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CERTIFIED PUBLIC ACCOUNTANTS

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

Washington State Medicaid Transformation

Independent Assessment of Semi-annual Report 8

Reporting Period July 1, 2021 – December 31, 2021

Findings Report: April 2022

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1. Overview and MTP Waiver Status

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

The MTP waiver was approved for a five year period, and has been in effect from January 9, 2017 through December 31, 2021. In early 2021, HCA requested an MTP one-year extension because of disruptions from the COVID-19 pandemic (discussed below). The Centers for Medicare and Medicaid Services (CMS) approved the request, and MTP will continue for a sixth year. MTP will now end December 31, 2022, unless CMS authorizes additional renewal/extensions. Washington State is seeking a renewal of MTP and, if approved, the MTP renewal will begin January 1, 2023 and end December 31, 2027.

As part of this engagement, and as required by the current waiver's Special Terms and Conditions (STCs), Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. These reports must demonstrate progress and attainment of project-specific milestones and metrics achieved during the reporting period to receive incentive dollars.

This findings report represents Myers and Stauffer's assessment of ACH semi-annual reports for reporting period July 1, 2021 – December 31, 2021. This is the final semi-annual report. For the waiver extension period, modifications have been approved to allow ACHs to submit modified reports based on an adjusted schedule. Myers and Stauffer will also evaluate these submissions.

2. Independent Assessor Review Process

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

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

3. Findings of the ACHs' Semi-Annual Report 8

All ACHs submitted their SARs by the January 31, 2022 deadline.

- **Findings.** Upon submission of RFI responses, all SARs included sufficient detail to reflect progress performance during the reporting period July 1, 2021 – December 31, 2021.

- **Recommendation.** The IA recommends HCA approve and award full credit to ACHs for milestone achievement towards Medicaid Transformation.

4. COVID-19 Pandemic

The health care system and the communities of Washington State continued to be impacted by challenges from the pandemic declared on March 11, 2020 by the World Health Organization (WHO) related to the novel coronavirus (COVID-19). Between the first reported case and the end of December 2021, there were 867,467 reported cases, with 46,260 hospitalizations and 10,098 deaths.[1] In an effort to reduce the spread of COVID-19, 70.6% of the Washington population age 5 and older was fully vaccinated by January 3, 2022. [2] In the same time span, the United States had over 54.8 million confirmed cases with over 827,393 deaths, and 62.5% of the population was fully vaccinated. There were over 182 million cases and over 3.9 million deaths reported across the world.[3]

Table 1 - COVID-19 Impact in Washington State

Time Period	Reported Cases	Cumulative Hospitalizations	Cumulative Death
Case 1 – June 2020	33,447	4,524	1,304
Case 1 – December 31, 2020	250,614	15,194	3,776
Case 1 – June 30, 2021	451,485	25,837	6,021
Case 1 – December 31, 2021	867,467	46,260	10,098

During this reporting period HCA, the ACHs, and partnering providers began to take steps to return to pre-pandemic activities, however some flexibilities of the Medicaid Transformation waiver approved by the CMS remained. These flexibilities allowed the semi-annual report template to be modified to collect COVID-19 response information, and the quality improvement strategy update and pay for reporting metrics were optional reporting requirements.

5. Highlights of the ACHs' Semi-Annual Report 8

The following summary describes findings noted by ACHs within their SAR 8 responses.

- **Project Updates:** Although the pandemic continued, ACHs indicated their Medicaid Transformation Project (MTP) activities were generally back on track. Updates indicated:
    - ACH activities continued to support COVID-19 recovery efforts including vaccination access and financial assistance for items such as rent, utilities, groceries, and household products.
    - Some ACHs continued to report that partnering providers are prioritizing interventions that address behavioral health needs, social determinants of health, and healthcare inequalities for black, indigenous, and persons of color (BIPOC) that have been magnified by the pandemic.
    - Some ACHs have prioritized supporting telehealth initiatives, through the expansion of data technology and health information exchanges.

[1] Washington State Department of Health. https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard#tables. [Accessed on March 8, 2022.]
[2] Seattle Times. https://www.seattletimes.com/seattle-news/health/how-to-get-a-covid-19-vaccine-in-seattle-king-county-and-washington-state/. [Accessed on March 8, 2022.]
[3] Our World in Data. https://ourworldindata.org/coronavirus/country/united-states# [September 22, 2021.]

Recommendation: In the midst of COVID-19 response, ACHs have focused their efforts on engaging with community-based partners in order to ensure effective programming for socially vulnerable communities. These targeted approaches have been essential in the growing behavioral health crisis that ACHs are facing, coupled with the concerns surrounding vaccination rates for BIPOC and underserved communities. It is recommended that ACHs continue to expand community-based work and create sustainability plans to allow partners to carry forward activities independently. ACHs should remain flexible in their strides to address health disparities.

- **Health and Social Equity Impact.** Addressing equity is a pillar for MTP, and ACHs continue to take enhanced action, especially around vaccine equity:
  - Cascade Pacific Action Alliance launched "The Equity Circle Podcast" to cover COVID-19 education, and whole person care through a health equity lens. CPAA's backbone agency, CHOICE, also received two new grants from the CDC foundation to accelerate COVID-19 and influenza vaccine uptake in communities of color.
  - Greater Columbia pursued partnerships within counties with low vaccination rates and higher social vulnerability indexes. In doing so, they conducted special outreach to Latinx and African-American communities, lowering barriers to vaccinations. Over 25 vaccine clinics and nearly 550 vaccinations were administered at trusted sites; including housing authorities, grocery stores, free medical clinics, churches, and food banks.
  - Elevate Health has begun program administration with community based partner organizations, which were selected based on their ability to provide culturally and linguistically appropriate care coordination services to a wide variety of populations across Pierce County. Elevate Health has been able to offer more inclusive support to traditionally underserved communities and those disproportionately impacted by the pandemic, including local Latinx, Black, East Asian and Pacific Islander communities.

Recommendation: ACHs have continued to collaborate with partners in outreach efforts to reach underserved populations. Mobile clinics, targeted outreach, and culturally relevant programming delivered by community health workers (CHWs) have been successful in minimizing misinformation and increasing vaccine uptake in socially vulnerable communities. ACHs will want to continue special outreach with health equity in mind, and maintain collaboration with community-based partners in order to elevate the voices of the members of underserved communities.

- **Escalating Behavioral Health Risks**. Due to the impacts of COVID-19, the behavioral health crisis among children, youth, and other community members has continued to increase. In response ACHs indicated they have taken the following steps:
  - Elevate Health has formed partnerships with Comprehensive Life Resources, Hope Sparks, Kids' mental Health of Pierce County, and Youth Engagement Services to develop a "Behavioral Health Workforce" strategic plan for the region.
  - North Central reported challenges in staffing of behavioral health providers. In order to mitigate this issue, North Central engaged in the House Bill 1504 Behavioral Health Internship program. In doing this, the goal is to support agencies by bringing on interns to alleviate some of the staffing concerns.
  - HealthierHere continues to support provider integration of physical and behavioral health through the Innovation Fund and investing in community-based non-licensed staffing. They continue to partner with providers to expand and enhance programs to provide behavioral

health care and supports to rural areas of King County disproportionately impacted by the pandemic.

Recommendation: Rising behavioral health concerns in the community should continue to be a focus for ACHs. Diverse, creative outreach efforts based on lessons learned regarding engaging hard to reach populations should be employed to address behavioral health disparities, including in the area of substance use disorder treatment.

- **Finances.** As observed in *Table 2* below, the total funds earned during the reporting period does not have a direct linkage to the total funds distributed during the same reporting period. Distribution of funds may not occur in the same period funds were earned due to a variety of reasons, including pending board approval for release of funds or partnering provider attainment of project milestones. Data presented in this table is provided by HCA from the Financial Executor Portal reports.

Table 2. Funds Earned and Distributed During the Reporting Period

	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
Total Funds Earned During Reporting Period	$757,226	$688,388	$826,065	$963,743	$1,514,452	$344,194	$1,032,581	$275,355	$481,871
Total Funds Distributed During Reporting Period	$7,295,507	$2,423,058	$5,756,210	$10,340,010	$12,666,674	$2,558,417	$4,759,248	$2,087,413	$2,367,938

- **Partnering provider roster.** As part of the submission of materials and to earn the associated achievement value (AV), ACHs are required to update and submit the list of partnering provider sites participating in Medicaid Transformation Project Toolkit activities. Table 3 summarizes the active partnering providers included in each ACH partnering provider roster. During the reporting period three ACHs saw an increase in active partners (e.g. GCACH, EH, and North Central ACH BHT saw a decrease in 15 active partners, HH and NSACH saw a decrease of two partners each.

Table 3. Active Project Partnering Providers

Project	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
2A: Bi-directional Integration of Care	107	57	64	92	108	42	115	59	33
2B: Community-Based Care Coordination	109	35	92	●	●	50	8	●	14
2C: Transitional Care	●	35	●	87	96	48	109	●	●
2D: Diversions Interventions	●	●	●	●	●	48	112	59	●
3A: Addressing Opioid Use	105	59	52	95	101	57	150	59	14
3B: Reproductive and Maternal and Child Health	●	68	●	●	●	●	85	59	●
3C: Access to Oral Health Services	●	●	●	●	●	●	36	59	●
3D: Chronic Disease Prevention and Control	105	46	24	87	92	42	92	59	34

Recommendation: Of note, a high volume of partners have remained involved in meeting the objectives of MTP. ACHs must continue to emphasize the value of this extended collaboration of clinical and social service providers and the resulting positive impact on the health of the community at large to sustain MTP practices into the future.

- **Pay-for-Reporting (P4R) Value-Based Payment (VBP).** During the SAR 8 reporting cycle, funding was available for Project P4R VBP milestones. The reporting period for P4R VBP milestones covered the full calendar year (January 1 through December 31, 2021). In their reports, ACHs identified barriers impeding the move toward value-based care and provided examples of how they helped partnering

providers overcome those barriers. They continue to note the largest barrier to implementation is the reluctance of MCOs to form VBP arrangements with small, rural providers.

