Medicaid Transformation

Accountable Communities of Health

SWACH Semi-annual Report

SAR 5.0

Reporting Period:

January 1, 2020 – June 30, 2020

DY4 Q1-Q2

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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Achievement values

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

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

Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period January 1 – June 30, 2020

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Attestation of successfully integrated managed care for DY4, Q1 2020 regions (Project 2A)		1						1	
Completion of Semi-annual Report	4	6	4	4	4	6	8	6	4
Completion/maintenance of partnering provider roster	4	6	4	4	4	6	8	6	4
Engagement/Support of Independent External Evaluator (IEE) Activities	4	6	4	4	4	6	8	6	4
Report on quality improvement plan	4	6	4	4	4	6	8	6	4
Completion of all P4R metrics (Project 2A, 3A only)	2	2	2	2	2	2	2	2	2
Total AVs Available	18	27	18	18	18	26	34	27	18

Table 2. Potential P4R AVs for Project Incentives, January 1, 2020 – June 30, 2020

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	5	4	-	-	5	-	-	4	18
Cascade Pacific Action Alliance	6	4	4	-	5	4	-	4	27
Elevate Health	5	4	-	-	5	-	-	4	18
Greater Columbia ACH	5	-	4	-	5	-	-	4	18
HealthierHere	5	-	4	-	5	-	-	4	18
North Central ACH	5	4	4	4	5	-	-	4	26
North Sound ACH	5	4	4	4	5	4	4	4	34
Olympic Community of Health	6	-	-	4	5	4	4	4	27
SWACH	5	4	-	-	5	-	-	4	18

Reporting requirements

The semi-annual report for this period (January 1, 2020 – June 30, 2020) includes three sections as outlined in the table below.

Semi-annual reporting requirements (January 1, 2020 – June 30, 2020)		
Section	**Item num**	**Sub-section components**
Section 1. ACH organizational updates	1-8	Attestations
	9-11	Documentation - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	12-13	Attachments - Implementation work plan - Partnering provider roster
	14	Documentation - Quality improvement strategy update
	15-16	Narrative responses - General implementation update - Regional integrated managed care implementation update
	17	Attestations
Section 3. Pay-for-Reporting (P4R) metrics	18	Documentation

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

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

File format

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

- *Main Report or Full PDF:* ACH Name.SAR5 Report. 7.31.20
- *Implementation work plan:* ACH Name.SAR5 Implementation work plan. 7.31.20
- *Partnering provider roster:* ACH Name.SAR5 provider roster.7.31.20
- *P4R metrics:* ACH Name.SAR5 P4R metrics.7.31.20

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

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than July 31, 2020 at 3:00p.m. PST.**

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

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

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "Semi-Annual Report 5 – July 31, 2020."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 5 – July 31, 2020.

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

Semi-annual report submission and assessment timeline

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

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2020 – June 30, 2020.

ACH semi-annual report 5 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute semi-annual report instructions for reporting period January 1 – June 30, 2020 to ACHs	IA	April 30, 2020
2.	Submit semi-annual report	ACHs	July 31, 2020
3.	Conduct assessment of reports	IA	August 3 – August 25, 2020
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	August 25-31, 2020
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	August 25-September 09, 2020
6.	If needed, review additional information within 15 calendar days of receipt	IA	August 26-September 24, 2020
7.	Issue findings to HCA for approval	IA	October 2020

Contact information

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

ACH contact information

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

ACH name:	Southwest Washington ACH
Primary contact name **Phone number** **E-mail address**	Barbe West 360-515-8252 Barbe.west@southwestach.org
Secondary contact name **Phone number** **E-mail address**	Susan Crandall 360-515-6958 Susan.crandall@southwestach.org

Section 1. ACH organizational updates

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

Attestations

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

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

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

Documentation

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

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

    If applicable, include current organizational chart.

10. **Budget/funds flow.**

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

    - Optional: The ACH may provide additional context to add clarity about the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal.

    b) For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.

See SWACH.SAR5 Payment reconciliation 7.30.20.xlsx

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

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

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

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

        iii) Description of use should be specific but concise.

