have a desire to increase accessibility to their services, none of them had an organizational definition of "health equity," and all requested support in creating practices that would make their organization more accessible. While training is an element of the Collaborative, the most substantial call is, "how does my organization implement sustainable, and equitable, change?" The assessment stage of the Collaborative was necessary to identify where organizations are at, the implementation stage more directly responds to this question.

**Describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner:**

The Equity Collaborative is based on peer-learning model. This means that the Collaborative was designed to include organizations at different levels of vis-à-vis diversity, equity and inclusion. This means that the content and conversations needed to start in a way that meet people, and organizations where they were. It took some time for the participants to learn about and trust each other. What this has allowed for is real participation, and collaboration. Some organizations are further along their DEI practice and these organizations have shared their experience, challenges and successes with assessments or policy change. Some organizations based on their geographic/demographic proximity have decided to coordinate their aim statements and change tactics.

**Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future:**

The main gap that remains is that equity work that leads to measurable change in outcomes is a long-term project. Healthcare as an industry often demands demonstrations of quick changes in outcomes and therefore this type of change effort can make long-term buy in a challenge. At times, some interpret this to mean that equity work is not sustainable. Developing strategies for measuring change to realize health equity, in a way that resonates with a short-term time sense is an important step to maintaining a commitment.

***Example 2) Pathways HealthConnect/ HealthConnect Hub***

SWACH's implementation of the *Pathways HealthConnect* care coordination program and development of the regional *HealthConnect Hub* asserts CHW/Peers as central to culturally competent care coordination.

CHWs and Peers with lived experience have an unusually close understanding of the communities served. Trusting relationships enable these workers to serve as a liaison/link/intermediary between health/social services and their communities to facilitate access to services and improve the quality and cultural competence of service delivery. Use of

community health workers is recognized as a fundamental strategy for the goal of culturally competent health care services.

SWACH's implementation of Pathways HealthConnect and the HealthConnect Hub is an approach to care coordination that asserts the community-based workforce (CHW/Peer Supporters) is vital to culturally competent whole person care while supporting this workforce through a central coordinating and training entity with an IT backbone infrastructure connecting a continuum of care coordination programs and related services.

**Pathways HealthConnect training/TA supports cultural competence:**

All SWACH trainings (listed below) for Pathways HealthConnect and the HealthConnect Hub recognize and maintain a focus on cultural humility and cultural competency as fundamental to the efficacy of community-based workers. Cultural competency is specifically called out as curriculum content focus area for the following:

- Pathways HealthConnect Foundations Training
- Common Principles and Practices of CHWs/Peers training

Additionally, SWACH supports community-based workforce partners in leveraging state-level trainings with cultural competency components including:

- DOH CHW training opportunities
- Washington State Peer Counselor certification training

**Table 1: Trainings/TA for a culturally competent community-based workforce**  
**Anticipated future training/TA:** Trainings developed and piloted by SWACH in 2019 will serve as a regional resource for continuing professional development and program expansion needs. In addition, SWACH will develop a resource library of webinars for the community-based workforce focused on the intersection of systems navigation and culturally competent community-based care coordination. SWACH will leverage these training resources as needed for the 2020 expansion of Pathways HealthConnect and HealthConnect Hub initiatives.

<b>Training Topics / Project/ Dates</b>	<b>Participating Organizations</b>
<b>Pathways HealthConnect Foundations Training / Pathways HealthConnect</b> (1.28.19 - 2.1.19/ 3.11.19 - 3.15.19) Pathways Care Coordination Framework, HealthConnect Hub IT Systems Training Foundations of Community Based Worker Training	Washington Gorge Action Program (WGAP) Skamania County Community Health (SCCH) SeaMar CHC Community Voices are Born (CVAB)
<b>Motivational Interviewing Trainings 1, 2 &amp; 3 / Pathways HealthConnect</b> (4.18.19; 5.23.19; 6.27.19)	WGAP, SCCH, SeaMar CHC, CVAB
<b>Crisis Response Training / Pathways HealthConnect</b> (7.25.19)	WGAP, SCCH, SeaMar CHC, CVAB
<b>Chronic Disease Self-Management Lay Leader Training / Pathways HealthConnect / HealthConnect Hub</b> (8.21.19 - 8.22.19 / 8.28.19 - 8.29.19)	WGAP, SCCH, SeaMar CHC, CVAB, Vancouver Housing Authority, Lifeline Connections, Washington State University-Extension, SW Washington Recovery Coalition, Vet Corp- WSU Extension, Vancouver Housing Authority
<b>Chronic Pain Self-Management Lay Leader Training / Pathways HealthConnect / HealthConnect Hub</b> (9.25.19)	WGAP, SCCH, SeaMar CHC, CVAB, Vancouver Housing Authority, Lifeline Connections, Washington State University-Extension, SW Washington Recovery Coalition, Vet Corp- WSU Extension, Vancouver Housing Authority
<b>Working with OUD: Barriers, Approaches and Resources in Urban and Rural Areas / Pathways HealthConnect</b> (10.24.19)	WGAP, SCCH, SeaMar CHC, CVAB

<b>CHW/Peer Supporters Common Principles and Practices: Co-Facilitator Training / Pathways HealthConnect / HealthConnect Hub</b> (11.7.19 / 11.14.19)	WGAP, SCCH, SeaMar CHC, CVAB, Rose Village CHWs, Community Health Advocate and Peer Support Network (CHAPS)
<b>Development of CHW/Peer Supporters Common Principles and Practices / Pathways HealthConnect / HealthConnect Hub</b> Training (Planned 2.19.2020- 2.20.2020 /3.11.2020- 3.12.2020/ 4.16.2020)	WGAP, SCCH, SeaMar CHC, CVAB, Rose Village CHWs, CHAPS

***Example 3) Overdose Awareness Training Series***

Opioid overdose deaths are one of the leading causes of preventable and accidental death in Washington. The state opioid response plan identifies reducing opioid mortality as a priority goal. SWACH secured 100 two-pack doses of naloxone, a lifesaving opioid overdose reversal drug, from WA State Department of Health, Office of Infectious Disease. SWACH partnered with Clark County Public Health to hold a series of Overdose Awareness Trainings to educate the community and reduce stigma around opioid overdose and opioid use disorders. SWACH began by partnering with local community members and the Clark County Opioid Taskforce as well to hold an Overdose Awareness Day event on August 31<sup>st</sup>, 2019. SWACH then held an event for community members on 10/25 focusing on training any individuals or family members of someone with OUD or high-dose opioid prescriptions. The next training was on 11/19 and it focused on educating a variety of health and behavioral healthcare providers directly following a Regional Health Improvement Council meeting. In total, SWACH trained and equipped over 100 individuals across different sectors and including community members.

**List of partnering provider(s):**

Clark County Public Health, Recovery Café, Rainier Springs Hospital, Lifeline Connections, Kleen Street, Providence, Legacy, PeaceHealth Southwest, ESD 112, Clark County Opioid Taskforce, Southwest Recovery Coalition, Clark County Lyn Anderson, Randell Brewster, Charlie Hanset, Kandice King, and other community members.

**The guidelines or evidence-based approaches:**

The overdose prevention training was arranged and supported by Clark County Public Health using evidence-based education from WA state Department of Health. The training was given by a Public Health Nurse trained and educated to deliver the trainings. The distribution of naloxone to community and helping populations is well supported by the efforts and outcomes of the Washington Department of Health, Office of Infectious Disease. SWACH’s efforts to broaden the population that SWACH trained was based on reported strategic gaps in the availability and knowledge of those without another entry point for initial awareness and education regarding opioid overdose.

**Specific needs that the training and/or technical assistance addresses:**

The needs for both increased low-barrier access to naloxone, proper training for overdose intervention, and reduced stigma to both accessing and using naloxone were expressed in the planning of these events. The needs were met by providing the training and naloxone at no cost to the attendees and including stigma-reducing and information about obtaining more doses at the trainings.

**Describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner:**

The trainer used state-approved materials and presented the information in a culturally competent and inclusive manner. The efforts to increase inclusion of populations with reduced access to naloxone due to barriers such as cost, lack of awareness, and stigma was addressed by this series.

**Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future:**

The major gap that remains for partnering providers continues to be the cost of the naloxone. The source of naloxone that was used to provide the kits to the attendees of the trainings is no longer able to provide the medications. The trainings have increased desire to continue the work of spreading information and access, but a new source of low-barrier naloxone kits that can be used to complement the training efforts will need to be found.

**17.a.i (Cont.)**

2. Implementation of bi-directional communication strategies/interoperable HIE tools to support project priorities. Be specific when describing the project(s), partnering provider(s), strategies and/or tools, and how these activities support project priorities.

**ACH Health IT Strategy.** All ACH Executive Directors collaborated to develop an ACH Health IT Strategy comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities. The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

*Better engage people, organizations, and community partners in the circumstances, health events, and care-system encounters to enable whole-person care in traditionally disconnected care settings and services through the use of health IT.*

**Example 1) Learning Community Portal**

A Learning Community Portal is provided for providers/members of care teams participating in the Integrated Care Collaborative and Equity Collaborative.