- According to the 2020 VBP survey, 36 providers in the GCACH region responded. GCACH found the greatest barrier cited to participating in VBP was "misaligned incentives and/or contract requirements." GCACH shared that this barrier was overcome in November 2021 when Coordinated Care developed a VBP contract with Merit Resources. The two were able to arrange an agreement to use different screening tools to better assess patients.
- NSACH found the top three barriers to VBP to be: shifting of priorities from implementing value-based contracts due to COVID-19, difficulty contracting MCOs, and issues with transitioning to integrate managed-care funding. NSACH continues to assist providers struggling to implement practice transformation and move toward value-based care through multiple activities including site visits, partner progress reports, and partner surveying.
- Elevate Health noted that provider partners cite similar challenges, especially with the ongoing pandemic environment. The ACH's efforts have included: ensuring well designed protocols and staff support, championing evidence-based practices and demonstrating outcomes, and exploring interoperable data systems and community information exchange.

6. Bright Spot

ACHs were requested to provide one best practice or "bright spot" that emerged during the reporting period as a result of COVID-19 response and recovery efforts. Highlights of ACH responses include:

- **Better Health Together (BHT):** BHT shared their goal to "build a culture of belonging within the BHT Board," by challenging themselves to "re-design the table." BHT Staff and local equity consultants set up guiding principles for a new Board structure, grounded in an evolved understanding of antiracist and decolonized non-profit practices. BHT noted that they met or exceeded several of the representation goals they set out. Twenty-six new board members were elected, and of these: 50% identify as BIPOC, and 75% have lived experiences navigating systems of oppression. BHT affirmed that this represents a significant shift in power towards more of the community having a voice in BHT's decision-making. BHT also believes this success in representation will "break down silos between health systems providers and community partners."

- **Cascade Pacific Action Alliance (CPAA):** CPAA shared a patient story submitted one of their Community Based Care Coordination agencies. A client who was unhoused, had COVID-19, and was struggling with recreational substance use said she was interested in the *Pathways* program, "not only to work on getting a PCP, but also to have someone that she could check in with regularly and be accountable to with some of the other changes she is trying to make." The agency was able to schedule her an appointment with a provider and offer information about the Pathways program. As a result, CPAA has "great hopes that she will open and close many more social determinants of health pathways with her designated Community Health Worker in the months to come, allowing her to realize more of her potential."

- **Elevate Health (EH):** Elevate Health has collaborated with the Department of Health, Tacoma-Pierce County Health Department, Community Care Partners, Innovacer, and community members in order to keep up with the quickly-changing requirements for COVID-19 response and prevention. In working with Innovacer, Elevate Health engaged in agile development of CareConnect workflows and continues

ongoing quality improvements through PDSA (Plan-Do-Study-Act) cycles to adjust electronic protocols responsively.

- **Greater Columbia ACH (GCACH):** GCACH shared their success with the Trusted Messenger Campaign. Compared to past individual efforts to target specific populations, their current partnerships proved more successful. GCACH leveraged a relationship with the Tri-Cities Hispanic Chamber of Commerce to reach the large Hispanic population in the Benton-Franklin counties. Their JEDI Specialist connected with local churches to reach the African American population. Once GCACH teamed up with these partners, the number of vaccinations went from 20-30 per clinic, to over 100 per clinic. These partnerships within the Trusted Messenger Campaign allowed GCACH to successfully reach underrepresented populations and drastically improve their vaccination rates.

- **HealthierHere (HH):** HealthierHere cited their investments in the first half of 2021 were pivotal for equipping clinical providers and community based organizations (CBOs) in increasing vaccinations in communities with low vaccination rates. HH used their Coverage Gap Analysis Tool to identify target communities and inform funding decisions. HH's history of authentic community, clinical, and tribal engagement gave the organization "an ear to the ground" regarding community needs. Thus, the team was able to quickly bring organizations together to meet and respond to these needs. Funded partners of HH also reported feelings of accomplishment in their efforts to pivot and meet the emerging needs of communities, while providing culturally relevant and accurate COVID-19 related information. Below are some of the specific activities the partners of HH implemented during this reporting period:

  - Sea Mar was able to use funding to hire additional call center specialists and staff to administer vaccines, which increased its ability to reach more individuals and schedule vaccine appointments.
  - Arms Around U focused their efforts on addressing COVID-19 and vaccine-related misinformation, by providing community members with fact-based information on the pandemic and preventive measures.
  - Atlantic Street Center (ASC) organized multiple community events with partnering mobile pop-up vaccine units. ASC also collaborated with Seattle Public Schools to promote COVID-19 back-to-school readiness. Additionally, ASC assisted families facing housing-related challenges by keeping them informed about the eviction moratorium and providing financial assistance for rent and utilities.

- **North Central ACH (NCACH):** North Central ACH reported that because of their COVID-19 response, their engagement with partners has been a major highlight in their region. These partnerships with organizations like Emergency Medical Services (EMS) and Okanogan County Public Health (OCPH) have proved to be supportive, as they continue to evolve and strengthen throughout the pandemic. North Central ACH cites these primary agencies that assist in COVID-19 efforts as bright spots in their local public health jurisdictions.

- **North Sound ACH:** One "bright spot" North Sound ACH observed during this reporting period as a result of COVID-19 was the increase in inclusion of CHWs and Promotoras in health care conversations and outreach events. The work of Promotoras within the Latinx and farmworker communities was vital to the decrease in vaccine hesitancy, increase in vaccine uptake, and provision of education about COVID-19. NSACH reiterates that the receipt of information in one's native language is invaluable to building trust and understanding in communities. The support of CHWs and Promotoras was also important for raising awareness of the marginalization and inequities faced by the communities they serve.

- **Olympic Community of Health (OCH):** OCH shared their success in hosting several in-person events in the midst of the COVID-19 pandemic. Partners included in the events have been enthusiastic and mindful of safety precautions and protocols. Overall, OCH regards these in-person events as a more meaningful way to network, connect and build relationships, when compared to their online events. Some of their recent in-person events include: the Board of Directors retreat, Discussion on Value based Payment, and the 2021 Stronger Together Regional Convening.

- **SWACH:** SWACH was very successful in their COVID-19 response efforts through their HealthConnect Hub, which has employed a culturally diverse cohort of CHWs. The achievements of their HealthConnect Hub has led to successful application for a Health Resources and Services (HRSA) grant of $1 million to promote COVID-19 information and vaccine access through a culturally relevant workforce. The HRSA grant prioritizes removing barriers to vaccine access and information in BIPOC, housing insecure, and medically underrepresented populations. SWACH has formed new partnerships with the Southwest Washington Equity Coalition and Youth and Family Link to create a team of ten culturally diverse CHWs. Existing partnerships were strengthened because the HealthConnect Hub had already integrated five diverse agencies to provide community-based care coordination services. (SeaMar, Share, Lutheran Community Services, Washington Gorge Action Programs, Clark Cowlitz Fire and Rescue). The HRSA grant will allow further support for the Hub and SWACH, and greatly improve efforts for reducing health inequities for historically marginalized populations.

6. Scale and Sustain

As ACHs prepare for sustaining MTP improvements, ACHs reported on activities and/or conversations regarding the sustainability of DSRIP funded infrastructure, activities, and/or evidence-based models. ACHs have formulated plans, begun implementing organizational changes and hiring, as well as built out financial modeling approaches to sustain MTP successes.

- **Better Health Together (BHT):** BHT has begun the implementation phase for scaling and sustaining its projects, by first restructuring its Board. With the new Board, they plan to adopt a 3-year strategic plan focused on the future of the ACH and community needs by September 2022.

- **Cascade Pacific Action Alliance (CPAA):** CPAA Board of Directors has made a priority investment to a three-year Blue Zones Activate initiative in efforts to build a healthier future for its region. Blue Zones is focused on environmental and place-based social determinants of health. Additionally, CPAA will provide an amendment for most of its community partner contract to continue or expand work in the upcoming year, and most of CPAA's MTP partners have sustainability plans in place to complete projects independently moving forward.

- **Elevate Health (EH):** Elevate Health has continued and sustained its Community-Based Care Coordination Hub as part of its Care Continuum Network. Elevate Health will be trialing a financial model for its Pathways Community Hub Institute (PCHI) to develop a value-based financial model for 2022 to evaluate potential for sustainability. Elevate Health is also the lead community partner for The Pierce County Opioid Task Force (OTF) and plans to host the 2022 Opioid Summit. Elevate Health has also launched a podcast called "Community Care Conversations" to share education and learnings from providers and community voices.

- **Greater Columbia ACH (GCACH):** GCACH has an ongoing evaluation of sustainability strategy by the Executive director, aiming to ensure the plan is flexible for the future. GCACH has proposed a braided

funding model that will include Fee for Service, Membership, grants, MCO, Philanthropy, and HCA funding. 2022 will serve as the development year for these financing models, and GCACH expects a rollout in 2023. In addition to rolling out the business plan and proposed financial model, GCACH has hired a new Executive Director, been actively pursuing state and federal grant opportunities, launched the first cohort for the Community Health Worker (CHW) Internship and Training program, and initiated a pilot program for justice, diversity, equity and inclusion.

- **HealthierHere (HH):** HealthierHere has focused its efforts this reporting period on Primary Care and Behavioral Care Integration, along with special attention to Social Determinants of Health and Community-Based Services. Several projects have continued or emerged during this reporting period, including: innovation projects, an investment in traditional medicine, the SharedCare Plan pilot, and the Connect2Community Network. HealthierHere is in the process of developing its 2022 investment strategy, which will build off current investments and the strength of existing systems. The strategy will be presented to the Governing Board in Q2 2022 for approval.

- **North Central ACH (NCACH):** North Central ACH has implemented their plan for the future structure of the organization. The organization has since begun working on developing a community-tested version of the three pillars they have decided to focus on. In order to operationalize the pillars, North Central has focused on their second and third pillars: Anchoring in shared measurement, and Building through an inclusive process of Distributed Leadership. To do so, North Central has begun recruitment for a Director of Community Data to develop the infrastructure for shared data and measurement, and invited agencies who have been practicing distributed leadership to present to their Board.

- **North Sound ACH (NSACH):** North Sound was engaged in several activities to ensure the sustainability of DSRIP funded infrastructure, activities, and/or evidence based models. North Sound had partners report their success and concerns at the ACH's partner convening in August 2021. During this convening the ACH was able to share its guiding principles, shared beliefs, and commitments. In late 2021, ACH leadership met individually with partners to discuss proposed partner contracts for 2022. In December 2021, the Board approved the ACH's 2022 budget and agreed NSACH would form a community group to advise the investment of the Community Resilience Fund.