Use of incentives to assist in the transition to integrated managed care		
Description of Use	**Expenditures ($)**	
	Actual	**Projected**
HIE/HIT and Clinical Assessments	**$655,000**	
Behavioral Health Integration support including: • Investments into provider organizations to support evidence based clinical integration models • Investments into provider organizations to support workforce development for integrated care teams • Investments to support shared learning and science of improvement across networks of care • Investments for practice transformation personnel and/or training • Partnership investments to support community and clinical linkages • Investments to support the advancement of using equity as a lens to support continuous quality improvements • Investments to support IT investments related to new clinical and administrative process.	**$4,902,094**	**$3,064,522**

Section 2. Project implementation status update

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

Attachments

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

12. Implementation work plan

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

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

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

13. Partnering provider roster.

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

Instructions:

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

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

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

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

Submit updated partnering provider roster.

See SWACH.SAR5 Provider Roster.7.31.2020

Documentation

The ACH should provide documentation that addresses the following:

14. Quality improvement strategy update

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

Narrative responses

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

15. COVID-19

a) **Provide an update on ACH activities in response to COVID-19 during the reporting period. Include a summary of how DSRIP activities and timelines have been impacted (i.e., which projects remain on track, which projects or areas of focus are on hold, etc.).**

COVID-19 impact on DSRIP Activities and timelines

<u>2A Integration</u>

- Partners had difference experiences in their ability to move work forward during the initial phase of the pandemic.
- Partner reporting for quarter one was optional. Quarter one funding was released to all partners regardless of their reporting status.
- Partners are required to complete a quarter two report to receive quarter two funding. For partners that did not complete a quarter one report, this will be a six-month report.
- The reporting has been streamlined and we will continue to work with partners to make adjustments as needed. We may revise timelines to allow partners more time to complete the work outlined in their SOW.
- The Integrated Care Collaborative continued to meet in a virtual setting, but the meetings were optional.
- SWACH is planning to extend the collaborative timeline by 3 months.

<u>2B Care Coordination (some further details in answer to 15b)</u>

- The ability of the Health Connect HUB to serve individuals seeking care coordination was impacted by the inability of CHWs and peers to meet people in person. HealthConnect HUB has supported the cohort in adapting to working in a virtual environment including working with changes in privacy considerations to support virtual/telephonic care coordination.
- CHW/Peers have had to pivot in their approaches supporting community members as COVID impacts access opportunities to resources, supports and services.

- HealthConnect HUB trainings and convenings of CHW/Peer regional cohort were impacted and could no longer take place in congregate settings. HealthConnect HUB has restructured meetings and training using virtual platforms.
- COVID-19 impacted the HealthConnect HUB expansion timeline. Training and onboarding of additional CHWs and Peers was pushed back one month from June to July.
- Training for onboarding 35 CHW/Peer/Community Care Coordinators into HealthConnect HUB was impacted as training was designed for congregate setting delivery. Development of training to shift to virtual delivery was required.

3A Opioid

- The Clark County Opioid Taskforce and its corresponding steering committee moved to a wholly online format but maintained a good level of engagement and support.
- The Klickitat Opioid Taskforce and OTN support meeting was cancelled for three sessions but then restarted in June.
- The Skamania County SUD Taskforce was cancelled and has not yet restarted.
- The Clark County OTN has continued to meet virtually and is working toward adding a CHW/Peer and Recovery Coach organization into the hospital network engagement and collaboration work.
- We were able to help connect the Clark County COVID-19 Homelessness Quarantine and Isolation Project with harm reduction and recovery support services on site.

3D Chronic Disease (some further details in answers to 15b)

- Planning, scheduling, and coordinating a system of evidence-based chronic disease self-management programs across the SWACH region was impacted. These programs have been designed for a congregate delivery setting. COVID-19 and the typically high-risk populations accessing CDSME programs required redesign of program for virtual and telephonic delivery.
- The work has been delayed but is on track as partners and strategies pivot to adjust to the virtual landscape.

Equity Collaborative

- The Equity Collaborative continued to meet in a virtual setting, but the meetings were optional
- Partners had difference experiences in their ability to move work forward during the initial phase of the pandemic.
- SWACH is planning to extend the collaborative timeline by 3 months.
- These sessions have been used as a place for shared learning, focusing on how organizations are responding to challenges in adapting to modified operations due to COVID-19.