The Equity Collaborative utilizes the Learning Community Portal for three purposes: to share resources, to share experiences/conversations and for logistical coordination. Providing partners with equity assessment tools has been vital for the partnerships. Because the Equity Collaborative is a peer learning project, the Portal also allows participating partners to share resources and partners are able to engage in dialogue between actual face-to-face meetings. Expectations have been created on the utilization of the Portal in order to create a tool that is highly utilized by all members of the Collaborative. There are nine clinical partners, five community-based partners and the Cascade Pacific Action Alliance ACH in the Equity Collaborative.

The Learning Community Portal is also used for SWACH's Integrated Care Collaborative, Chronic Disease Self-Management Education coordination in the Southwest Washington region,

and ACH Care Coordination Collaboration for ACHs implementing Pathways using a common IT infrastructure (SWACH, CPAA, North Central, North Sound).

### ***Example 2) and 3) HealthConnect Hub***

SWACH's HealthConnect Hub provides backbone infrastructure for bidirectional and multidirectional communication across and between community-based workers, care teams, as well as physical health, behavioral health, community paramedicine, and social service sectors.

Strategies/ Tools supporting bi-directional communication strategies and interoperable HIE and CIE (Community Information Exchange):

- *Community Health Record (CHR)*
  - HealthConnect Hub Infrastructure captures individual community member information across services, over time, across programs and care models.
  - Allows multiple agencies/providers serving one individual to work together.
  - Prevents unintentional duplication of services.
  - Prevents unnecessary (potentially retraumatizing) repetition of screenings/assessments across service providers.
  - Interoperable HIE/CIE capacity through direct messaging and/or API integration with EHRs.
- *Resource and Referral platform for agencies and services: HealthBridge partnered with 211 and embedded in HealthConnect Hub Infrastructure*
  - Closed loop referrals between resources, community members, and/or their providers.
  - Referral and engagement information held by HealthConnect Hub in community member's CHR and accessible by designated care team as permitted by community member.
  - "Build the Bridge" program- Robust community engagement structure to mobilize community "bridge builders" and "ambassadors" to verify, update and connect community resources, agencies, and information.
- *HealthConnect Hub infrastructure for referral, coordination and connection of community members across care and coordination programs: "Care Traffic Control"*
  - Supports transitions and continuity of support/care across services, agencies and systems for community members.
  - Supports coordination of care coordinators.
  - Supports communication across systems and sectors.
  - Prevents duplication and fragmentation of care and care coordination.
- *CPAA-SWACH Hub: SWACH and CPAA partnership creates an aligned 10 County Hub*
  - Bi and multi-directional communication, coordination, and collaboration across 10 counties.
  - Aligned and continuous quality assurance /quality improvement of the system.
  - Technical assistance in using CPAA-SWACH Hub model.

**Table 2: Projects currently integrated or in process/planning for HealthConnect Hub integration:**

Project	Partnering Providers	How these activities support project priorities.
Pathways HealthConnect	WGAP, SCCH, SeaMar CHC, CVAB, PeaceHealth Medical Group, Lifeline Connections, Council for the Homeless, North Shore Medical Group, Klickitat Valley Health, Skyline Hospital, CPAA- SWACH Hub	<ul style="list-style-type: none"> <li>Community based Care Coordination program coordinated through HealthConnect Hub and the CPAA-SWACH Hub.</li> <li>Community and clinical partners refer through HealthConnect Hub to connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Providers' communication and coordination across sectors and agencies facilitated by HealthConnect Hub</li> <li>Integrated with CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub</li> </ul>
Community Paramedicine	Clark County Fire and Rescue, Clark College, CPAA, SWACH, Cowlitz EMS, Agency for Aging and Disabilities of SW Washington, CPAA-SWACH Hub	<ul style="list-style-type: none"> <li>Connection and communication between and across paramedicine initiatives in SWACH and CPAA regions</li> <li>Communication and coordination between paramedicine providers and agencies/providers addressing SDOH, BH and PH, as well as multi-disciplinary care teams.</li> <li>Community paramedicine refer through HealthConnect Hub to connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Integrated with CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub</li> </ul>
Chronic Disease Self-Management Education programs: CDSMP/ CPSMP/DPP	Washington State University-Extension, WGAP, SCCH, SeaMar CHC, CVAB, Vancouver Housing Authority, Lifeline Connections, SW Washington Recovery Coalition, Vet Corp- WSU Extension, Vancouver Housing Authority, CPAA-SWACH Hub	<ul style="list-style-type: none"> <li>Referrals through HealthConnect Hub/ CPAA-SWACH Hub connect community members to CDSME programming</li> <li>IT infrastructure tracks data, pre and post PAM assessments as part of CHR</li> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Integrated with CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub</li> </ul>
Programs connecting people in supported housing with multi-disciplinary care teams	PeaceHealth, Share, HHIP, Vancouver Housing Authority	<ul style="list-style-type: none"> <li>HealthConnect Hub supports multidisciplinary/multi-agency care team to refer, communicate and collaborate</li> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Integrated with CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub</li> </ul>
Outreach and engagement of unengaged high utilizers: Community Health Engagement Teams (CHET)	SeaMar, Legacy, PeaceHealth, CPAA-SWACH Hub	<ul style="list-style-type: none"> <li>Hub supports multidisciplinary/multi-agency care team to refer, communicate and collaborate</li> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Connects to CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub alignment</li> </ul>

Neighborhood Based CHW programs: Access to Health	Rose Village CHWs, Peace Health, CHAPs	<ul style="list-style-type: none"> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Connects to CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub alignment</li> </ul>
Programs to engage, screen and refer uninsured: Wise Woman	PeaceHealth, CPAA-SWACH Hub, DOH	<ul style="list-style-type: none"> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Connects to CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub alignment</li> </ul>
Hepatitis C Treatment and Peer Support program: Hep C Cures	CVAB, SeaMar, Lifeline, Syringe Exchange,	<ul style="list-style-type: none"> <li>Referrals through HealthConnect Hub connect community members to this project and to a continuum of care coordination and services as needed/appropriate</li> <li>Connects to CHR, HealthBridge, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub alignment</li> </ul>
Closed loop resource and referral platforms: HealthBridge	Free and accessible to community members and agencies	<ul style="list-style-type: none"> <li>Connects to CHR, HealthConnect Hub's "Care Traffic Control", 10 county CPAA-SWACH Hub alignment</li> <li>Connects to 211 resources regionally and state-wide</li> <li>Community engagement structure verifies, updates and connects community resources, agencies, and information.</li> </ul>

**17.a.i (Cont.)**

- Mechanisms that have been established for coordinating care management and/or transitional care plans with related community-based services and supports such as those provided through supported housing programs. Be specific when describing the project(s), partnering provider(s), care management and/or transitional care approaches/supports, and how these activities support project activities.

HealthConnect Hub provides the following mechanisms for coordinating care management and/or transitional care plans:

**Table 3: Mechanisms for coordinating care management and/or transitional care plans**

Mechanisms	Implications for care management coordination and/or transitional care plans
HealthConnect Hub referral, coordination and connection of community members across care and coordination programs: "Care Traffic Control"	<ul style="list-style-type: none"> <li>Supports transitions and continuity of support/care across services, agencies and systems for community members.</li> <li>Supports coordination of care coordinators.</li> <li>Supports communication across systems and sectors.</li> <li>Guards against duplication and fragmentation of care and care coordination.</li> <li>Access to evidence-based Coleman care transitions model and software application. SWACH IT partner has acquired Coleman's Care Transitions program to be integrated into HealthConnect Hub infrastructure.</li> </ul>
Community Health Record (CHR) across HealthConnect Hub	<ul style="list-style-type: none"> <li>HealthConnect Hub Infrastructure captures individual community member information across services, over time, across programs and care models.</li> <li>Supports transitional care plans: seamless and supported transitions of care.</li> </ul>

	<ul style="list-style-type: none"> <li>• Allows multiple agencies/providers serving one individual to work together.</li> <li>• Prevents unintentional duplication of services.</li> <li>• Prevents unnecessary (potentially retraumatizing) repetition of screenings/assessments across service providers.</li> <li>• Interoperability capacity with EHR's through direct messaging and/or API integration.</li> </ul>
HealthBridge partnered with 211 and embedded in HealthConnect Hub Infrastructure	<ul style="list-style-type: none"> <li>• Community sourced resource and referral platform for agencies and services.</li> <li>• Closed loop referrals between resources, community members, and/or their providers.</li> <li>• “Build the Bridge” program- Robust community engagement structure to mobilize community “bridge builders” and “ambassadors” to verify, update and connect community resources, agencies, and information.</li> <li>• Referral and engagement information held by HealthConnect Hub in community member’s Community Health Record accessible by care team.</li> </ul>
CPAA-SWACH Hub: Aligned 10 County Hub through partnership between SWACH and CPAA	<ul style="list-style-type: none"> <li>• Bi and multi-directional communication, coordination, and collaboration across 10 counties.</li> <li>• Supports transitions and continuity of support/care for community members across ACH regions, services, agencies and systems.</li> <li>• Aligned and continuous quality assurance / improvement of the system.</li> <li>• Technical assistance in using CPAA-SWACH Hub model.</li> </ul>

HealthConnect Hub supports coordination, access, continuity and care transition across the continuum of care management and services. HealthConnect Hub mechanisms coordinate with related community-based services and supports to connect and support transition across care teams, projects, partners, services and supports.