- **Olympic Community of Health (OCH):** The OCH Board of Directors unanimously approved the 2022-2026 strategic plan in August 2021. The plan details the future of the organization, and includes a value proposition, overarching goals, focus areas, strategies, a defined target population, roles for the organization, and a high level partnership, funding, and governance model for the first two years. OCH aims to soft-launch the plan in 2022, coinciding with the conclusion of MTP. By 2024, OCH will implement a full launch of future state work.

- **SWACH:** During this reporting period, SWACH Board of Trustees approved the formation of a regional HealthConnect Advisory and HealthConnect expansion. The purpose of the HealthConnect Advisory is to ensure accountability and diverse community engagement, and SWACH aims for 2022 expansion planning to include: the opportunity for current partner agencies to increase the number of community-based staff, an RFP opportunity for new HealthConnect partnerships with regional community and clinical agencies, and HealthConnect funding for operations and partnerships through an HRSA contract.

7. ACHs Reflect on MTP

As a part of the final semi-annual report, ACHs were asked to share their reflections on changes and improvements that have occurred and/or lessons learned over the past five years of MTP. Please note, each ACH response has been included in ACH-specific tables below. The tables are left in the voice they were written in to honor the perspectives and experiences shared by ACH staff.

The following notable lessons from ACHs can be used to by CMS, HCA, other states, clinical and social service providers, or anyone seeking to actively make changes in the way that health care is delivered and paid for.

- **Successful transformation starts with putting the person at the center** and depends on strategies that focus not only on providing the right care in the right setting and at the right time, but also in the manner and from the providers that people prefer.
- **Transformation is not a big sweeping idea but instead, it is the nuts and bolts that really drive change.** It boils down to specific activities that providers and communities can do.
- **The best place to start with equity is to just start.** There is no perfect way to roll this out, and you will make mistakes. It's more important to start, humbly and be prepared to learn a lot along the way. You build the trust and the muscle with consistency, not perfection.
- **Standardization is powerful, but only if individualism is allowed.** Our state is a blend of urban and rural communities, each with their own special needs and preferences. We are not a one size fits all state. By allowing the ACH regions to achieve the same goal, with different strategies, breeds success.
- **Team-based care is critical to the success of whole-person health.** The addition of a Community Health Worker on the team is the key to addressing the social determinants of health.
- **Providers like learning from each other.** The Learning Collaboratives have enhanced provider knowledge of best practices, and facilitated agreements and compacts between organizations.
- **Transformation can happen quickly,** as evidenced by COVID-19, and requires regulatory flexibility, funding, and a shared sense of urgency and commitment.
- **Time and space to focus on and carry out transformation are essential.** A structure to rally around and knowledge of quality improvement processes facilitate success.
- **Collaboration is key.** Partnering across sectors and building relationships are vital.
- **Timely data is essential** to understanding if we are moving in the right direction and for quality improvement.
- **A** key lesson learned through the MTP was that **we need to systematically measure and communicate the impact** of SWACH's complex efforts to our community partners and other stakeholders.

8. Summary Recommendations for Payment of Incentives

Tables 4 through *8* below provide an overview of ACH projects, AVs, and incentives ACHs can earn for achieving project milestones for the reporting period July 1, 2021 to December 31, 2021. Each ACH can earn 1.0 AV per milestone per project. After review of responses to RFIs, the IA found all ACH reports to be fully responsive and complete, and the IA recommends HCA award full credit to each ACH for all milestones as noted in Table 5.

Table 4 provides the total potential AVs for each ACH by project that can be earned. If an ACH is not participating in a project, the table will display a dash (-). *Appendix A - MTP Projects* includes a list of all projects and project codes for reference.

Table 4. Potential P4R AVs for Project Incentives, July *1, 2021* – December *31, 2021*

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	5	4	-	-	5	-	-	4	18
Cascade Pacific Action Alliance	5	4	4	-	5	4	-	4	26
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	5	-	-	4	5	4	4	4	26
SWACH	5	4	-	-	5	-	-	4	18

Table 5 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the results of the independent assessment.

Table 5. Potential P4R Achievement Values (AVs) by Milestone by ACH for Semi-annual Reporting Period July 1 – December 31

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
Potential AVs for semi-annual reporting period July 1 – December 31, 2020									
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 (Replaced by COVID-19 Response)	4	6	4	4	4	6	8	6	4
Completion of all P4R metrics (Project 2A, 3A only) (Replaced by COVID-19 Response)	2	2	2	2	2	2	2	2	2
Achievement Values for First Reporting Period									
Assessed August 2021	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	18	26	18	18	18	26	34	26	18
Total AVs Available	18	26	18	18	18	26	34	26	18

For each ACH, Table 6 provides incentives available by funding source for completion of SAR 8.

Table 6. Total P4R Project Incentives Available by ACH for Achievement of the Implementation Plan Milestone

ACH	Earned AVs	Project Incentives
Better Health Together	18	$757,226
Cascade Pacific Action Alliance	26	$688,388
Elevate Health	18	$826,065
Greater Columbia ACH	18	$963,743
HealthierHere	18	$1,514,452
North Central ACH	26	$344,194
North Sound ACH	34	$1,032,581
Olympic Community of Health	26	$275,355
SWACH	18	$481,871
Total	**202**	**$6,883,875**

9. COVID-19 Observations by ACH

ACH-specific observations of regional resiliency and vulnerability in handling the pandemic response are included in tables below. A resilient structure/system/community is one that has the ability to respond, absorb, and adapt to, as well as recover from, a disruptive event with minimal damages and functionality disruptions.[4] Vulnerability refers to weaknesses in a system to withstand such disruptions.

ACHs described project intervention supports that enabled COVID-19 response activities through improved delivery system infrastructure, as well as described risks or issues that impacted their response activities.

[4] https://en.wikipedia.org/wiki/Resilience_(engineering_and_construction); Accessed September 14, 2020.

Better Health Together (BHT)

Table 7. Better Health Together (BHT) COVID-19 Observations

Findings for Better Health Together (BHT)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community-Based Care Coordination: Through the Care Connect Washington Care COVID Coordination Hub, BHT is working with Spokane Regional Health District to support the Compact of Free Association (COFA) Marshallese communities through the distribution of tangible resources by Community Health Workers. They have received 2,322 referrals to the Hub, and served 1,990 individuals with resources including rent and utility assistance, fresh groceries and food kits, and care kits. • Telehealth Access: BHT funded 11 organizations to support telehealth access. Organizations were able to define their needs as fitting for their clients, and chose to purchase cell phones to distribute, or laptops, tablets and accessories to be checked out. • School Based Telehealth Access: BHT convened a group of community partners and stakeholders to develop a program for school-based urgent and basic primary telehealth services, while ensuring continuity of care by looping back to an established provider when applicable. The pilot has since launched on schedule at six elementary schools and three more schools are scheduled to be brought on by the end of the 2021-2022 academic year.	• Workforce burnout and shortages: Workforce burnout in Spokane has persisted due to increasing community mistrust of public health and science based approaches. The rising number of staff resignations and position eliminations has been a huge concern for BHT, as their collaboration efforts have been disrupted and thus, services and care coordination to vulnerable populations has been disrupted. • Access to care: To increase vaccine uptake in the area, the Johnson & Johnson vaccine was widely used for patients who were houseless, experiencing housing instability, or otherwise difficult to locate. However, these patients have also been difficult to locate to administer their booster shot. To help mitigate this, BHT is hosting a one-day vaccine event in March 2022 aimed to serve persons who are houseless or housing instable. The event will also include wraparound services such as Hepatitis testing, flu vaccines, and other medical services. • Rural Counties: Like other regions of the United States, many of BHT's rural counties are being hit hard by COVID-19, due to many factors including workforce shortages and vaccine hesitancy or resistance. Once the vaccine mandate was enacted, many healthcare workers quit their jobs instead of being vaccinated. BHT hoped their Trusted Messenger campaign would help to dispel barriers and myths to incite more people to be vaccinated. • Decreased Provider Capacity: BHT had four clinical partners who chose not to sign Year 3 contracts for Medicaid Transformation. Of those, three cited organizational capacity as the reason for not contracting, particularly workforce shortage issues exacerbated by COVID.

Table 8: Better Health Together (BHT) Reflections

Reflections by Better Health Together (BHT)
Reflections on changes, improvements, and/or lessons learned over the past five years
BHT states that the past five years have been full of lessons to learn. BHT reflects on some lessons they have determined worth noting: It sometimes seems that the past five years have been nothing but lessons learned. However, when examined closer, there are some succinct and concrete lessons that are worth noting. • **The behavioral health system was more fragmented and fragile than we expected.** This sector has long struggled with the complexity of patient needs and an insufficient workforce. The pandemic only highlighted and heightened those challenges. It's evident that we need a more holistic approach to solving the problem. Specifically, while we appreciate the added investment that the legislature made in the 2021 budget, it didn't appear to take into consideration the fragility and fragmentation of the current "system". • **The best place to start with equity is to just start.** There is no perfect way to roll this out, and you will make mistakes. It's more important to start, humbly and be prepared to learn a lot along the way. You build the trust and the muscle with consistency, not perfection. • **Transformation is not a big sweeping idea but instead, it is the nuts and bolts that really drive change.** It boils down to specific activities that providers and communities can do. • **The money matters.** The Waiver funds propelled our work in a way that nothing else could have. It was an incentive to bring folks to the table and keep them there long enough to build trust, demonstrate the benefits of ACH's role, and the advantages of working collaboratively. • **The ACH serving as the backbone entity was necessary for our region to move forward in more dynamic cross-sector collaborations.** While our region has a long history of collaboration, the ACH was able to act as a bridge and synthesizer to fully develop those partnerships in ways that had not been achieved before. • **Systems of power need to be held accountable.** A lot of what we have wanted to and been working to accomplish is undermined by systems of power and structural policies that organizations like the Health Care Authority and CMS have accountability for. If systems of power aren't taking active strides to dismantle inequities at their level, it's going to be at the expense of the community. These communities continue to bear the extra burden because the systems at the top aren't doing the work. This must change. • **The metrics as the system evolved were not reliable indicators of success.** It has been nearly impossible to quantify our impact when the data isn't available.