SWACH COVID-19 Response

Support for Partners and the Broader Community

- Emergency Funding - Contracted partners were eligible for one-time funding to support their response efforts. Up to $300,000 of SWACH funding was allocated for this response. This started at the end of March and we have awarded funding to 13 partners for a total of

$193,533 as of June 30. SWACH also contributed $200,000 to the Community Foundation of Southwest Washington for their COVID-19 response fund.

- Resources/information
  - COVID -19 resources and information available through the HealthConnect platform.
  - Resources relevant to clinical partners are being collated and disseminated.
  - Nine ACH regions created a common website to demonstrate their support for COVID-19 actions - healthierwashington.org. ACHs also have resource links available on each of their regional sites.
- Training
  - Offering/sharing the DOH Front Line Worker COVID-19 training to Commnity Based Workers (CHW/Peers) in our region with opportunities for collaboration and shared learning discussions immediately following the training.
  - Sharing relevant training opportunities with partners.
  - Assessing training needs and opportunities to fill any gaps/provide support.
- Partner alignment and support
  - Adjusting convenings and meetings to align with the needs of our partners and the community. In some cases that means cancelling meetings. In other cases, that means using the time to address current needs and offer space for sharing.
  - Using our collaborative infrastructure to reach out to partners and the broader community to understand the needs in the community, particularly among people whose voices are often missing. That information is then used to inform training, policy, direct action, etc.
  - Staffing support – assisted Clark County Public Health and Council for the Homeless by offering temporary SWACH staff support.
- HealthConnect Hub
  - Updates/guidance/trainings to Care Coordinating Agency partners to support care coordination in virtual and telephonic environment.
  - Supporting Clark County Public Health and Council for the Homeless regarding the hotel for quarantine/isolation (Q&I Hotel). Created partnerships to allow individuals to be referred to the HealthConnect Hub for additional support during isolation/quarantine and beyond.
  - Mobilization of SWACH staff to respond to needs of clients staying in temporary housing operated by Council for the Homeless and refer as appropriate to the HealthConnect Hub.

<u>Support for our staff</u>

- Flexible work schedules to allow for self-care and care of family.
- Work from home to support stay at home orders and physical distancing.
- Created a work plan so there were no layoffs or reduction in hours for all staff.
- Creating a COVID-19 plan for safely returning to the office at the appropriate time.

b) **Describe any project intervention supports that enabled COVID-19 response activities through improved delivery system infrastructure (e.g., care coordination, information exchange, telehealth access, data analytics, population health training and technical assistance, etc.), as applicable. Indicate whether this applied to specified sub-populations within your region.**

Project and Project Intervention	Impact on COVID response activities through improved delivery system infrastructure
Amplifying Voices Initiative *Elevate community voices to allow cross-sector partners to better respond to the needs of the community*	**Problem Statement:** Currently, cross-sector partners in SW Washington do not have a mechanism across systems with community members as partners related to COVID-19 information, resources, understand challenges, key learnings, how information is received and shared to influence policy and organizational system change. o SWACH is in the development stages of its Amplifying Voices Initiative (AVI) which will provide a forum to elevate community voice and share information across the region related to COVID-19. o SWACH will collect information to 1) Understand regional needs, barriers and challenges, 2) Understand how responses to COVID-19 has magnified discrimination, racism, and/or stigma, 3) Identify priorities to achieve policy and organizational change, 4) Identify regional trainings needs, and 5) Provide feedback for collective impact response. o As a result of this process, SWACH will be positioned to provide shared learning opportunities to collectively solve problems, influence policy and system change and support health partners at local, regional and state levels related to COVID-19.
2A Integration *Provided ongoing forum for partners to discuss and receive technical assistance to assist with integration challenges that arose from COVID-19 protocols*	**Problem Statement:** COVID-19 created a need to provide services via telehealth which many partners were not already providing. o SWACH continued to hold regularly scheduled monthly webinars for its partners in the Integrated Care Collaborative. o The webinars were optional and provided content on how to provide integrated patient/client-centered care in a virtual environment. o Our integration experts also provided technical assistance to partners as needed to help them walk through setting up their telehealth services in response to COVID-19. o We have also helped our partners in thinking through how to utilize and optimize telehealth sustainability, beyond COVID-19.
2B Care Coordination: *Pathways HealthConnect expanded eligibility for Community Care Coordination to broadly include vulnerable populations impacted by COVID-19.*	**Problem Statement:** COVID-19 will have cascading and compounding impacts on community members with a disproportionate impact on communities of color, exacerbating health disparities. o Target populations for Pathways HealthConnect contracted agencies to include vulnerable populations impacted by COVID-19. o Vulnerable populations include individuals who have higher risk of negative outcomes as a result of COVID-19 impacts. As COVID-19 has demonstrated—and the World Health Organization asserts—children, pregnant women, elderly people, malnourished people, and people who are ill or immunocompromised are particularly vulnerable and bear a