**Table 4: HealthConnect Hub Projects and Partnerships**

Project	Partnering Providers
Pathways HealthConnect	WGAP, SCCH, SeaMar CHC, CVAB, PeaceHealth Medical Group, Lifeline Connections, Council for the Homeless, North Shore Medical Group, Klickitat Valley Health, Skyline Hospital, CPAA- SWACH Hub
Community Paramedicine	Clark County Fire and Rescue, Clark College, CPAA, SWACH, Cowlitz EMS, Agency for Aging and Disabilities of SW Washington, CPAA- SWACH Hub
Chronic Disease Self-Management Education programs: CDSMP/ CPSMP/DPP	Washington State University-Extension, WGAP, SCCH, SeaMar CHC, CVAB, Vancouver Housing Authority, Lifeline Connections, SW Washington Recovery Coalition, Vet Corp- WSU Extension, Vancouver Housing Authority, CPAA- SWACH Hub
Connecting supported housing with multi-disciplinary care team: Multi-Disciplinary Health Engagement Team (MHET)	PeaceHealth, Share, HHIP, Vancouver Housing Authority
Outreach and engagement of unengaged high utilizers: Community Health Engagement Teams (CHET)	SeaMar, Legacy, PeaceHealth, CPAA- SWACH Hub

Neighborhood Based CHW programs: Access to Health	Rose Village CHWs, Peace Health, CHAPs
Programs to engage uninsured through connection to screening and resources: Wise Woman	PeaceHealth, CPAA- SWACH Hub, DOH
Hepatitis C Treatment and Peer Support program: Hep C Cures	CVAB, SeaMar, Lifeline, Syringe Exchange,
Closed loop resource and referral platforms: HealthBridge	Free and accessible to all clinical and community partners as well as individual community members

**17.a.i (Cont.)**

4. Systems or rapid-cycle quality improvement processes that have been developed to monitor performance, provide performance feedback, implement changes and track outcomes.

***Example 1) Integrated Care Collaborative and Equity Collaborative***

In its learning collaboratives, SWACH is incorporating the Institute for Healthcare Improvement’s (IHI) Model for Improvement training and technical assistance. Participating partners are developing specific aim statements, measures and identifying small tests of changes for iterative plan-do-study-act cycles. This approach to physical health and behavioral health integration and equity will support the systems changes needed for sustainability. Participating partners will provide regular (monthly or quarterly) updates to the collaborative for faculty and peer feedback.

***Example 2) Hep C Cures QI Project***

The Hep C Cures project is a cross-sector, community-clinical linkages improvement project. The project partnered a clinical setting, SeaMar CHC, where Hep C treatment was initiated, and a community peer support agency, Community Voices are Born (CVAB), which imbedded a certified peer with lived experience in Hep C and addiction into the clinical milieu.

The project utilizes multiple quality improvement (QI) processes, methods and tools including convening a key stakeholder QI team for regular meetings (weekly and bi-weekly) over 12 months; charter development; flow diagram development; developing, testing and implementing changes through multiple ongoing Plan-DO-Study-Act (PDSA) cycles; data collection and analysis; and development and communication of progress and outcomes through regular leadership reports.

See SWACH.SAR4. Attachment Hep C Cures QI Project Overview and Outcomes 1.31.20

<b>Hep C Cures QI Project Aim:</b>	<b>Hep C Cures QI Project Outcomes (11.10.19):</b>
<ul style="list-style-type: none"> <li>• By the end of the 12-month project, there will be a minimum of 20% increase in the number of hepatitis C treatment patients that follow up with a test of cure as compared to baseline data of 18.5% follow up rate (for 6 months previous to peer provider services).</li> <li>• Outcomes achieved through a community /clinical collaboration bringing peer providers alongside the clinical team to improve treatment adherence through care coordination and patient self-management support.</li> </ul>	<ul style="list-style-type: none"> <li>• 69.4% of peer supported patients completed a test of cure and were cured who were due for a test of cure.</li> <li>• Peer currently working full time with over 100 patients to whom she provides support.</li> <li>• Peer in regular contact/providing continuing support for over 90% of all program participants. Less than 10% are lost to care.</li> </ul>

**Example 3) Pathways HealthConnect**

Pathways HealthConnect incorporates the Institute for Healthcare Improvement’s Model for Improvement training and technical assistance. The project utilizes multiple quality improvement (QI) processes, methods and tools including regular QI focused convenings of key stakeholders (bi-weekly and monthly); charter development; developing, testing and implementing changes through multiple ongoing Plan-DO-Study-Act (PDSA) cycles; data collection and analysis; and development and communication of progress and outcomes through regular community reports and at HealthConnect Advisory Committee meetings of community stakeholders.

See SWACH.SAR4. Attachment Pathways HealthConnect Data for RHIP.1.31.20

**Example 4) Access to Health**

The Peace Health Family Medicine Southwest (FMSW) clinic, the Rose Village Community-Based CHWs, and SWACH are working together to improve clinical-community linkages, i.e. how can the clinic better serve the community and what can the community do to support individual health management outside the walls of the clinic? SWACH-FMSW: Access to Health partnership was formed to address this question. The Rose Village CHWs, SWACH staff, and FMSW staff have been working together to identify, test, and implement activities that meet the cultural needs of Rose Village residents who are eligible to enroll in Medicare benefits. Regularly scheduled monthly meetings allow updates and feedback on the project that then result in improvements to efforts to meet the needs of the community.

**17.a (Cont.)**

- ii. For each project in the ACH Project Plan, provide clear, specific, and concise responses to the below as applicable. For projects the ACH is not implementing, indicate “Not Applicable.”
  - 1. Project 2A: Provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.

As of 12/31/2019 SWACH has provided \$3,527,677 to clinical providers to support integrated care activities.

- 2. Project 2B: Provide information related the following:
  - a. Schedule of initial implementation for each Pathway.

As indicated in the “date of implementation” column below, Pathways are not implemented incrementally but all together as a comprehensive approach to whole person risk assessment. An initial assessment of risk across all 20 pathways is conducted to develop an action plan with the community member. Subsequent to the assessment, community-based workers support community members with connection to resources and services (“pathways”) as indicated from the assessment.

SWACH go-live date for Pathways HealthConnect was March 18, 2019.

<b>Pathway</b>	<b>Date of implementation (actual or anticipated)</b>	<b>Notes Number of Pathways Opened since Implementation</b>
<b>Adult education</b>	March 18, 2018	29
<b>Employment</b>	March 18, 2018	66
<b>Health insurance</b>	March 18, 2018	42
<b>Housing</b>	March 18, 2018	93
<b>Medical home</b>	March 18, 2018	118
<b>Medical referral</b>	March 18, 2018	255
<b>Medication assessment</b>	March 18, 2018	131
<b>Medication management</b>	March 18, 2018	6
<b>Smoking cessation</b>	March 18, 2018	127
<b>Social service referral</b>	March 18, 2018	1294
<b>Behavioral referral</b>	March 18, 2018	94
<b>Developmental screening</b>	March 18, 2018	0
<b>Developmental referral</b>	March 18, 2018	3
<b>Education</b>	March 18, 2018	1180
<b>Family planning</b>	March 18, 2018	8
<b>Immunization referral</b>	March 18, 2018	1
<b>Lead screening</b>	March 18, 2018	2
<b>Pregnancy</b>	March 18, 2018	5
<b>Postpartum</b>	March 18, 2018	0

### 17.a.ii.2 (Cont)

- b. Partnering provider roles and responsibilities to support Pathways implementation.

Roles and responsibilities for partnering providers that are Care Coordinating Agencies are established in Pathways HealthConnect policies and Procedures and supported through continuous quality assurance and quality improvement processes.