Table 9. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$367,140
2B: Community-based Care Coordination	4	4	$252,409
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$45,892
3D: Chronic Disease Prevention and Control	4	4	$91,785
Total	**18**	**18**	**$757,226**

Cascade Pacific Action Alliance (CPAA)

Table 10. Cascade Pacific Action Alliance (CPAA) COVID-19 Observations

Findings for Cascade Pacific Action Alliance (CPAA)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Financial Assistance: The WA Care Connect program was able to provide over $647,560 in financial relief through its Household Assistance Request process. CPAA provided relief for 1,089 household bills, 766 grocery orders, and distributed 32,700 PPE items from FEMA. • Vaccine Outreach: Beginning in July, CPAA began working with MTP partners and public health departments across the seven counties in order to organize vaccine clinics, host group discussions to dispel COVID misinformation, and address vaccine hesitancy and resistance. At all outreach events, vaccines were made available through the partnership with two vaccine administrators: Birdseye Medical and Medical Teams International. CPAA achieved the following outcomes during the reporting period: ○ 36 vaccination clinics held ○ 1,488 adults and youth vaccinated ○ 691 (47% of 1,488) vaccinated adults and youth were from BIPOC communities • Priority Investment and Projects: CPAA has collaborated with CHOICE Regional Health Network and made a priority investment decision to fund the Blue Zones Activate, a three-year initiative focused on the largest health determinant: the place we live. Fully executed in December 2021, the Blue Zones contract focuses on behavioral health using a systems-focused model approach to make healthy choices easier in all the places people spend the most time.	• Workforce Challenges: CPAA discusses a growing concern surrounding staff turnover. Multiple partners have expressed that the departure of their most experienced program managers and coordinators has resulted in considerable negative impact on the oversight of projects. Staff turnover has also affected the timely submission of quarterly reports from partners and a delay in integration efforts. Despite these difficulties, CPAA has responded by offering partners technical assistance and one-on-one coaching around MTP work. This coaching is designed to reiterate the purpose and spirit of the Medicaid Transformation project, reporting requirements, and look at other metrics important to this work. CPAA has also been very flexible with their partner needs in the preparation of reports.

Table 11. Cascade Pacific Action Alliance (CPAA) Reflections

Reflections by Cascade Pacific Action Alliance (CPAA)
Reflections on changes, improvements, and/or lessons learned over the past five years

As a result of the MTP, many changes, improvements and lessons have been learned. The waiver period, although short in duration of only five years to adequately measure change, has proven to demonstrate the continual need for focusing on our overall health care system. Disparity in access to providers is still blatant within the Medicaid population.

Changes -

- **Much growth has taken place in the past 5 years between state agencies and ACHs.** Relationships are being built and planning together is manifesting. We have established important multi-stakeholder platforms across the region where partners can engage regularly to discuss key healthcare priorities and share opportunities. We continue to receive positive feedback on the value of these platforms, especially our Local Forums that are in each of the seven counties.

Improvements –

- **One of the significant improvements noted in the CPAA region has been the ability to connect individuals and families in need of assistance to resources.** Through our Community Based Care Coordination platform, named CarePort, we have connected thousands of clients to resources, including permanent housing. Washington State's coordinated entry system for housing has funds for approximately 25% of residents in need, with a placement rate of approximately 43% in that subset. Compared to CPAA's pilot program where the success rate for permanent housing, for the same subset, is 94%.
    - Utilizing a process where a trained Community Health Worker or trusted peer builds a relationship with a client, while using an algorithm or pathway to guide assistance, a foundation of trust is built, and progress is measured while staying the course.
    - The CPAA region is a leader in the state in permanent housing placement largely due to our CarePort HUB services of training, quality assurance and billing/invoice assistance. This process can, and as demonstrated, should be replicated statewide.
- **Another significant improvement has been seen when we get out of our own way and head space, or in other words, reduction of stigma.** In our opioid workstream, much focus has been placed on harm reduction measures and anti-stigma efforts. When embraced by leaders, such as county commissioners, change can take place. Allowance of a needle exchange site not only provides clean needles, but it allows for a trusting relationship to be built over time where resources can be shared and accepted by clients that will enhance their health. This has been a struggle in Grays Harbor County.
    - One cannot rush a process of trust, but we can forge forward with anti-stigma campaigns, campaigns that aim to ensure everyone is treated with dignity. Although difficult to measure, acceptance has been promoted in our region. Acceptance of those that are different than one's self. Whether it is skin color, age, or recreational drug usage. We will continue to seek acceptance in our region and elimination of stigmas.

Lessons learned –

- **Standardization is powerful, but only if individualism is allowed.** Our state is a blend of urban and rural communities, each with their own special needs and preferences. We are not a one size fits all state. By allowing the ACH regions to achieve the same goal, with different strategies, breeds success. The ACHs are a powerful resource to the state, and if allowed to be a part of the planning process, we can achieve more together.

Reflections by Cascade Pacific Action Alliance (CPAA)

- **Our region faces some significant challenges and barriers to care that the present MTP work may not truly address.** The CPAA region is a rural territory whose proximity to Seattle, King County and the I-5 Corridor has served to push healthcare workers out more than attract them. Inadequate resources means both providers and counties are not able to attract talent, pay competitive wages and retain workers they really need. Lack of adequate housing and ancillary services such as an urban transport system, quality schools, colleges and institutions of higher learning are often mentioned among key barriers to workforce development.
    - Also, low population spread out in a large rural territory is a barrier to attracting providers. It would appear there is no critical mass in Wahkiakum (pop. 4,000); and Pacific County (pop. 20,000). Telehealth remains an impossible proposition due to lack of broadband and internet connectivity across large swathes of the territory.
    - CPAA continues to convene meetings with partners for the purposes of gaining a better understanding of these challenges and exploring possible sustainable solutions. We have also received funding, including from Cambia Health Solutions that we seek to leverage to bridge this gap in Wahkiakum and Pacific.
    - *Despite our efforts, it's clear: providing quality housing as homes for potential new hires, or erecting telecommunication towers and laying broadband cables for connectivity is way beyond the capacity of the ACH, CBOs and individual counties.* We are hopeful that the Federal and State government could help address these challenges as a matter of priority. In our assessment, such investment would be worthwhile for they will help unlock the region, attract new populations, providers and boost access to quality, affordable and reliable care.

Table 12. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$262,244
2B: Community-based Care Coordination	4	4	$180,292
2C: Transitional Care	4	4	$106,536
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$32,780
3B: Reproductive and Maternal and Child Health	4	4	$40,975
3D: Chronic Disease Prevention and Control	4	4	$65,561
Total	**26**	**26**	**$688,388**

Elevate Health of Washington

Table 13. Elevate Health of Washington COVID-19 Observations

Findings for Elevate Health of Washington	
Examples of Pandemic Response Resiliency	• **Examples of Pandemic Response Vulnerability**
• OnePierce Community Resiliency Fund: The One Pierce Community Resiliency Fund, the investment arm of Elevate Health has been extremely responsive to the vulnerabilities onset by the pandemic. They held a competitive application process for $200,000 in grants to support the expansion of access to behavioral health services and integration. Six organizations were awarded with funding covering both rural and urban geographies, and offer diverse projects including culturally relevant wellbeing programming, and mental health outreach and assessments. • Care Continuum Network Activities: The Department of Health Washington Care Connect Program Contract contractual partnership between Elevate Health and the Washington State Department of Health (DOH) has expanded since the last reporting period, and is on track to continue providing COVID-19 specific care coordination support to Pierce County. - By the 2021-year end, Elevate Health received 1870 referrals from DOH, and assigned 1528 referrals. - Additionally, Elevate Health processed 506 individual housing and rental assistance placed 586 fresh food orders. - In response to emergent needs, Elevate Health has expanded their partner network: beginning programming with five community based partner organizations, and three new partners (Asia pacific Cultural Center, Community Health Clinic, and Virginia Mason Franciscan Health). • PPE Distribution Activities are ongoing. Elevate Health has continued to support the warehousing and distribution of PPE in Pierce County. During this reporting period, Elevate Health was able to distribute 22,700 pieces of PPE to community partners and organizations.	• Community Health Worker and Hub Administrative Capacity Challenges: Elevate Health has expressed that despite their efforts, the Care Connect Hub has continued to experience challenges with network service capacity since the initial summer 2021 surge. Unfortunately, cases are backlogged with the overwhelming demand for services. • Risk to Maternal and Infant Outcomes: Elevate Health has expressed concerns because Pierce County experiences some of the poorest outcomes for maternal and infant health in Washington State, and these have been exacerbated by the pandemic. In order to mitigate the further risks posed by COVID-19, OnePierce has engaged with multiple birth worker organizations, including Open Arms Perinatal and Quilted Health, to develop strategies to offer doula trainings for African-American and BIPOC-identifying people, because of the particularly high adverse maternal and infant outcomes in BIPOC communities. • Youth Mental Health and Substance Use Disorder Services: Elevate Health has shared that since the beginning of the pandemic in March 2020, there has been a 67% increase in hospital emergency room visits for children and adolescents experiencing mental distress. Workforce shortages have also impacted this issue, with families waiting 4 months, on average, for psychiatric consultation. In efforts to undertake the youth mental health crisis, Elevate Health has established relationships with local mental health providers, and participating in Kids Mental Health Pierce County Action Team Meetings for community planning. Elevate Health aims to develop a "Behavioral Health Workforce" strategic plan for the region through its partnerships with Comprehensive Life Resources, Hope Sparks, Kids' Mental Health of Pierce County, and Youth Engagement Services.