	relatively high share of the disease burden associated with emergencies. o Vulnerable populations include people of color as these populations have been shown to be disproportionately impacted by COVID-19, exacerbating existing racial disparities in health outcomes. o Due to the specific nature of the COVID-19 pandemic, SWACH also considers the unemployed as a vulnerable population, regardless of whether they fit into another of the aforementioned categories.
2B Care Coordination: *Launched Pathways HealthConnect Second Phase Expansion to 1) build community care coordination infrastructure readiness for addressing COVID-19 impacts on community members and 2) enhance system and partner capacity for alignment and integration of community care coordination with other COVID-19 efforts, such as Public Health contact tracing.*	**Problem Statement**: Impacts of COVID-19 will have cascading and compounding impacts on community members- increasing need for community care coordination supports. o Expanded from 4 to 10 the numbers of HealthConnect partnering Care Coordinating Agencies (CCAs) o 2019 Anchor Agencies (*2019 partners with HealthConnect Hub*): SeaMar CHC, CVAB, WGAP, SCCH. o 2020 HealthConnect Expansion Agencies: Council for the Homeless, Share, Community Services NW, White Salmon Education Foundation, Comprehensive Healthcare, Lifeline, Clark County Fire and Rescue. o Quadrupled to 48 the number of regional community-based workforce trained to use HealthConnect technology platform and Pathways HealthConnect care model to work with community members to access social need, behavioral health, physical health services and supports.
2B Care Coordination: *Launched "Digital Divide- Virtual Literacy" COVID-19 Response Project to develop training resources for community members with no or low technological literacy- increasingly dependent on virtual environment for access to supports and services.*	**Problem Statement:** With COVID-19 the digital divide is more than ever an equity barrier compounded by the public health implications of infection transmission among and beyond populations with no/low tech access and/or tech literacy. o Partnered with AAADSW to support multipronged digital divide strategies around tech access and tech literacy o Partnered with technology educator and CHW trainers to create videos supporting mind-set/stages of change approach to engaging with technology. o Videos to serve as care coordination training tool for community-based care coordinators as well as a public resource for SWACH community partners and agencies.
3D Chronic Disease Management: *Developed COVID-19 appropriate (non-congregate) Chronic Disease/Pain Self-Management Program delivery options for coordinated networked regional systems change approach to increased CDSME access.*	**Problem Statement**: EB CDSME programs are designed for a congregate delivery setting. COVID-19 and the typically high-risk populations accessing CDSME programs requires redesign of program for virtual and telephonic delivery. o Worked with national and regional partner agencies to assess options for program delivery in virtual landscape. o Successfully piloted CPSMP in virtual setting. o Convened partners to collaboratively plan next steps and scheduling using virtual or telephonic options.

	o Collaborated with CoMagine, DSHS, CPAA other state partners to advance referral system that support access and engagement to CDSME programs in COVID-19 times.
3D Chronic Disease Management: *Integrated Community Paramedicine partners into HealthConnect HUB community care coordination infrastructure to position for coordination and alignment with multi sector/agency COVID-19 response efforts*	**Problem Statement**: Community Paramedicine opportunities to collaborate across sectors, programs and agencies in the COVID- 19 response will not be fully realized if Community Paramedicine work is occurring in a systems silo. o Collaborated with Community Paramedicine partners to explore community testing and stay at home guidance possibilities. o Community Paramedicine partners received HealthConnect HUB systems integration training allowing for access to a community health record that can follow supported community members across provider sectors and agencies.