See SWACH.SAR4.Attachment Pathways HealthConnect Policies and Procedures.1.31.20

<b>Pathways HealthConnect Policies and Procedures: Table of Contents</b>	
1.1 General Job Description	<b>Privacy Requirements and Standards</b>
1.2 Boundaries, Ethics, and Training	3.1 Privacy Requirements and Standards
1.3 Identification & Recruitment of the Pathways Participant	3.2 Confidentiality and Release of Information
1.4 Referrals	3.3 HIPAA Compliance

1.5 Referral Allocation to contracted Care Coordination Agency	<b>HealthConnect Monitoring and Quality Assurance/Quality Improvement</b>
1.6 Pathways HealthConnect Care Plan Development and Pathways Implementation	4.1 Quality Assurance (QA)/Quality Improvement (QI)
1.7 Supervisor Role & Function	4.2 Community Needs Assessment
1.8 Caseload	4.3 Reporting of Results and Outcomes
1.9 Health Equity and Transparency	4.4 Completion of Deliverables
1.10 Providing Information and Health Education	<b>HealthConnect Operations</b>
1.11 Urgent Medical or Behavioral Health Issues	5.1 Meetings/Required Meetings
1.12 In-person and Home Visit Procedure and Safety	5.2 Marketing and Communications
<b>Documentation</b>	5.3 Conflict of Interest Attestation
2.1 Documentation and Data Collection	5.4 Contractual Compliance
2.2 In-person visits and Documentation	5.5 Fiscal Management
2.3 Documentation Between In-Person Visits	5.6 Invoicing
2.4 Pathways Status, Tracking, and Follow-up	

Referral Partners- Responsibilities for provider partners to refer to the Pathways HealthConnect Program are as follows:

- Utilize the HealthConnect Client Referral to HUB portal to refer high risk clients to SWACH's Pathways HealthConnect, ensuring information is as complete as possible.
- Provide Referral Practice and Individual Provider information to facilitate care coordination

See SWACH.SAR4.Attachment HealthConnect Referral Partner Responsibilities.1.31.20

**17.a.ii.2 (Cont)**

- c. Inventory of Care Coordination Agencies (CCAs) and the number of referrals initiated to date.

CCA Name	Total # of Referrals to CCA for any Pathway	Total number of individual Pathways Opened
Community Voices Are Born-CVAB	72 referrals for Pathways HealthConnect Support	1055
SeaMar CHC	48 referrals for Pathways HealthConnect Support	649
Skamania County Community Health	67 referrals for Pathways HealthConnect Support	1259
Washington Gorge Action Program	52 referrals for Pathways HealthConnect Support	491

- d. Systems the HUB lead entity is using to track and evaluate performance. Provide a list of the related measures.

<b>Systems to track and evaluate performance</b>	<b>Related performance and process measures</b>
<p><i>HealthConnect Hub</i></p> <ul style="list-style-type: none"> <li>• Built-in reporting platform tracks and evaluates performance</li> </ul>	<p><i>Performance Measures</i></p> <ul style="list-style-type: none"> <li>• Number of community members referred</li> <li>• Number of community members on caseload</li> <li>• Frequency of client engagement</li> <li>• Types and number of Pathways initiated</li> <li>• Percentage of Pathways closed successful and unsuccessful</li> <li>• Pathways aging (opened more than 30 days and not yet closed)</li> <li>• ROI completion rate</li> <li>• Initial checklist completion rate</li> </ul>
<p><i>Monthly QI meetings held with Pathways HealthConnect agency supervisors</i></p> <ul style="list-style-type: none"> <li>• Review of regional and agency level performance measures</li> <li>• Review of strengths, gaps and next steps of system implementation</li> <li>• Review of individual staffing strengths, needs, and performance</li> <li>• Coordination of quality improvement efforts and PDSA cycles</li> </ul>	<p><i>Process Measures</i></p> <ul style="list-style-type: none"> <li>• Number and regularity of meetings</li> <li>• Attendance of supervisors</li> </ul>
<p><i>Monthly meetings of full Pathways HealthConnect cohort</i></p> <ul style="list-style-type: none"> <li>• Review of regional and agency level performance measures</li> <li>• Face to face convenings support cohort trust and interdependence</li> <li>• Professional development training opportunities</li> <li>• Facilitated shared learning and cross training opportunities</li> <li>• Collective quality improvement efforts and PDSA cycles</li> </ul>	<p><i>Process Measures</i></p> <ul style="list-style-type: none"> <li>• Number and regularity of meetings</li> <li>• Attendance of cohort members</li> <li>• Evaluation feedback from cohort members</li> </ul>
<p><i>Development of HealthConnect Advisory Committees</i></p> <ul style="list-style-type: none"> <li>• Data and outcomes presentations specific to counties as well as reflecting SWACH region</li> <li>• HealthConnect Advisory Committees established in each SWACH county</li> <li>• Community stakeholder accountability /feedback on program performance and opportunities</li> </ul>	<p><i>Process Measures</i></p> <ul style="list-style-type: none"> <li>• Number and regularity of meetings</li> <li>• Attendance of community stakeholders</li> </ul>

**17.a.ii.2 (Cont)**

- e. Success in hiring staff, a listing of open positions and efforts to fill those. Describe barriers or gaps that exist in retaining staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.

SWACH contracted partners have reported no significant challenges in hiring staff. Retention of staff has not been a significant barrier to program implementation. Retention was an issue early in the program for one SWACH partner (CVAB), however, staffing at this agency stabilized over time as the program gained traction. One agency (WGAP) had turnover of one staff. The position was filled expeditiously. Two agencies have not experienced turn over (SeaMar, SCCH).

There are currently no open positions in the Pathways HealthConnect program. Based on feedback and program support from current and potential community partners, SWACH plans for a 2<sup>nd</sup> wave program expansion in 2020. Approximately 30 additional community-based workers are anticipated to be trained/integrated within Pathways HealthConnect and HealthConnect Hub.

SWACH supports contracted partners in hiring, retention, and professional development:

- SWACH provides partner agencies with guidance and best practices for recruitment and hiring of community-based workers.
- SWACH supports/facilitates shared learning across partnering agencies for best practices in recruiting and hiring community-based workers.
- New hires provided with one on one onboarding training in Pathways and HealthConnect systems.
- Supervisors supported in bringing on new staff.
- All Pathways HealthConnect community-based workers receive regular and on-going trainings in a variety of professional development focus areas.

**17.a.ii.2 (Cont)**

- f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.

***Onboarding training for Pathways HealthConnect CHW/Peers***

Onboarding training for Pathways HealthConnect is provided to four key contracted CCA partners: SeaMar, CVAB, WGAP, SCCH. The training includes three core components:

Training Core Components	Evaluation and assessment post-training	Numbers Trained
Documentation /HealthConnect IT systems	<ul style="list-style-type: none"> <li>• Demonstrated competency assessment</li> <li>• Post training evaluation</li> <li>• Post training QA monitoring and feedback on competencies and performance (by Pathways HealthConnect supervisor and HealthConnect Hub staff)</li> </ul>	17
Pathways Care Coordination Framework	<ul style="list-style-type: none"> <li>• Demonstrated competency assessment</li> <li>• Post training evaluation</li> <li>• Post training QA monitoring and feedback on competencies and performance (by Pathways HealthConnect supervisor and HealthConnect Hub staff)</li> </ul>	17

Principles and Practices of CHW/Peers	<ul style="list-style-type: none"> <li>• Demonstrated skills and techniques assessment</li> <li>• Post training evaluation</li> <li>• Monitoring and feedback on competencies and performance (by Pathways HealthConnect supervisors)</li> </ul>	14
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**Ongoing Pathways HealthConnect trainings:**

Ongoing Pathways HealthConnect trainings are accessed at monthly cohort meetings. Pathways HealthConnect supervisors are responsible for identifying individual CHW/Peer training needs and goals and collaborating with Hub team on training plans. Training subjects are identified based on:

- CHW/peer and supervisor feedback
- Skills identified from the Community Health Worker Core Consensus (C3) Project
- Pathways Community HUB Institute Certification requirements.

Trainings organized by the HUB are required. Other training opportunities provided in the community are identified but not required. No assessments are done in monthly trainings, but participants complete post-training evaluations.

- Number of Pathways HealthConnect participants engaged in ongoing trainings: 17

**Trainings for Pathways HealthConnect and broader Community-Based Workforce:**

Leader training on Chronic Disease Self-Management Programs and Chronic Pain Self-Management Programs.

SWACH has supported training of community partners across the region as CDSMP and CPSMP lay leaders. As of December 18, 2019:

- 24 individuals from 10 organizations have been trained as CDSMP leaders
- 17 individuals have been cross trained as CPSMP leaders.
- CDSMP and CPSMP lay leaders represent 8 organizations and 9 programs across SWACH

In addition to SWACH trainings, community-based workforce partners are supported in leveraging state trainings pertinent to community-based workforce development:

- SWACH to connect regional CHW's to DOH CHW training opportunities and Washington State peer counselor certification
  - 2 Pathways HealthConnect peers have received peer counselor certification training.