Table 14. Elevate Health Reflections

Reflections by Elevate Health of Washington
Reflections on changes, improvements, and/or lessons learned over the past five years

- **Community-Based Care Coordination Outcomes:** *One of our greatest learnings over the course of the MTP has been around community-based care coordination (CBCC).*
  - Our risk-stratified systems approach to care by means of a centralized CBCC Hub addresses the micro and macro social influences bearing upon those in our communities and advances a pro-health rather than pro-disease response.
  - In administering two evidence-based practice models, the Pathways Community Hub Institute (PCHI) Model and the state-endorsed Health Homes program, we've been able to demonstrate substantiated cost savings to the health care system. In a sample aggregation, we were able to demonstrate an acute care cost savings across programs of approximately $15M for 365 patients.
  - Interestingly, the rising risk Pathways program demonstrated more cost savings per patient than the high-risk Health Homes program at $72k and $25k per patient, respectively. Please note these calculations have not been validated against actual claims data and are assumptively based on generally accepted acute care costs. However, data from Collective Medical Technologies was cross matched with our CBCC client population data to determine utilization for program enrolled clients; this data resulted in a 1:5 (Pathways) and 1:4 (Health Homes) ratio of acute utilization days.
- **Community-Based Care Coordination Sustainability:** *While we have and are demonstrating the effectiveness of risk-stratified CBCC through our Hub demonstration project, long-term sustainability remains our greatest challenge in the environment of misaligned incentives and supportive cost structures.*
  - The cost of this type of community-based care delivery is an expensive proposition as our financial modelling has shown, especially given the high infrastructure costs of technology and adequate program staffing. This said, data provides convincing evidence that it is incumbent upon us as a State collective to consider the potential return on investment for community-based care coordination against the background of exorbitant acute care costs and less than exemplary outcomes. Ultimately, the fate of sustainability of these significantly impactful programs will depend upon endorsements at the macro level.
- **Transformation is Dependent Upon Systems Partnerships:** *The ACH experience in Pierce County has demonstrated that true partnerships, including through contractual relationships, are required for shifting to value-based systems of care.*
  - As a neutral convener, Elevate Health has held space at the table for both clinical and community entities to come together and discuss the triple aim of healthcare. However, conversation alone cannot deliver improved care, and the contracts with clinical partners, especially hospital systems and insurers that attach dollars to the value-based models of care are critical for moving forward with value-based arrangements.
- **Tension Between Local Solutions and Policy-Driven Decisions:** *Many local solutions for value-based care center on products and systems that are used or built for local circumstances.*
  - In the case of data sharing and integration, we have been part of local partnerships resolving this issue using software and platforms. However, there is a balance between co-developing solutions at the local level and seeking sustainability by aligning with state and federal policy. When state policies shift to favor a particular solution, the local co-designed frameworks can be endangered, trust with community partners can be damaged, and funding wasted.

Reflections by Elevate Health of Washington

- **Pairing Funding with Technical Assistance:** *Through both grants and contracts, we have learned that funding is only part of the equation for some grassroots service providers who are rapidly expanding in response to equity needs and pandemic-related work.*
  - Even when technical assistance is not a stated part of our support, we have delivered substantial assistance to our partners, from supporting them to understand federal funding requirements and regulations to assisting them in setting up ACH/electronic payments to improve the speed and ease of payments, to providing Information Technology and marketing assistance.
  - Working at a local level enables us to support new, smaller, and BIPOC-led organizations with business supports they may not otherwise be able to afford. We have taken on capacity building and assistance as an unstated responsibility alongside funding in many instances.
- **Community Information Exchange Solutions Require Coordinated, Regional Support Efforts:** *We have learned through our many efforts that the development of technological solutions for the community must be concertedly organized as various funding streams enable pieces of the data exchange work through various organizations, but the solutions do not come together and in many cases, creating further silos.*
  - While this is true of our work from evidence-based practice clinical work to integration practice, the business of technology is a costly venture for everyone. The more we can come together in collaboration around data sharing, technology solutions and practices, the greater the opportunity for standardized care, realized savings for the entire region to include small providers, and robust analysis for prescript intervention for the whole community.

Table 15. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

Elevate Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$400,516
2B: Community-based Care Coordination	4	4	$275,355
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$50,065
3D: Chronic Disease Prevention and Control	4	4	$100,129
Total	**18**	**18**	**$826,065**

Greater Columbia ACH (GCACH)

Table 16. Greater Columbia ACH (GCACH) COVID-19 Observations

Findings for Greater Columbia ACH (GCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Resiliency Campaign: GCACH launched *Practice the Pause* last reporting period, and during this reporting period, GCACH continued distribution of the Practice the Pause toolkits and trained multiple community organizations. Almost 300 community members received training on the phases and behavioral responses to a natural disaster, along with reframing techniques to cope with anxiety and stress. • COVID-19 Vaccination Collaboration: Early in the reporting period, GCACH partnered with Medical teams International and the Benton-Franklin Health District (BFHD) to create and host pop-up COVID-19 vaccination clinics in Benton and Franklin counties. GCACH targeted efforts in the two aforementioned counties because they were shown to have low vaccination rates and a higher social vulnerability index. GCACH's resulting partnerships coupled with Spanish outreach, lowered the barriers to vaccination for populations in these areas, and as a result, they hosted over 25 vaccine clinics and administered over 550 vaccinations. The use of Spanish translation services, incentivizing vaccinations, and working with Spanish-speaking community members allowed for this successful vaccination campaign. • COVID-19 Vaccination Collaboration: GCACH's Justice, Diversity, Equity and Inclusion (JEDI) Specialist led additional special outreach to the African-American community. For this outreach, GCACH also partnered with local churches, Tri-Cities Hispanic Chamber of Commerce, Tri-Cities Diversity Council, Women of Wisdom Tri-Cities, Pacific Northwest National Laboratory, and Heritage University to host, market, and supply vaccine clinics targeting this population.	• Workforce Shortages: GCACH cited continued staffing shortages as a severe impact to service delivery. The shortage also caused a lack of staff for reporting and quality improvement initiatives. In order to mitigate the impact of workforce shortages, GCACH employed additional retention and hiring strategies, including incentives and retention bonuses for existing employees, and recruitment bonuses for potential candidates. Workforce shortages have also significantly impacted behavioral health provider availability, especially in rural areas. GCACH found telehealth to be very beneficial for providers, as they were able to engage staff members from other sites, increasing their bandwidth. • Care Management for High Risk Patients: COVID-19 has greatly impacted care management through staff availability and patient adherence. GCACH states many sites in their region are having difficulties filling key staff positions for the care management team for high-risk patients. Additionally, patients are hard to reach for enrollment in care management, or they are missing appointments. • New Strategies: The use of telehealth, and virtual tools such as Zoom became widely utilized by Care Management and providers to meet with patients or their teams. GCACH created over 200 online tools and resources to provide to patients, and Community Health Workers were widely used for care coordination for patients who could not attend in-person or needed assistance in setting up telehealth appointments.

Table 17. Greater Columbia ACH (GCACH) Reflections

Reflections by Greater Columbia ACH (GCACH)
Reflections on changes, improvements, and/or lessons learned over the past five years

- **Transformation of the Delivery System:**
  - ACHs have demonstrated their ability to react quickly to address such issues as the COVID-19 pandemic, social determinants of health, infrastructure needs, personal protective, equipment distribution, workforce shortages, and build relationships with Tribal nations.
  - ACHs in the role as a neutral convener have driven healthcare transformation across the state.
  - The Cross ACH Executive Leadership Cohort has been invaluable in achieving statewide goals and driving policy changes.
  - Transformation of the healthcare system has been effective using Practice Transformation Navigators to help clinics make workflow, culture, and infrastructure changes within their organizations.
  - Team-based care is critical to the success of whole-person health. The addition of a Community Health Worker on the team is the key to addressing the social determinants of health.
  - Integration of Social Determinants of Health into patient care requires care coordination which is not covered by MCOs.
  - Bi-directional integration requires funding, policy changes, workflow accommodations, infrastructure, culture change, and upper management to ensure that it happens.
  - Care coordination requires, at a minimum, local and regional approaches to get all parties working toward the same goals. The Local Health Improvement Networks have served a vital purpose for GCACH in facilitating care coordination efforts and initiatives within their communities.
- **Resources:**
  - It is essential to have a diverse and engaged Board of Directors in order to advance collective action.
  - The Greater Columbia Cares Model (GCCM) has been transformative for providers wanting to engage in whole person care, but transformation requires leadership and dedicated staff for reporting.
  - Bi-directional integration requires more people in behavioral health occupations, better wages, and inter-professional training opportunities.
  - Providers like learning from each other. The Learning Collaboratives have enhanced provider knowledge of best practices, and facilitated agreements and compacts between organizations.
- **Financing:**
  - Financial incentives to change clinic practices are essential in order for organizations to justify and convince upper management of the value of the GCCM model.
  - Transformation of the healthcare system requires transformation of the payment system.
  - The fee for service model, while providing predictable payments for services, is hindering many provider organizations from including value-added services that would benefit patient outcomes.

Reflections by Greater Columbia ACH (GCACH)

- Funding is required to ensure all provider organizations use certified electronic health record technology.

- **Communication:**
  - It is essential to keep elected officials, especially state Legislators informed and appraised of the activities and progress of practice transformation.
- **Health Information and Analysis:**
  - Population Health Management tools such as Collective Medical have been a valuable resource in helping reduce emergency department utilization and re-hospitalizations.
  - Providers in the healthcare system need alignment on measures and metrics across payer groups to ease administrative burdens. Reporting on measures and metrics needs to be efficient, with providers receiving feedback in a timely fashion.
  - Data analysis, in order to be to be truly helpful, must be at the provider site level. The Healthier WA Dashboard which is aggregated to the ACH level, is not helpful for individual provider sites. Also, because the claims data has to be "cleaned and scrubbed," it is eighteen months late in being useful. Quarterly data analytics that are not lumped into quarterly rolling averages would provide a more accurate picture for providers.
  - A community information exchange, in order to be most helpful would be organized, coordinated and funded by the Health Care Authority who, at a minimum, should be working with the other state agencies, such as the Department of Health, Department of Corrections, Department of Commerce, Department of Children, Youth and Families, and the Department of Social and Health Services. All of these agencies have created their own client exchange data bases and need to be connected with each other.