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

SWACH has been collating and distributing COVID-19 related information and resources to its clinical partners, including our Tribal partners. Cowlitz Tribal Nation has provided feedback that these resources have been useful and asked us to include more members of their staff in our communications. Additionally, Tribal partners are eligible to apply for SWACH's COVID-19 Emergency Response funding. However, they have not applied for emergency funding. SWACH released it's quarter one 2020 funds to all partners, including Tribal partners, without requiring reporting to assist partners with COIVD-19 response activities.

DOH consultant provided information to SWACH regarding COVID-19 outbreak in Yakama. This has resulted in DOH project to develop a model of contact tracing and follow-up with health department.

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

<u>Reporting & Payments</u>

- Partner reporting for quarter one was optional for all partners. Quarter one funding was released to all partners (clinical and community serving) regardless of their reporting status.
- All partners (clinical and community serving) are required to complete a quarter two report to receive quarter two funding. For partners that chose not complete their quarter one report, their quarter two report will cover both quarter one and quarter two (6 months of activities).

<u>Contracts</u>

- SWACH is planning on amending partners contracts to account for COVID-19. The length of time of this extension has not been finalized. We have built in questions into our quarter two report to help us get a sense of where our partners are at in their contracted scope of work and how the work and associated timelines need to be adjust due to COVID-19. As part of SWACH's review of the quarter two reports, we will determine how long we will extend contracts and work with each partner to adjust their scope of work.

COVID-19 Emergency Funding Payment Strategy

- Contracted partners are eligible for one-time funding to support their COVID-19 response efforts. Up to $300,000 of SWACH funding was allocated for this response. This started at the end of March and we have awarded funding to 13 partners for a total of $193,533 as of June 30th.

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

The already existing behavioral health workforce shortage was exacerbated by COVID-19. Behavioral health agencies and their clients were not able to quickly adjust to a virtual environment. Mitigation strategies included financial assistance to buy telehealth equipment and training and support for providers to adjust to a virtual environment.

Hospitals and primary care providers struggled to adjust to necessary staffing changes related to COVID-19. The need to preserve staff and PPE to be prepared for COVID-19 resulted in cancelled appointments, surgeries and procedures. This led to lay-offs and financial challenges for many providers and systems. Community-based organizations also struggled to meet the increased need with existing staff. SWACH provided temporary staff support to one partner organization to assist with COVID-19 response.

PPE was in short supply, putting providers and front-line workers at risk. SWACH helped distribute donated masks to the community.

Many members in our community lost employment and struggled to meet basic needs. SWACH helped mitigate this in several ways:

- SWACH contributed emergency funding to partner organizations to help them meet the needs of the community.
- SWACH partnered with the Community Foundation of SW Washington to provide funding for organizations who were on the brink of closing or the demand for services was beyond their funding capabilities.
- Our staff distributed a food donation from a local company to community partners.
- We continue to use the HealthConnect HUB as a platform to connect people in the community with resources with the help of a CHW.

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

SWACH and the HealthConnect Hub partnered with Clark County Public Health, Clark County Department of Community Services, and multiple community based and clinical agencies to support community members at the Quarantine and Isolation Hotel (Q&I Hotel) - connecting hotel "guests" to community health workers and community care coordination services.

In April, Clark County established 116 hotel rooms for unhoused people who come into contact with the novel coronavirus. From the outset, SWACH partnered to support unsheltered community members placed at the Q&I hotel who may be challenged with strange and unfamiliar circumstances including stress and disorientation of quarantine, managing a positive

COVID-19 diagnosis, and continuing impact/exacerbation of any pre-existing social, behavioral and/or physical health challenges.

SWACH's HealthConnect HUB established a coordinated outreach and engagement model to connect guests to community health workers- trusted members of the communities they serve. CHWs are experienced in building supportive one-on one relationships and provide needed support and human connection to community members in their time of need at the Q&I hotel. Community members who test positive for COVID-19 are helped to stay in the hotel for their assigned isolation time. CHWs also act as liaisons to providers, care takers, and social services/supports and, as appropriate upon transition, provide a warm hand-off to continuing community care coordination after quarantine through referrals to care models such as Pathways HealthConnect.