Training Topics / Project	Dates
<b>Pathways HealthConnect Foundations Training</b> / Pathways HealthConnect <ul style="list-style-type: none"> <li>• Pathways Care Coordination Framework,</li> <li>• HealthConnect Hub IT Systems Training</li> <li>• Foundations of Community Based Worker Training</li> </ul>	1.28.19 - 2.1.19/ 3.11.19 - 3.15.19
Motivational Interviewing Trainings 1, 2 & 3 / Pathways HealthConnect	4.18.19; 5.23.19; 6.27.19
Crisis Response Training / Pathways HealthConnect	7.25.19
<b>Chronic Disease Self-Management Lay Leader Training</b> / Pathways HealthConnect / HealthConnect Hub	8.21.19 - 8.22.19 / 8.28.19 - 8.29.19
<b>Chronic Pain Self-Management Lay Leader Training</b> / Pathways HealthConnect / HealthConnect Hub	9.25.19
<b>Working with OUD: Barriers, Approaches and Resources in Urban and Rural Areas</b> / Pathways HealthConnect	10.24.19

<b>CHW/Peer Supporters Common Principles and Practices: Co-Facilitator Training</b> / Pathways HealthConnect / HealthConnect Hub	11.7.19 / 11.14.19
<b>Development of CHW/Peer Supporters Common Principles and Practices</b> / Pathways HealthConnect / HealthConnect Hub	Training Planned 2.19.20- 2.20.20 /3.11.20- 3.12.20/ 4.16.20

**17.a.ii.2 (Cont)**

- g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.

ACH’s implementing Pathways have not yet received the necessary data sharing support at a statewide level to integrate with clinical information captured through the statewide health information exchange. This barrier has been raised as an ongoing subject of discussion at state level meetings of ACH’s, MCO’s and the HCA. SWACH care coordination initiatives use a variety of technology enabled tools (see table below). SWACH welcomes opportunities to integrate and partner with statewide health information exchange initiatives.

Technology Enabled Care Coordination Tools	Implications for Care Coordination
HealthConnect Hub infrastructure	<ul style="list-style-type: none"> <li>• Supports referral, coordination, connection, transitions and continuity of support/care across services, agencies and systems for community members.</li> <li>• Supports coordination of care coordinators.</li> <li>• Supports communication across systems and sectors.</li> <li>• Guards against duplication and fragmentation of care and care coordination.</li> <li>• Access to evidence-based Coleman care transitions model and software application. SWACH IT partner has acquired Coleman’s Care Transitions program - integrated into HealthConnect Hub infrastructure.</li> </ul>
Community Health Record (CHR) across HealthConnect Hub	<ul style="list-style-type: none"> <li>• HealthConnect Hub Infrastructure captures individual community member information across services, over time, across programs and care models.</li> <li>• Supports transitional care plans: seamless and supported transitions of care.</li> <li>• Allows multiple agencies/providers serving one individual to work together.</li> <li>• Prevents unintentional duplication of services.</li> <li>• Prevents unnecessary (potentially retraumatizing) repetition of screenings/assessments across service providers.</li> <li>• Interoperability capacity with EHR’s through direct messaging and/or API integration.</li> </ul>
HealthBridge partnered with 211 and embedded in HealthConnect Hub Infrastructure	<ul style="list-style-type: none"> <li>• Community sourced resource and referral platform for agencies and services.</li> <li>• Closed loop referrals between resources, community members, and/or their providers.</li> <li>• “Build the Bridge” program- Robust community engagement structure to mobilize community “bridge builders” and “ambassadors” to verify, update and connect community resources, agencies, and information.</li> <li>• Referral and engagement information held by HealthConnect Hub in community member’s Community Health Record accessible by care team.</li> </ul>
CPAA-SWACH Hub: Aligned 10 county partnership between SWACH and CPAA	<ul style="list-style-type: none"> <li>• Bi and multi-directional communication, coordination, and collaboration across 10 counties.</li> <li>• Supports transitions and continuity of support/care for community members across ACH regions, services, agencies and systems.</li> <li>• Built-in continuous quality assurance / improvement of the system.</li> <li>• Technical assistance in using CPAA-SWACH Hub model.</li> </ul>

### 17.a.ii.2 (Cont)

- h. Include two examples of checklists or related documents developed for care coordinators.

Pathways HealthConnect CHW/Peers use checklists for care coordination including 1) an initial assessment conducted with community members to identify risk areas, and 2) checklists, or “Pathways”, that serve as a road map to supporting a community member to successful outcomes in addressing specific risk areas. Both the assessment tool and the appendix are components of the HealthConnect IT infrastructure supporting Pathways HealthConnect. They are attached to the SAR as hard copy documents, but are typically accessed by the CHW/Peer through the HealthConnect Hub IT infrastructure.

See SWACH.SAR4.Attachment Pathways Adult Initial Checklist.1.31.20 and SWACH.SAR4.Attachment Pathways Appendix.1.31.20

### 17.a.ii (Cont.)

3. Project 2C: Provide a summary of activities that increase the availability of POLST forms across communities/agencies, where appropriate and when applicable based on the strategies the ACH has promoted. Describe activities that have been most successful as well as any continued challenges in increasing the availability of POLST forms, as applicable. **Not Applicable.**
4. Project 3A: Provide two examples of the following:
  - a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recovery supports.

**Example 1) Prevention, Treatment, Recovery, and OD Prevention:** Provided backbone support for Clark and Skamania County Opioid Treatment Networks as well as launched and supported Clark County Opioid Taskforce and Skamania County SUD Taskforce.

**Example 2) Overdose Prevention:** Collaborated on hosting multiple Overdose Prevention Trainings in 2019: 8/31/19, 10/25/19, and 11/19/19. Trained and equipped (with naloxone) over 100 community members.

**Example 3) Prevention and OD Prevention:** Partnered with ESD 112 on the Starts with One Campaign to distribute Opioid Crisis Response materials. Distributed over 4000 cards, posters, and fact-sheets to clinical partners and community serving organizations.

**Example 4) Treatment and OD Prevention:** Partnered with Providence Medical Group to hold a Community Health Summit: Understanding Opioid Use Disorder and Chronic Pain on November 6<sup>th</sup>. Brought provider and professionals specializing in pain management and opioids to discuss pain-related complex care issues for community education.

### 17.a.ii.4 (Cont.)

- b. Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical

guidelines and incorporate any changes into project implementation plan.

**Example 1)** Attending “Tactical Interagency Opioid Meeting” virtual meeting

**Example 2)** Referencing the WA State Opioid Response plan and attuning to information coming out of the State Opioid Response Workgroup as well as other Department of Health communiques.

- c. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.

**Example 1)** Formed and continued support for Clark County Opioid Taskforce (Started Apr. 2019)

- Has an inclusive collective-impact approach with a Steering Committee to facilitate strategic and administrative support.
- Meets Monthly.
- **Successes:** True cross-sector engagement: medical, recovery, elected official representation, treatment, community members, public health, MCO, community serving agencies, prevention and more attending and engaged.
- **Challenges:** We are focused in 2020 on more fully engaging other sectors not well represented such as law enforcement, corrections, youth voice, and others.

**Example 2)** Skamania County SUD Taskforce (Started 9/19)

- Meeting every 2-3 months.
- Close partnership with Skamania County Community Health to create and maintain structure and engage stakeholders across sectors.
- **Successes:** Facilitating further collaboration between treatment, public health, and corrections. Discussing how we can support MAT access in the county jail.

#### **17.a.ii.4 (Cont.)**

- d. Describe gaps in access and availability of providers offering recovery support services and provide an overview of the ACH’s planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

**Example 1)** There is still a gap in availability in Klickitat and Skamania Counties in access to MAT services and post-release engagement in treatment services. SWACH is working in partnership with local agencies and sheriff’s offices to collaborate on establishing and implementing policies and procedures between treatment and support agencies and the jails. This addresses the location and accessibility of current providers.

**Example 2)** There are varying and disconnected efforts in some regional hospitals. SWACH is collaborating with multiple hospitals in both Clark and Klickitat counties to find areas of collaboration including continued support for Opioid Treatment Networks (OTNs), Engaging with Six Building Blocks supported locally by SWACH, and other intra and inter-agency efforts to incorporate opioid response efforts into hospital policies and procedures. This addresses both the number and location of providers offering recovery support services.

**Example 3)** There is still needed connection and coordination of care work in hospital settings. SWACH is working in partnership with agencies that can provide CHW/Peer and Recovery Coach services and connecting them with local hospitals. This addressed the number and effectiveness of recovery support services.

### **17.a.ii (Cont)**

5. Project 3C: Provide the following:
  - a. A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.
  - b. Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.
  - c. A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

### **Not Applicable**

6. Project 3D: Provide the following:
  - a. Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

### **Chronic Disease Self-Management Education (CDSME)**

#### **Networked, Coordinated, Consistent**

SWACH supports a systems change approach to increasing regional access to the following evidence-based CDSME:

- Chronic Disease Self-Management Program (CPSMP)
- Chronic Pain Self-Management Program (CDSMP)
- Diabetes Prevention Program (DPP)

CDSME programming that is community coordinated, consistently available across the region and scheduled out for two years into the future and referred into by a supported network of providers across clinical and community settings.

## **Regional Administrator/Coordinator**

WSU-Extension is partnered with SWACH to serve as a regional administrator/coordinator for scheduling and delivering of CDSMP/CPSMP and DPP programming for our region.