Table 18. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$541,049
2C: Transitional Care	4	4	$219,801
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$67,631
3D: Chronic Disease Prevention and Control	4	4	$135,262
Total	**18**	**18**	**$963,743**

HealthierHere

Table 19. HealthierHere COVID-19 Observations

Findings for HealthierHere	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Regional and Community Vaccination: HealthierHere (HH) reports their reallocation of $840,000 and partnership with 28 partners and 24 community based organizations (CBOs) to increase vaccination rates in King County. HealthierHere funded several activities including: vaccine capacity building, information sharing, outreach and engagement, and develop and implementation of clinical and community partnerships, with the goal of introducing an equitable and accessible vaccination campaign in the region. In July 2021, HealthierHere launched the Community and Clinical Vaccine partnership office hours, designed to allow community and clinical partners to work together on vaccine efforts, and discuss methods for best serving the needs of the community. The group met on an ad hoc basis during this reporting period. • Improving Health Literacy among Racial and Ethnic Communities and Vulnerable Communities: As previously reported in SAR7, HealthierHere and Public Health Seattle and Kings County (PHSKC) were awarded nearly $4 million over the course of two years by the office of Minority Health (OMH) within the U.S. Department of Health and Human Services (HHS). This award was designated for the improvement of health literacy among racial and ethnic communities in King County. During this reporting period, HealthierHere has been in the planning phase: HH has established an advisory group of 12 community members to assist in the planning process and implementation of project activities. In Q1 of 2022, HH plans to select community partners, who will develop and implement a health literacy plan, culturally informed health literacy strategies, and provide training for public health providers, healthcare providers and COVID-19 testing and vaccination providers to improve organizational health literacy. • Expanding Access to and Engagement with the Health Care System: In Q2 2021, HH announced its plans to expand health care access and engagement in King County through a $2.35 million investment in community-based non-licensed healthcare team members, such as community health workers (CHWs), peer support specialists, cultural navigators, and recovery coaches.	• Amplification of Ethnic/Racial Disparities: As reported in previous SARs, the pandemic has exacerbated existing racial and ethnic disparities in the region. Based on available data on vaccination and COVID-19 case rates, HH has identified the following geographic areas and communities of focus: ○ Auburn: youth, Hispanic/Latinx, Pacific Islander communities ○ Federal Way: Immigrants, Youth ○ Pacific/Algona: All residents ○ Tukwila: Black/African-American, Hispanic/Latinx ○ Seattle/Central District: Black/African-American ○ Seattle/Downtown, Belltown, SoDo: Black/African American, Hispanic/Latinx, Teenage youth ○ South Seattle: Hispanic/Latinx, Black/African-American ○ Renton: Black/African-American ○ Fall City: Rural, White ○ Enumclaw: Rural, White

Table 20. HealthierHere Reflections

Reflections by HealthierHere
Reflections on changes, improvements, and/or lessons learned over the past five years
The past five years have been a period of immense and rapid change for the King County health care delivery system. HealthierHere's commitment to its vision and approach to building trusted relationships with clinical, community, tribal, social service, and public health partners enabled the organization to achieve improvements in the system during this challenging time. No decisions impacting partners were made without their representation and direct participation. Below are examples of improvements in the region made possible by this approach: • **New innovative care models** that improved community-clinical linkages • **Better coordinated care** through the C2C Network and Collective Medical • **Increased delivery of integrated care** as evidenced in increased MeHAF scores • **Improved provision of person-centered and culturally relevant care** • **Centered health equity and anti-racist practices in care delivery** • **Improved population health** as reflected in HealthierHere' s achievement of performance targets for 11 MTP quality metrics across its selected MTP projects. Over the past five years, HealthierHere learned the following lessons: • **Successful transformation starts with putting the person at the center** and depends on strategies that focus not only on providing the right care in the right setting and at the right time, but also in the manner and from the providers that people prefer. • **Transformation is successful when led by a "backbone organization,"** like an ACH, that convenes and coordinates stakeholders, provides administrative and financial support, analyzes available data to develop actionable insights, and can activate a network to deploy a coordinated response to regional needs based on a shared vision. • **Transformation requires investments in foundational tools and technologies, remaining flexible and nimble, and partnership.** HealthierHere took this approach for the MTP and partners remained engaged, implemented MTP activities, pivoted work to address COVID-19, and improved health in the region. • **Traditional funding approaches are inadequate to support transformation.** The state should continue to seek creative financing mechanisms to invest in drivers of health (e.g., housing and food insecurity) and to support new models of care; traditional quality and performance measures do not adequately capture social needs and efforts to address them. • **Opportunities to better support CBOs include** centering BIPOC CBOs in community health efforts; providing funding that enables CBOs to close gaps in the cost of existing services, build their resilience, and reimagine their work; and creating opportunities for CBOs to convene with peers and access targeted support/TA. • **Transformation can happen quickly,** as evidenced by COVID-19, and requires regulatory flexibility, funding, and a shared sense of urgency and commitment.

Table 21. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$850,219
2C: Transitional Care	4	4	$345,401
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$106,277
3D: Chronic Disease Prevention and Control	4	4	$212,555
Total	**18**	**18**	**$1,514,452**

North Central ACH (NCACH)

Table 22. North Central ACH (NCACH) COVID-19 Observations

Findings for North Central ACH (NCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Partner Engagement: NCACH continued to support their existing partners and remain flexible in contracting partners due to the stressors of the COVID-19 pandemic. NCACH was able to increase its social media presence in 2021, and thus, able to share COVID-19 related posts from local public health and healthcare partners on Facebook, Twitter, and Instagram.	○ Workforce Shortages and Challenges: The surges in COVID-19 put strain on NCACH's healthcare and public health partners. Staffing shortages due to contracting COVID-19, possible exposure, and the vaccine mandate, put the region's providers into greater capacity issues. In order to support behavioral health providers who were hit significantly by loss of staff due to the mandate, NCACH has engaged in the House Bill 1504 Behavioral Health internship program. With the goal of offering support to these agencies, NCACH plans to engage with four behavioral health organizations to provide internships across the region, once approved by Washington Health Care Authority.

Table 23. North Central ACH (NCACH) Reflections

Reflections by North Central ACH (NCACH)
Reflections on changes, improvements, and/or lessons learned over the past five years

Reflections on Changes and Improvements:

- NCACH conducted two Ripple Effects Mapping sessions in Quarter 3 of 2021. The report released at the end of 2021 found that **NCACH partners are generally positive about the impact support that NCACH is having on their work.**
    - Specifically, participants indicated that funding (and the support it allowed) from NCACH has resulted in high levels of collaboration among partners.
    - This, in turn, has expanded the service each is able to offer.
    - Key to the success of this expanded service has been quality standards and accountability measures that incentivize the whole person approach.
    - Support from NCACH has successfully and, by several accounts, permanently shifted the partners' mindsets toward providing whole person care.
    - While several individuals said they fear the end of the five-year grant cycle will end the work, some believe the momentum achieved during the granting period will be durable enough to allow the work to continue.

Reflections on Lessons Learned:

- NCACH recognizes that **we should have done a better job at the front end of the Medicaid Transformation Project in bringing in our community-based organization partners and engaging our coalitions to address whole person health and health equity.**
    - As we started our work, we were primarily focused on clinical process improvement; although that aided us in building our partnerships with clinical partners, it also caused a number of our community partners to disengage due to not understanding their role in the work.
    - This is evident in a report from the Population Health Innovation Lab released in January 2021 that demonstrated that 3 of the top 4 sector types represented in our region were healthcare focused. This report is part of the Aligning Systems for Health (AS4H) initiative and is testing a cross-sector alignment theory of change.
- The AS4H report also found that **North Central ACH has effectively supported and increased collaboration across organizations, sectors, and tribal partners.** These results were based on 76 survey respondents, and 86% somewhat or strongly agreed that NCACH had increased collaboration, while 90% somewhat or strongly agreed that NCACH had effectively provided support for collaboration.
    - However, the depth of that collaboration has been less clear. A majority of partners said that collaborative linkages with other community agencies "somewhat increased" (41%) or "neither increased or decreased" (35%) as part of their engagement with NCACH. Even fewer respondents saw increases in referral linkages and data exchange. This shows that while conversations have occurred, actual partnership to complete the work still need to be fostered.
- Another reflection is that we **could have been more effective at engaging our tribal partners and individuals with lived experience at the start of the MTP.**
    - Our initial philosophy was to have partners and the community join the projects and workgroups that NCACH chose and developed.

Reflections by North Central ACH (NCACH)

- As a result, our primary partners were those who could easily identify with the work and had the capacity to dedicate staff.
- We have learned that it is most important to go to partners, learn what the needs are, and figure out the best way we can support them in filling those gaps instead of inviting them into a predefined table.

- Finally, NCACH is currently **in the process of strengthening our value by bringing partners together to identify and address a regional portfolio to advance whole person health and health equity**.
  - Though these themes have come across in projects through the Medicaid Transformation Project, it has caused some partners to view us more as a clinical project management organization.
  - Going forward, NCACH will ensure that partners understand our broader scope and ways they can assist in being part of improving health in our region (funded or not). This is especially true for non-clinical partners.
  - Based on AS4H survey results, NCACH scored a 1.68 out of 5 on communicating the value of the ACH's work to potential funders/investors. A score of 1.68 means that we are right between Not doing this (score of 1) and doing this a little (score of 2) NCACH also consistently scored in the low 2s (out of 5) for measures of engagement with the broader community.