While providing direct CHW support to Q&I guests, HealthConnect Hub has built and strengthened its network of referral agencies and worked with partners to improve system efficiencies include streamlining consent and ROI processes that expedite connection to community care coordination. Q&I partner agencies referring to HealthConnect HUB include:

PeaceHealth SW Medical Center	Rainier Springs
Providence Health Clinics in Clark County	St. Paul Shelter (Outsider's Inn)
Clark County Jail	X-Change Recovery
Share Shelters and Outreach	Council for the Homeless Motel Vouchers
YWCA SafeChoice Shelter	Clark County Public Health
Family Promise of Clark County	Kaiser Permanente facilities in Clark County
Janus Youth Shelter, Perch, Outreach	Sea Mar Community Health Center - Vancouver
Lifeline Connections (inpatient & outpatient)	CSNW Outreach Programs
Homeless Outreach & Sobering Center	The Vancouver Clinic (all locations in Clark County)
Vancouver VA Hospital	City of Vancouver HART Team
Safe Park Programs within Clark County	Open House Ministries
City of Vancouver Safe Park Zone	

To date HealthConnect HUB has provided care coordination outreach and engagement, support, and services to 80+ Q&I hotel guests. CHW's field calls from the hotel daily and connect guests to supports and services ranging from food boxes and PPE, to medical transportation, health insurance enrollment, coordination with schools for families with children, resources on rental assistance, employment and others. Brandi Williams, a SWACH staff member and CHW supporting the Q&I hotel, reports that feedback from guests has been "very positive and inspirational".

16. Regional integrated managed care implementation update

a) For **2020 adopters**, list the date in which the ACH region implemented integrated managed care.

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

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

There were three major challenges to be addressed with Mid-adopters: COVID-19, implementation of PreManage, and ability to recruit behavioral health staff. SWACH reached out to Comprehensive Healthcare (mid-adopter clinic) and offered staffing support as well as additional financial support for Telehealth. Some of the funding provided for behavioral health integration will support the development of kiosks on two campuses which will allow patients to self-check in for visits, update their information, complete forms, and apply for Medicaid assistance. The PreManage implementation has been delayed due to issues related to 42 CFR, Part 2, i.e., Comprehensive Healthcare's electronic health record contains both mental health and substance use information. There is continued work on this issue, but it is not resolved as of this date.

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

The ACH Executive Directors meet monthly in person, weekly via a conference call, and weekly with the HCA via conference call. These meetings/calls have allowed us to identify potential statewide approaches to improve care and service overall. Several examples of work in progress are: Consideration of Statewide Information System support for providers and community based organizations; creation of a social investment fund strategy, and strengthening the partnership between ACHS and Department of Health.

SWACH has established monthly meetings with each of the managed care plans that support patients in Southwest Washington. These meetings include problem solving and identifing longer term issues that could be addressed by the MCO's and SWACH.

In early 2020, SWACH awarded 2-year contracts to community partners with the expectaion that clinical and community based partners would implement cross-functional proposals that demonstrate collaboration among partners to improve health equity. Seven partners in the rural communities were approved for implementation of a proposal with the goal of establishing a Community-Clinic Collaborative group made up of healthcare providers, behavioral health providers, social service providers, public health, school districts, law enforcement, and others that will improve health care delivery in Klickitat County; increasing care coordination supports

for Medicaid enrollees, students, & families, by doubling the number of CHWs in the WAGAP Pathways HealthConnect program and hiring two full-time Family Health Advocates to serve schools in western Klickitat County; and increasing health care services by hiring two new behavior/mental health providers (Peer Support Specialist, Behavior Health Provider) and build skills of existing staff at local agencies. Additionally, five partners in the urban area were approved for implementation of a proposal with a goal of having housing case managers cross-trained in the Pathways model and using the HealthConnect HUB, having Personal Care Services available to people who are homeless and need it most, and having the homeless crisis response system be a systemic partnership with behavioral and physical health providers.

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

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

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

Documentation

18. P4R Metrics

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

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

Related resources and guidance:

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

Instructions:

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

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

Format:

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

Optional: The ACH may submit P4R metric information.