- Regular availability of Chronic Pain Self-Management classes will be prioritized as needed self-management education critical for effective response to the opioid epidemic.
- WSU-Extension manages a Healthier Washington Collaboration Portal for Regional (Clark, Skamania, Klickitat) coordination and collaborative learning with partnering agencies/program leaders.
- Programming scheduled out two years in advance – providing a consistent and reliable resource for community and clinical providers to refer and supplement an individual's whole person care plan.
- WSU-extension, with SWACH support, to manage outreach and communication strategies for support and development of a community and clinical referral network.

## **Communication, Referral, Data Sharing**

SWACH's HealthConnect Hub supports CDSME programming as a resource and referral infrastructure - connecting providers and community members to WSU-Extension for follow up, registration and coordination.

- HealthConnect Hub captures participant engagement data as part of an individual's Community Health Records.
- HealthConnect Hub infrastructure includes Patient Activation Measure (PAM). PAM scores will be collected pre and post program participation.
- With participant consent, CHR's communicated and shared across clinical/community sectors, care teams and providers.
- HealthConnect Hub capacity to coordinate transitions/referrals for CDSME participants to appropriate supports along the care continuum.

## **Workforce Development**

SWACH has trained community partners across the region as CDSMP and CPSMP lay leaders. As of December 18, 2019:

- 24 individuals from 10 organizations have been trained as CDSMP leaders
- 17 individuals been cross trained as CPSMP leaders.
- CDSMP and CPSMP lay leaders represent 8 organizations and 9 programs across SWACH.

**SWACH CDSME Partners:** Vancouver Housing Authority, Washington Gorge Action Program (WGAP), Lifeline Connections, Skamania County Community Health (SCCH), SW Washington Recovery Coalition, SeaMar CHC, Vet Corp- WSU Extension, Community Voices are Born (CVAB), Washington State University-Extension

## **Community Paramedicine**

### **CCFR- Community Assistance Resource and Education Services (CARES) Program**

SWACH has supported Clark County Fire & Rescue (CCFR) in planning and development of a Community Assistance Resource and Education Services (CARES) Program. The community

paramedicine program will deliver a wide variety of community outreach and resource referral activities in CCFR's service area. Beneficiaries include community members with chronic conditions and/or behavioral health conditions who are not connected nor receiving appropriate upstream care services and supports. Beneficiaries may have a history of utilizing 911 calls to address downstream needs or needs that traditional paramedicine may not be well equipped to address.

The program goals are to increase safety and access to appropriate social, physical and behavioral health services, improve whole person health and well-being, and reduce inappropriate emergency transports, admits, and care.

- Modeled after the Spokane Fire Department CARES Program.
- Utilizes a dedicated community paramedic.
- Utilizes an experienced Social Worker (MSW).
- Utilizes social work student interns through a partnership with Clark College/Eastern Washington University.
- CCFR has submitted a two-year statement of work to start in 2020.
- Recruitment for the community paramedicine program begins in Q1 2020.

### **Communication, Referral, Data Sharing**

CCFR community paramedicine will utilize HealthConnect Hub infrastructure for resources and referrals. CCFR will explore opportunities to leverage HealthConnect Hub infrastructure to maximize community benefit through:

- HealthConnect Hub capacity to coordinate transitions/referrals for community paramedicine beneficiaries to appropriate supports along the care continuum.
- HealthConnect Hub tracking of participant engagement data through individual Community Health Records (CHR).
- With participant consent, CHR's communicated and shared across clinical/community sectors, care teams and providers.
- CCFR utilization of HealthConnect risk assessments and participation in Pathways HealthConnect care coordination program.
- CPAA-SWACH Hub- partnership alignment around common Hub infrastructure supports continuity of referrals and coordination/alignment of community paramedicine initiatives across ACH boundaries.

### **17.a.ii.6 (Cont)**

- b. Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).

### **Opioid Treatment Network (OTN) and Pathways HealthConnect Integration**

SWACH supports community and clinical partners in the cultural shift towards understanding and treating Opioid Use Disorder as a chronic brain disease. SWACH supported cross-sector collaborative efforts in Clark and Klickitat counties established OTNs that increased and diversified access points to Medication Assisted Treatment (MAT). Care transitions across hospital systems, behavioral health clinics and jails are central to OTN success. OTN partners can refer community members into the Hub for peer support. Treatment retention is supported

when community members who have MAT initiated in a hospital or ED can receive transition support from a HealthConnect Peer to continuing post discharge treatment at a behavioral health clinic.

Pathways HealthConnect Peers and CHWs have been integrated into regional OTN initiatives. SWACH supports peers as key to engagement and recovery of people with OUD. The “PeerConnect” initiative leverages the value of Peers who are trained and working within the Pathways HealthConnect program and framework to support community members who have initiated recovery through the OTN.

Peers employed with partnering care coordinating agencies (CCAs) are connected to OTN partners through the SWACH HealthConnect HUB. HealthConnect Peers support individuals in transition to continuing treatment post-discharge and also provide access for community members in recovery to the full Pathways program. HealthConnect Peers utilize the care coordination framework and HealthConnect HUB to connect individuals to physical, behavioral health and social services.

Community members supported by a HealthConnect peer establish a Community Health Record (CHR) in the Hub. This CHR is available to all members of that community member’s care team, per consent of the community member, allowing for data sharing and shared care planning across multi-disciplinary or/and multi sector teams.

**OTN and Pathways HealthConnect - Partnering Organizations:** SW Washington Accountable Community of Health (SWACH), Klickitat Valley Health Hospital, Community Voices are Born (CVAB), Lifeline Connections, Washington Gorge Action Program (WGAP), Klickitat Jail, PeaceHealth Southwest Medical Center, Comprehensive Behavioral Health.

### **Chronic Disease Self-Management Education (CDSME) and Pathways HealthConnect Integration**

HealthConnect Hub and Pathways HealthConnect “anchor agencies” are central to SWACH’s systems change approach to increasing access to CDSME through networked, coordinated, and consistent programming.

Pathways HealthConnect CHW/Peers working in anchor agencies received CDSME leader training. The training served multiple and overlapping purposes:

- Professional development of CHW/Peers to lead Chronic Disease and Chronic Pain Self-Management trainings
- Professional development of CHW/Peers to support individual Pathways HealthConnect participants with best practices for chronic disease or chronic pain self-management.
- Professional development for CHW/Peers, with implications for addressing the opioid crisis, by supporting community members with best practices for chronic pain self-management.

Anchor agencies contracted with SWACH to be early adopters/partners for the Pathways HealthConnect program will deliver CDSMP and CPSMP programming. WSU-Extension will work with anchor agencies and coordinate a regular and consistent schedule of programming/workshops. WSU-Extension will work with additional community partners

interested in providing CDSME to supplement and coordinate the regional schedule for programming/workshops.

**Pathways HealthConnect Anchor Agencies**

Clark County	Skamania County	Klickitat County
SeaMar CHC	Skamania County Community Health (SCCH)	Washington Gorge Action Program (WGAP)
Community Voices are Born (CVAB)		

Pathways HealthConnect anchor agencies, additional CDSME trained agencies, and WSU-Extension are integrated into HealthConnect Hub infrastructure. This facilitates access and referrals across programs and agencies to CDSME opportunities as well as referral and access to Pathways Health Connect and/or other appropriate care or care coordination services supported by HealthConnect Hub.

**17 (Cont)**

- b) 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.

In SWACH’s quarterly reports, Partners are asked to identify challenges or barriers that they are facing in each of their projects. Across all partners and projects, the largest barriers identified in July-October 2019’s report were: workforce/capacity (30%), partnerships (22%) and technology (16%). Many Partners are facing capacity-building and staff turnover challenges, particularly smaller behavioral health and community serving organizations. Large clinical partners also face capacity challenges, such as conflicting priorities and hiring behavioral health providers. Partnership challenges are typically around partnerships with other, non-SWACH Partner organizations, lengthy contract processes, or other challenges out of the Partner’s control. Technology barriers are often related to EMRs and data sharing. Other challenges identified were policy (10%), such as reimbursement, and financial barriers (6%).

Project 2a) Whole Person Care: Key challenges identified in this project have been the recruitment and retention of behavioral health providers, general capacity and data sharing. The potential impact of these challenges impact implementation and sustainability of systems change. SWACH has offered or will be offering training and technical assistance around job descriptions/recruitment, patient registries, and the Collective Medical Platform. Working with MCO’s on reimbursement, particularly as it relates to physical health and behavioral health integration, will be a key strategy for SWACH in 2020.

Project 2b) Care Coordination: Key challenges to SWACH care coordination work concern data sharing, a common definition of CIE, and proliferation of “CIE” platforms:

- Data Sharing: Data sharing barriers is a key challenge to the HealthConnect Hub’s capacity to optimize coordination across care management programs and initiatives. Access to data supporting the HealthHomes program and PRISM scores has not been made available to ACH Hubs. ACH’s have discussed this

barrier with HCA on multiple occasions. This challenge is a barrier to coordination across care coordination programs, including Pathways and HealthHomes, and limits a clear and present opportunity for the HealthConnect Hub to support improved engagement of eligible community members with the HealthHomes program. SWACH is exploring opportunities to overcome this challenge through partnering directly with HealthHome leads and MCO's with a focus on the HealthConnect Hub improving coordination across care management programs.