Table 24. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$119,720
2B: Community-based Care Coordination	4	4	$82,307
2C: Transitional Care	4	4	$48,636
2D: Diversions Interventions	4	4	$48,636
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$14,965
3D: Chronic Disease Prevention and Control	4	4	$29,930
Total	**26**	**26**	**$344,194**

North Sound ACH (NSACH)

Table 25. North Sound ACH (NSACH) COVID-19 Observations

Findings for North Sound ACH (NSACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**

• Vaccine Access and Equity: NSACH aimed to provide equitable access to vaccines and information, and to do so, they organized multiple vaccine equity initiatives:
  ○ Rapid testing at local food banks and migrant farmworker health fairs primarily focused on serving the Latinx community in North Sound. NSACH provided financial and organizing support for interpreters to be present during clinics.
  ○ NSACH partnered with Community based organizations (CBOs) to translate education information and fliers in multiple languages, including indigenous Latin American languages such as Mixteco and Triqui.
  ○ NSACH partnered with Community to Community (C2C), a women-led grassroots organization dedicated to food sovereignty and immigrant rights, and Skagit Pediatrics to hold vaccine clinics for adolescents aged 12 and up.
• COVID-19 Response Activities:
  ○ North Sound ACH supported 84 organizations with COVID-19 rapid antigen tests during this reporting period.
  ○ NSACH conducted multiple activities related to food insecurity. NSACH provided groceries, gift cards and food kits to local organizations to distribute. NSACH also collaborated with CBOs to distribute food to Latinx families of farmworkers. The fresh food was culturally appropriate.
  ○ NSACH distributed PPE including masks, hand sanitizer, gloves, gowns, face shields, food and care kits, to the five county region and neighboring regions.
	• Workforce Shortages: Like many ACHs, NSACH is experiencing shortages in their healthcare workforce due to COVID-19 surges. NSACH shares there is a limited number of Medicaid providers in Island County. WhidbeyHealth, the main hospital and urgent care facility for this county, has experienced severe staffing and funding shortages have only intensified since the pandemic. The lack of Medicaid providers causes disproportionate access to care and inequitable care across the North Sound region.
	• Behavioral Health Capacity: Behavioral health care providers have reached their capacity, with a sharp increase in clients needing care for mental health challenges since the pandemic. Wait times are on the rise, which has become increasingly problematic for pediatric patients in crisis.
	• Barriers to Vaccine Uptake: North Sound ACH reports COVID-19 educational materials are available in few languages other than English, which poses a barrier to vaccine uptake. The lack of available materials in other languages is further complicated by the complexity of understanding the ever-changing landscape of COVID-19, vaccines, and public health protocols, as print and online materials are constantly needing updates.

Table 26. North Sound ACH (NSACH) Reflections

Reflections by North Sound ACH
Reflections on changes, improvements, and/or lessons learned over the past five years

Over the last five years, much has changed for North Sound ACH and its partner organizations in the region. Several key areas of change have emerged in partner reporting:

- Increased collaboration between partners;
- Training received by partners has positively impacted their work;
- Increased capacity to address health disparities; e
- Expansion of the health workforce (although workforce challenges continue to be an issue across the board); and
- Successful implementation of effective evidence-based practices.

Examples of improvements in each area are below:

- **Increased collaboration between partners:** As a result of North Sound ACH's MTP work, partners have done more co-creation of programming with other organizations and partnering with other organizations to better serve their communities.
  - For example, creating a Skagit county based Latinx Healthcare Access Advisory Group, which included information collecting, funding targeted recommendations made by the group, and seeking funding and other resources to support leadership and local career development opportunities for group members.
  - One partner noted that "*the partnership with North Sound ACH has brought a sense of relief and a positive example for… demonstrating what equal partnership can look like*."
  - Another partner noted that "*the connections to other organizations [provided by] the ACH is of tremendous value to [our organization]. We have always been collaborative as an agency, but we see our connections turning into strong partnerships and view our membership in the ACH as instrumental in making that happen*."
- **Training received by partners has positively impacted their work:** North Sound ACH partners reported two areas of training their staff received during MTP that made a positive impact on their work: 1) training hosted by North Sound ACH as part of the Equity and Tribal Learning series and 2) training to prepare staff to implement evidence-based practices.
  - One partner noted they "*see North Sound ACH as a visionary leader, pushing equity work to the forefront, educating us about Targeted Universalism, anti-racist efforts and so much more… You help us see new possibilities – and that keeps us motivated to keep working even when things are difficult… I think of the ACH as the rock dropped into a pond or lake – it creates ripples that cascade further and further. And you enable more rocks to be dropped and ripples to continue – leading to greater equity and inclusion… It would feel overwhelming of where to start, and what steps to take without the ACH's support.*"
  - Partners also noted repeatedly that the training provided by the ACH, especially those related to equity and Tribal learning, were instrumental in helping them make progress on their organizational commitments to equity work.

Reflections by North Sound ACH

- **Increased capacity to address health disparities:** As a result of MTP, many partners expressed they had an increased capacity to address health disparities in their work.
  - Strategies like improving language access to services, hiring staff from the communities they serve, and others contributed to increasing this capacity, and partners specifically mentioned that they used these strategies during their COVID response work.
  - For example, many partners noted that they had adapted their COVID-19 work to reach those who may be struggling to access testing and vaccines, such as "*outreach and setting appointments for non-English speaking community members and other vulnerable [individuals] who may lack access… coordinating care for vulnerable seniors and people with disabilities*."
  - Several organizations noted hiring community health workers who represent specific communities, such as Black, Latinx, and Tribal communities, to address COVID-19 concerns and other care coordination efforts.
  - One organization noted that "*to better assist the LGBTQ+ patient population, a provider champion has been identified with the goal of providing guidance and training to other providers*."
- **Expansion of workforce:** Though workforce continues to be a huge challenge for providers in the North Sound region, partner organizations have noted that they have seen growth or expansion of their workforce happen as a result of MTP.
  - For example, organizations reported adding positions or expanding the scope of existing positions to reach new populations, such as Latinx individuals, transgender clients, and pregnant and parenting individuals; hiring new staff to oversee Diversity, Equity, and Inclusion (DEI) work; and expanding specialties, such as opening a dental clinic or adding physical therapy to the practice.
  - Care coordination was a large area of growth, with several organizations adding community health workers, peer navigators, and other care coordination roles.
- **Successful implementation of evidence-based practices:** Partners reported successful implementation of evidence-based practices they committed to as part of their MTP work, and that they have seen these evidence-based practices change workflows and clinical practices, and result in improvements in patient outcomes.
- **Eagerness to know what comes next:** Partners have been pushing the ACH team to share a vision of next steps, wanting to continue working with each other to find ways to learn, evolve and transform together.
  - As we shifted to our focus from 'improving health' to advancing equitable well-being, partners began to see intersections between health and housing, climate change and livable communities, workforce and affordable wages. We are seeing common understanding and agreement that we need to focus on moving communities from suffering and struggling to thriving.
- **Need for more generalized support/funding that is not incident-specific:** The most significant thing that 2020 and 2021 have taught us is that our traditional approach of bucketed funding will not serve us in the future.
  - When funds in one hand will pay for wildfire response, and in the other hand we have dollars for those who test positive for COVID-19, but won't pay for flood response needs (unless the person is COVID-19+ or running from a wildfire) we find ourselves unable to meet immediate needs, even if we have access to dollars.

Reflections by North Sound ACH
○ A warehouse of "wildfire food-kits" needed permission from a state agency in order to be used for people displaced by unprecedented flooding. We have clearly entered a period of overlapping and simultaneous crises that are most likely to continue looking forward. Allowing communities to navigate – and have control over – emergency response without checking to see if we can use the dollars in Hand #1 or Hand #2 is critical. ○ Perhaps that is the challenge of clinical and community providers as well – we want an integrated system, but we still pay for services using varied streams of dollars that each have their own set of restrictions and allowances. ○ North Sound ACH and our partners are interested in finding different ways to meet the needs of those in our region. The Medicaid Transformation Project created and fostered the environment that have the ACH and partners working in concert to take that next step.

Table 27. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$330,426
2B: Community-based Care Coordination	4	4	$227,168
2C: Transitional Care	4	4	$134,236
2D: Diversions Interventions	4	4	$134,236
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$41,303
3B: Reproductive and Maternal and Child Health	4	4	$51,629
3C: Access to Oral Health Services	4	4	$30,977
3D: Chronic Disease Prevention and Control	4	4	$82,606
Total	**34**	**34**	**$1,032,581**

Olympic Community Health (OCH)

Table 28. Olympic Community Health (OCH) COVID-19 Observations

Findings for Olympic Community Health (OCH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Partner Site Visits: Olympic Community Health staff was able to visit with its implementation partners over the summer, both virtually and in-person and was able to hear about how they have gone above and beyond for the health of communities. OCH shares that despite the ongoing stress of the pandemic, their partners have been able to deliver creative solutions to meet the needs for their communities. OCH calls their partners "the true face of resilience" for their continued partnership and efforts to improve systems to address inequities for the people they serve across the region. OCH details some of the creative partner projects taking place: - Determinants of Health: Peninsula Community Health Services has created a Social Determinants of Health screening tool and process for patients to prioritize needs, allowing for appropriate referrals based on the patient's priorities. - Community-Clinical Linkages: Across the region, most partners are expanding existing referral systems to create more community-based clinical partnerships. - COVID-19 Vaccination Efforts: Jefferson Healthcare vaccinated 26,000 individuals, and Jamestown Family Health Clinic vaccinated over 18,000 individuals over the reporting period. - Health Equity: YMCA of Pierce and Kitsap counties, Olympic Area Agency on Aging, Jefferson Healthcare, and Kitsap Children's Clinic have all launched equity measures or training for their staff. From trauma-informed care training to the creation of an equity index tool, OCH's partners are building staff expertise by offering care that is more inclusive and advocating for unique community needs. • Local Health Jurisdictions Communication Meetings: OCH Staff has continued to meet with Kitsap Public Health District and Jefferson County Public Health to discuss communications surrounding COVID-19. This collaboration has been effective in its aim to strengthen and align COVID-19 messaging across the region. The group most recently shared best practices on how to combat misinformation and disinformation via social media platforms.	• Workforce Shortages: Workforce shortages, especially with behavioral health partners were among some of the main pandemic response challenges for OCH. There was an additional administrative burden for managing six different contract requirements (5 MCOs and SBH-ASO). This burden was a heavier due to the decreasing numbers of available staff. OCH shares their integration efforts have also exacerbated workforce challenges, as more providers must compete for the limited pool of applicants. • Increased Demand on Behavioral Health Services: OCH and its partners have previously identified a lack of behavioral health services in the area. The COVID-19 pandemic has increased the need for behavioral health services, thus increasing the demand on the limited number of providers available. In efforts to address the behavioral health needs of the region, OCH's partners have implemented a variety of projects: - Kitsap medical Group, Forks Community Hospital, and Jamestown Family Health Clinic have expanded telepsych services. - Kitsap Public Health District's Perinatal Learning Collaborative quarterly meetings focused on the mental health of mothers and expectant mothers. - First step Family Support Center offers peer and parents support groups. - Olympic Community Action programs was able to hire three additional housing case managers. OCH aims to continue outreach and communication with partners in order to monitor their already burdened behavioral health access system.