- Operational Definitions of CIE: Alignment and planning for “CIE”'s at regional and state levels are hindered by the lack of a common operational definition of Community Information Exchange (CIE). SWACH has prioritized community and clinical access to Hub infrastructure (“**c**”- below) as the highest value approach to CIE implementation: one supporting community care coordination capacity and connectivity across the care continuum.
- Discussions about CIE's at local, regional, state and national levels suggest a range of definitions are being subsumed under the single CIE acronym:
  - Closed loop resource and referral platforms (i.e. HealthBridge integrated in the HealthConnect Hub or Kaiser Permanente's UniteUs platform)
  - Platforms that support specific care coordination programs (i.e. Health Homes or Pathways HealthConnect)
  - Comprehensive connective Community Hub infrastructure (i.e. SWACH's HealthConnect Hub and CPAA's CarePort) for communication and collaboration across the care coordination and service continuum. Infrastructure which supports community health records (CHR's), and also integrates and connects the above-mentioned platforms and programs (“**a**” and “**b**”) as well as platforms supporting multi-disciplinary/multi sector care teams (i.e. community paramedicine).
- Proliferation of “CIE” platforms: Proliferation and lack of alignment of various “CIE” approaches, particularly closed loop resource and referral platforms, risks overwhelming and confusing community and effectively causing community disengagement. This is a risk recognized in UC San Francisco's Siren Report, *Community Resource Referral Platforms: A Guide for Health Care Organizations*.

<https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/wysiwyg/Community-Resource-Referral-Platforms-Executive-Summary-1.pdf>

In the SWACH region, deep community engagement has mobilized community stakeholders and partners for development, implementation and engagement with Pathways HealthConnect and the HealthConnect Hub. Community stakeholders now are presented with the recent launch of Kaiser Permanente's national ThriveLocal initiative- a closed loop resource and referral platform run by Unite Us. This platform is similar to an existing closed loop resource and

referral platform in the SWACH region, HealthBridge, that is integrated into the HealthConnect Hub infrastructure.

As noted in the Siren report, community engagement is central to success of initiatives aiming for connectivity and enhanced care coordination. Community engagement is at risk when stakeholders are presented with multiple platforms that are neither aligned nor interoperable. SWACH is in discussion with Kaiser Permanente and UniteUs to address this challenge to community engagement- exploring collaboration, interoperability and alignment between the Unite Us platform and Thrive Local with the HealthConnect Hub.

### 18. Pre- and post-project implementation example

- a) Highlight a success story during the reporting period that was made possible due to DSRIP investments, including how DSRIP removed the barrier to implementation and lessons learned that the ACH has used to make modifications moving forward.

DSRIP investment made possible the development, implementation and realization of the HealthConnect Hub as infrastructure for community and provider access to a connected continuum of care, care coordination, programs and services. Such infrastructure to support a connected community clinical health ecosystem across the SWACH region did not exist prior to DSRIP investment. In rural and frontier areas community care coordination investments prior to DSRIP were minimal to non-existent.

HealthConnect Hub- Key Attributes
<ul style="list-style-type: none"><li>• A <b>local, neutral, equitable</b> and <b>centralized entity</b> supports care management coordination</li><li>• Provides <b>standardized risk assessments</b> that identify a client's and their families health and social needs</li><li>• Maintains a <b>Community Health Record</b></li><li>• Provides access to a <b>continuum of care, programs &amp; services</b> designed to meet individuals where they are</li><li>• <b>Develops and trains</b> a workforce of coaches, navigators, and trusted community-based workers</li><li>• Provides smooth on-ramps and off-ramps in public assistance programs, care models and services through a <b>trusted community-based workforce</b></li><li>• Provides a <b>payment model for engagement and outcomes</b></li><li>• Provides <b>real-time data</b> – for quality improvement, resource alignment, investment in communities with greatest need</li></ul>



March 2019 saw launch of the first program supported by the HealthConnect Hub infrastructure: the community-based community care coordination program - Pathways HealthConnect. Over the last reporting period we have seen the following outcomes:

- 239 total people referred
- 145 active enrolled clients (60% engagement rate)
- 1620 completed “Pathways” – successful outcomes for engagement with services and care to address identified social, behavioral and physical health risk areas
- HealthConnect Advisory committees established and convening across the SWACH region for input and engagement from community members and stakeholders on maximizing community health opportunities.

Contracted care coordination agencies report high satisfaction with the program and HealthConnect infrastructure. There is readiness and desire across all currently contracted

agencies to expand/train staff on the Pathways HealthConnect model and HealthConnect Hub integration.

During the last reporting period, planning for additional programs and services to be supported by the HealthConnect Hub has progressed.

Partnerships for HealthConnect Hub supported services and programs across a continuum of care include:

- Access to Health (Neighborhood-based Community Health Worker program)
- Community Paramedicine
- Evidence-Based Self-Management Programs
  - Chronic Disease Self-Management Program (CDSMP)
  - Chronic Pain Self-Management Programs (CPSMP)
  - Diabetes Prevention Program (DPP)
- Health Homes
- HealthBridge.care (Close loop resource and referral platform)
- Hepatitis C Cures (Community/Clinical Peer Support Program)
- Multi-Disciplinary Health Engagement Teams (specialized care access for high acuity complex community members)
- Opioid Treatment Networks
- Pathways HealthConnect
- WiseWoman (Screening and referral program)

An expanding network of community and clinical stakeholders now partners with the HealthConnect Hub.

**HealthConnect Hub Community and Clinical Partners:** Washington Gorge Action program (WGAP), Area Agency for Aging and Disabilities (AADSWA), Vancouver Housing Authority, Vet Corp- WSU Extension, Skamania County Community Health (SCCH), Washington State University- Extension, PeaceHealth, Adult Mobile Crisis Intervention (AMCI), SeaMar CHC, Clark County Opioid Taskforce, PeaceHealth Medical Group, Xchange Recovery, Community Voices Are Born (CVAB), Comprehensive Behavioral Health, Skyline Hospital, Cascade Pacific Action Alliance (CPAA), Lifeline Connection, Share, Klickitat Valley Health, Klickitat County Jail, Clark County Fire and Rescue, Council for the Homeless, NorthShore, Skamania County Jail

Additionally, SWACH's HealthConnect Hub is partnered with Cascade Pacific Action Alliance (CPAA-ACH) to form an aligned CPAA-SWACH Hub for care management coordination with supported connectivity and access to services and care coordination across a ten-county area.

The following success story demonstrates the value of HealthConnect Hub infrastructure from the perspective of a community member and the case study of "Jane Smith".

## **HealthConnect Hub and Opioid Crisis Response- Case Study** ***“Jane Smith”***

### Identified Risk Areas

- Opioid Use Disorder
- Housing Insecurity
- Food insecurity
- Mental Health
- Unemployed

“Jane Smith” was inducted on Medication Assisted Treatment (MAT) through Klickitat Valley Health’s Opioid Treatment Network Program. KVH is a referral partner with the HealthConnect Hub and referred Jane for community-based care coordination. Jane was connected to a local HealthConnect Peer- a person with lived experience with opioid use disorder.

The Peer supporter assessed her risk areas and worked with her on a plan to address them. A saying in the recovery community is that “the opposite of addiction is connection”. The HealthConnect Peer worked with Jane to connect her to local members of the recovery community.

Opioid Use Disorder is a chronic disease affecting the brain and characterized by relapses. In July, Jane relapsed and was discharged from the MAT program for diverting her medication. She then went to court for drug related charges.

Jane faced losing access to treatment and was looking at jail time. The judge ruled that she would be allowed to participate in the MAT program again only after she received inpatient detox treatment. She would also be able to avoid jail time if she could complete intensive inpatient treatment.

However, there is no inpatient treatment in Klickitat county. To receive treatment, Jane would have to work with a facility in Clark County.

The HealthConnect Hub and HealthConnect Peer provided essential support. The Peer worked with a Clark County treatment facility to secure a date for detox and advocated for Jane at a court hearing. The judge agreed to release Jane only if the Peer continued to work with Jane and ensure that she received inpatient treatment in Clark County.

The HealthConnect Hub connected the Klickitat Peer with a Clark County Peer. Even before Jane arrived in Clark County for detox treatment, the Clark County Peer advocated for her to be admitted into inpatient treatment.

Upon arrival in Clark County, HealthConnect HUB transferred Jane to the caseload of the Clark County Peer. This Peer successfully secured a bed for Jane in inpatient treatment before Jane left detox so that she would not risk going back to jail in Klickitat county. The Peer worked with Jane while she was in treatment, helping her with housing applications and transferring her case to drug court. Jane successfully completed inpatient treatment.

Jane then returned to Klickitat county. HealthConnect Hub transferred her back to the Klickitat Peer who continued providing her with support on her risk areas. To date she has secured housing and has been housed for over 30 days. She also reentered the MAT program and reports that she has been doing well in her recovery. She continues working with her HealthConnect Peer and has most recently secured employment.

DSRIP removed the barrier to implementation of HealthConnect Hub infrastructure by:

- Establishing ACH’s as local, neutral, centralized and community accountable entities- critical attributes for effective functioning as a Hub.
- Establishing “whole person health”, “empowered local communities”, and “value over volume” as MTP investment priorities.
- Incentivizing community and clinical stakeholders to engage, convene, coordinate, plan and commit as “early adopter” partners in regional coordinated tests of change to improve care coordination, connectivity and cross sector collaboration.
- Providing the opportunity for Hub IT infrastructure investments.
- Providing resources for implementation of an outcome-based reimbursement model for whole person health.

Lessons learned that the ACH has used to make modifications moving forward:

- The community value of a connected Hub infrastructure to coordinate care management, connect care teams' members across sectors and agencies, and support community member access to a continuum of care models and services extends beyond any single program or service supported by the Hub.
- HealthConnect Hub's role as a "care traffic controller" has capacity to support complementary functioning of individual care coordination programs by improving engagement outcomes. For example:
  - Community care coordination engagement success (60% referral engagement rate) supports warm handoff and increased engagement for HealthHomes.
  - Community Paramedicine referrals evaluated and directed as appropriate to Pathways HealthConnect, HealthHomes, other service providers.
- Clarification of opportunities to braid funding of fee for service reimbursement models (i.e. Foundational Community Supports) and pay for performance reimbursement models (i.e. HealthConnect Hub outcome-based payments) have significant implications for improving community care coordination capacity, sustainability planning, and whole person health outcomes.

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

- a) For **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, in partnership with providers and MCOs, to address these challenges?

The following challenges have been identified via integration:

- Client enrollment-availability of funding specific for development of WA Health Plan Finder capacity; particularly around equipment needs, i.e., the purchase of technology (tablets) for mobile navigator services, workstations for offices, etc.).
- Client enrollment/eligibility-enrolling clients and confirming eligibility with Beacon Health Options is different than how clients are enrolled with a MCO and eligibility is confirmed via ProviderOne or the MCO portals. The disaggregation of processes increases the amount of staff training required and increases the risk of billing errors.
- Provider payment-it is unclear how HCA is passing behavioral health enhancement monies to the MCOs and then how MCOs remit to providers.
- Reporting-all MCOs and ASOs have varying templates used to gather the same, or sometimes only similar, information. This creates a significant administrative increase for providers.
- Native data-integrated healthcare will be difficult to achieve if the reporting of information between physical health and behavioral health remains as divergent as it is. An example is that physical health only has to submit encounters, whereas behavioral health must submit both encounters and BHDS data.

- Washington State’s HIE/CDR-at this time, due to the complexities of SUD client record protection through and compliance with 42 CFR Part 2, behavioral health organizations are unable to establish bidirectional interfaces with the HIE/CDR. This poses problems when attempting to leverage the HIE for a true whole-person picture as the information within the HIE only tells the physical medicine story.

Some of the above challenges have attempted to be addressed through IMC forums, however there is often little agreement and few action items the MCO’s or the HCA takeaway from the meetings that result in any substantial change in the divergences noted above. Providers have not been invited to the HCA table to have an intentional discussion of issues. ACH’s have provided information to MCOs in their quarterly meetings about the challenges providers are confronted with while providing patient care and services.

ACH funding is not sufficient to address specific integration goals. This only allows for incremental changes as these funds are not significant enough to truly bring about the legislative changes necessary.

ACH funding has allowed partners to strengthen technical infrastructure on a shorter timeline than what would have otherwise been possible.

- b) 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. **Not Applicable**
- c) For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the region has identified as it pertains to integrated managed care. What steps has the ACH taken, in partnership with providers and MCOs, to address these needs? **Not Applicable**

## 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
<p><b>20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation.</b> ACH support or engagement may include, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Identification of partnering provider candidates for key informant interviews.</li> <li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li> <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>	<p>X</p> <p>X</p> <p>X</p>	

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 3, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2019).*

### Narrative responses

#### **21. Identification of providers struggling to implement practice transformation and move toward value-based care**

- a) Describe methods the ACH uses to identify providers struggling to implement practice transformation and move toward value-based care and a general overview of activities the ACH conducted to support those providers. **Include one detailed example** of the ACH's efforts to support a provider to address the identified struggles, progress that was made, and lessons learned.

SWACH engages with providers to understand the barriers to value-based care delivery via the Integrated Care Collaborative, care coordination services, the Regional Health Improvement Council and individual meetings with provider groups. In addition, SWACH meets regularly with MCO's serving Southwest Washington to convey feedback from provider groups and collaborate on potential strategies to support caregivers.

Detailed Example: A behavioral health provider began meeting with an MCO to move towards value-based care. In addition, this provider was participating in the ACH Integrated Care Collaborative (ICC) with a partner primary care clinic. The ICC (composed of 14 organizations) meets quarterly and participates in monthly conference calls. The behavioral health provider also began meeting with the MCO which has majority of their clients. The messaging of the MCO and the Integrated Care Collaborative was not aligned and created confusion and frustration for the behavioral health provider. As a result, the ACH Transformation Director and the MCO met to clarify the steps they were taking with the behavioral health provider and agreed to meet monthly to ensure there was improved coordination. Most recently, the behavioral health provider was informed their rates were going to be decreased for 2020 due to several previous agreements between two organizations. This has created additional frustration for the behavioral health provider and significant concern about the viability of their organization. The lesson learned from the provider's perspective is that "sometimes the changes that need to be made" are even outside of the control of the MCOs and require change at the State level.

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

- a) **Provide three examples** of how the ACH has supported providers to implement strategies to move toward value-based care, including provider type, provider needs, supportive activities, description of action plan, and key milestones that have been achieved. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers

(25 FTEs or fewer), and 3) behavioral health providers.

**Example 1:** In the fall of 2019, SWACH launched a funding opportunity designed to encourage partnerships and collaboration between physical health providers, behavior health providers, and community partners from a broad spectrum of sectors. The Community Clinical Linkages Request for Proposals (RFP) offers funding over two years to collaboratives that demonstrate evidence in moving toward value-based care. Some of the specific criteria organizations were asked to respond to which address commitment to VBP model are:

- How your project will improve one or more of SWACH's pay-for performance measures and have a substantial impact on value-based performance.
- Describes outcomes that may be identified and measured.
- How will you measure value-based care across the continuum?

As of the end of 2019, SWACH staff and external stakeholders reviewed 20 letters of interest and invited eight collaboratives to complete a full application. The invited organizations represent urban and rural physical and behavioral health providers and community organizations with a wide range of knowledge and sophistication regarding value-based care. Full proposals will be reviewed in Q1 2020 and funding awarded in Q2 of 2020.

**Example 2)** SWACH has met with individual practitioners and small clinical groups, but this has not resulted in substantial change. Providers have indicated they are receiving little to no support from MCOs to understand the concepts of value-based payments and the issues faced by these small groups. They are concerned about their financial viability. Relationship building between MCO's and providers was documented as having the most potential for success. Until there is trust between MCOs and provider groups, VBP will not be 100% successful. As a result, SWACH has established regular meetings with all MCOs as a group, and the ACH to collaborate on strategies to build trust with clinicians, both primary care and behavioral health.

**Example 3)** Held meetings with behavioral health providers who have indicated they have more significant challenges because traditional VBP is more related to primary care. Informed MCO of these challenges.

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

- a) **Provide three examples** of the ACH's efforts to support completion of the state's 2019 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.

In every clinical provider setting, prior to the Paying for Value Survey being administered, SWACH staff identified the upcoming survey and encouraged clinics to participate. During the actual survey timeline, SWACH staff contacted the providers and asked them to complete the survey explaining the results will be helpful to each clinic in the future. Finally, clinic support staff were contacted asking that they assist their providers in the completion of the survey.

There were no incentives utilized to complete the survey.

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

When SWACH was identified as a “low performer” in last year’s survey, this information was utilized to be more assertive in asking providers to complete the 2019 survey. Because our survey results were low, we did not utilize the survey information to work with providers who might have needed technical support.

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

### Documentation

#### **24.P4R Metrics**

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. Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. 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. ACHs will gather the responses and report an aggregate summary 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](#).
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under “ACH pay for reporting metrics.”
- The value of the P4R metric information to HCA is to track progress by primary care, behavioral health and community-based organizations in implementing changes that advance clinical integration and strengthen statewide opioid response. Reporting may evolve over time to ask ACHs to generate reports or increase the participation among providers as needed to track progress on Projects 2a and 3a.

#### **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.

#### ***Submit P4R metric information.***

See SWACH.SAR4.Attachment P4R Metric reporting.1.30.20