Table 29. Olympic Community Health (OCH) Reflections

Reflections by Olympic Community Health (OCH)
Reflections on changes, improvements, and/or lessons learned over the past five years
Lessons learned: • **True transformation necessitates a long-term view and approach.** Transformation won't be achieved in a short five years – we must think ten, twenty, even fifty years from now if we are going to truly and sustainability transform the system. • **Time and space to focus on and carry out transformation are essential.** A structure to rally around and knowledge of quality improvement processes facilitate success. • **Collaboration is key.** Partnering across sectors and building relationships are vital. • **Timely data is essential to understanding if we are moving in the right direction and for quality improvement.** **Changes and improvements:** • **We have reached a new level of collaboration.** Partners have built relationships that didn't exist before and have learned much about each other's services, approaches, and value. Communication and awareness of resources have improved as a result. • **Workforce knowledge has expanded to offer care that is more culturally appropriate and trauma -informed.** • **Shared goals and understanding of what it takes to improve health outcomes and transform the system.** More awareness of the importance of addressing the determinants of health and implementing equity-driven practices exists.

Table 30. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$135,559
2D: Diversions Interventions	4	4	$55,071
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$16,945
3B: Reproductive and Maternal and Child Health	4	4	$21,181
3C: Access to Oral Health Services	4	4	$12,709
3D: Chronic Disease Prevention and Control	4	4	$33,890
Total	**26**	**26**	**$275,355**

Southwest Washington ACH (SWACH)

Table 31. Southwest Washington ACH (SWACH) COVID-19 Observations

Findings for SWACH	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Care Coordination: Southwest Washington ACH (SWACH) has made significant stability improvements for HealthConnect Hub and Care Connect WA (CCW) in terms of workflows, processes, trainings, and community-based workforce (CBW) confidence in program services. In this reporting period, the HealthConnect Hub was able to conduct the following activities: ○ During this reporting period, the Hub CBW has supported 1,666 households and over 6,600 individuals. ○ SWACH contracted with a new delivery service to deliver food and care kits across Clark County. This service provides significant support to the CCW program by ensuring availability and timeliness of resource allocation to community members. ○ HealthConnect Hub provided over 900 households with a total of $1,099,144 in household assistance, 912 grocery orders, and $188,930 in fresh food orders in Clark, Skamania, and Klickitat counties. ○ HealthConnect was able to expand to offering long-term community-based care coordination (CBCC) for community members. With this expansion, the HealthConnect Hub trained 12 new care coordinators, and cross-trained all CCW contracted agencies. • Equity Training: SWACH completed the digital equity project and created six "Technology Mindset" training videos in both English and Spanish. The digital equity project is designed to support increased digital access in the region, and its early prioritization during the pandemic has allowed for diverse feedback from cultural community leaders before, during and after development. Digital equity resources have now been championed and distributed through: ○ Vancouver School district, primarily to support Spanish-speaking families ○ Washington Department of Health, statewide ○ Area Agency for Aging and Disabilities of SW Washington, primarily to support the aging population	• HealthConnect Hub: The HealthConnect Hub experienced a significant surge in referrals and high numbers of new enrollments due to the rise of COVID-19 cases across the region, which contributed to strain on the Hub overall. Mitigating this required program design updates and increased capacity from care coordinators. • Workforce Shortages: Agency staffing has been an issue for SWACH. After partner agencies issued a COVID-19 vaccine mandate within their organizations, SWACH saw the loss of many staff at multiple agencies. The reduced staffing caused the workload to shift, and HealthConnect Hub Staff and care coordinators took on additional duties. High workload continues to impact staff wellness and functionality of Health Connect. • Partnering Providers: Many of SWACH's partnering providers have reported the unvaccinated workforce and unvaccinated members of the communities they serve have posed additional risks and barriers to the existing workforce challenges. In addition, recruitment and retention has been a challenge for partners. This has caused significant wait time for clients, and limited staffing for supporting clients through online modalities.

Table 32. Southwest Washington ACH (SWACH) Reflections

Reflections by SWACH
Reflections on changes, improvements, and/or lessons learned over the past five years

Over the past five years, SWACH has witnessed a variety of improvements in our region through this work. We serve as a neutral convener in the area, bringing together partners that have often worked independently or lacked an established relationship with one another. Building those relationships and fostering collaboration in our community demonstrates that our work has lead to real change in the community. Our efforts in collaborative impact, convening collaboratives, community-based care coordination, and equity, demonstrate the impact this work has had on our region. Through our programs and partnerships, we have also learned a lot that has informed our efforts.
• **Collaborative Impact**
  ○ SWACH serves as a trusted backbone entity for collaborative impact initiatives that improve health and whole person care outcomes. Diverse leadership and stakeholders across community and clinical sectors have been convened by SWACH to share learning and collectively advance needed health and system improvement opportunities. Through collaborative impact, we have been able to remove many of the barriers that prevent organizations from working together on similar projects.
  ○ Collaborative impact efforts have included (but not limited to):
  - Clinical Integration of Physical and Behavioral Health
  - Collective Response to the Opioid Epidemic (Opioid Treatment Networks; Opioid and
  - Substance Use Disorder Workgroups/Taskforces in each of SWACH's three counties)
  - Trueblood Settlement (Cross sector collaboration for systems change to help individuals detained in jails awaiting competency evaluation)
  - Chronic Disease Management Initiatives (Chronic Disease/Pain Self-Management Programs; Hepatitis C Cures Program; Community Paramedicine CARES program)
  - HHIP program (Housing and health system collaborative -Clark County)
  - K-Link (Housing, health system, education and social service collaborative – Klickitat and Skamania counties)
  - Housing Crisis Response System (HCRS)
  - Integrated Care Collaborative
  - Equity Collaborative
• **Learning Collaboratives - We have learned valuable lessons through collaborative impact during this time frame.**
  ○ Learning Collaboratives can be easily adapted to meet the changing needs of our partners and the environment.
  ○ During the COVID-19 pandemic, we saw a significant impact on integration work which had to be adapted. We also had to find ways to provide virtual care in the pandemic. We have also seen great improvements by supporting partners in convening collaboratives.
  ○ Occasionally, our community partners work on similar projects independently or "siloed". This can lead to a redundancy in work, overlapping outcomes and limited effectiveness.

Reflections by SWACH

- By creating a space and system for these organizations to work on these projects together, we can improve the outcomes and effectiveness of the work. It can also foster long-lasting relationships that will continue to benefit the community.

- **Community Based Care Coordination**
  - SWACH spearheaded development and implementational of a regional Community Based Care Coordination (CBCC) infrastructure, the HealthConnect Hub. The HealthConnect Hub addresses the region's siloed health care and social services systems by centering the community-based workforce and serves as a central care coordination system aimed at advancing whole-person health.
  - Through a partnership with a network of agencies and community leaders, HealthConnect Hub has developed and strengthened a regional cohort of culturally diverse community-based workers (CBW) that function in a connected, collaborative and integratedway by using a common community health record platform.
  - HealthConnect supports CBWs to:
    1) systematically identify program participant needs
    2) consistently coordinate referrals across physical health, behavioral health, and social services partners, and
    3) provide support in navigating currently fragmented systems.
  - HealthConnect partners with a diverse and representative cross-sector of community and clinical agencies including five housing agencies; five physical and behavioral health agencies; one EMS-community paramedicine agency; three home and community-based services agencies; and two education agency partners.
  - These partnerships deliver nine HealthConnect integrated community-based care coordination programs including: Department of Health Care Connect WA (CCWA); the region's first Community Paramedicine program; and HealthConnect Pathways.
  - In the past five years HealthConnect Hub has trained over 150 community-based workers, integrated community health records for more than 17,000 regional community members.

- **Race, Community Voice and Experience**
  - Through our work, we have furthered our understanding of the importance of centering race, community voice, and experience to inform opportunities for improvement and their solutions. We continue to educate ourselves on the connection between health equity and racial equity. Improving systems cannot be done without these valuable lenses.
  - Our work in funding disbursement, COVID-19 response, and utilizing the Community-Based Workforce to capture community voice demonstrate this learning in action. SWACH remains committed to creating a space where all community members in our region can have access to the support and services they need.

Additional Lessons Learned

- SWACH's community and systems change transformation work is complex, multi-tiered, cross sector, and intersectional.
  - A key lesson learned through the MTP was that we need to systematically measure and communicate the impact of SWACH's complex efforts to our community partners and other stakeholders. Independent evaluation has confirmed the diverse and significant impacts.
    - Asking ourselves important questions like, how will we move forward to systematically measure impact and share outcome?

Reflections by SWACH

- How best to frame and measure SWACH's impact towards the goals of creating a more aligned and integrated community health resource ecosystem, generate better, more equitable health outcomes for all, and improve communities' capacity to address complex shared challenges and invest in the upstream determinants of health?
- What would be the best way to frame and measure SWACH's impact towards our goals?

- To address these questions, SWACH developed a key performance indicator model. The model is based on a driver diagram and anchored by five foundational elements that are key to needed system change improvements and transformation:
  1) Community Engagement and Power Building
  2) Integrated Service Model
  3) Data and Program Infrastructure
  4) Community Based Workforce, and
  5) Community Investment, Finance and Sustainability.
- Each foundational element is supported by key concepts for the foundational elements to be successfully realized.
- Each key concept has associated metrics that let us and SWACH's stakeholders know if we are making an improvement.
- The model evaluates impact, identifies opportunities for improvement and supports accountability.
- As SWACH moves forward beyond the first five years of the MTP, we see this model for measuring impact and for accountability to community and stakeholders as central to SWACH's continuing success driving systems change transformation and community/organizational collaboration in the SW Washington region.

Table 33. Achievement Values and Earned Incentives for Reporting Period July 1, 2021 – December 31, 2021

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$233,634
2B: Community-based Care Coordination	4	4	$160,624
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$29,204
3D: Chronic Disease Prevention and Control	4	4	$58,409
Total	**18**	**18**	**$481,871**

Appendix A – MTP Projects

MTP Projects	
Project Code: Project Title	
Domain 2: Care Delivery Redesigns	
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	
2B: Community-based Care Coordination	
2C: Transitional Care	
2D: Diversion Interventions	
Domain 3: Prevention and Health Promotion	
3A: Addressing the Opioid Use Crisis	
3B: Reproductive and Maternal and Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	