MYERS AND STAUFFER LC
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 7

Reporting Period January 1, 2021 – June 30, 2021

Findings Report: October 2021

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1. Overview

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).

As part of this engagement, and as required by the Special Terms and Conditions (STCs) of the waiver, 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 January 1, 2021 – June 30, 2021.

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 that 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 one ACH. The RFI serves as an opportunity for ACHs to offer clarification to responses that were initially found to be incomplete and to address identified gaps.

3. Findings of the ACHs' Semi-Annual Report 7

All ACHs submitted their SARs by the August 2, 2021 deadline.

- **Findings.** Upon submission of RFI responses, all SARs included sufficient detail to reflect progress performance during the reporting period January 1, 2021 – June 30, 2021.
- **Recommendation.** The IA recommends HCA approve and award full credit to ACHs for milestone achievement towards Medicaid Transformation.

4. COVID-19 Pandemic

Due to the impact of the Delta variant of the novel coronavirus (COVID-19), the health care system and the communities of Washington State saw continued burden through the first half of 2021. The duration of the pervasive challenges of the pandemic declared on March 11, 2020 by the World Health Organization (WHO), and extent of morbidity, resulted in continued anxiety and medical risks. Between the first reported case and the end of June 2021, there were 451,485 reported cases, with 25,837 hospitalizations and 6,021

deaths.[1]50.1% of the Washington population was fully vaccinated[2]. In the same timespan, the United States had over 33.7 million confirmed cases with over 604,600 deaths, and 46% 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

Due to the Delta variant, hospital bed capacity decreased, and communities continued to require strategies to address housing, food insecurity, and ongoing remote education. HCA, the ACHs, and partnering providers maintained pandemic response protocols, including modifications and flexibilities to the Medicaid Transformation waiver approved by the Centers for Medicare and Medicaid Services (CMS). These flexibilities allowed for the semi-annual report template to be modified to collect COVID-19 response information. The implementation plan update, quality improvement strategy update, and pay for reporting metrics became optional reporting requirements.

5. Highlights of the ACHs' Semi-Annual Report 7

The following summary describes findings noted by ACHs within their SAR 7 responses.

- **Project Updates:** Although the pandemic continued, ACHs indicated that their Medicaid Transformation Project (MTP) activities were generally back on track. Updates indicated:
    - ACH activities moved from mitigation of COVID-19 to supporting recovery efforts including vaccination access and financial assistance for items such as rent, utilities, groceries, and household products.
    - Some ACHs continued to accelerate the release of funding.
    - 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.
    - Reporting requirements and schedules generally returned to pre-COVID conditions.

Recommendation: ACHs have successfully managed their responses to COVID-19 even while new developments continue to occur that demand adjustments to partnering provider engagement, staffing, funding allocations, methods of communication and timelines. ACHs were quick to support distribution of both personal protective equipment (PPE) and CARES Act funds. ACHs then turned their attention to addressing vaccine distribution, health equity disparities and rising behavioral health concerns. It is recommended that ACHs utilize their unique ability to quickly survey, prioritize and pivot to address rising health concernsas ACHs refocus on advancing the goals of MTP.

[1] Washington State Department of Health. https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard#tables. [Accessed on September 22, 2021.]
[2] Seattle Times. https://www.seattletimes.com/seattle-news/health/coronavirus-daily-news-updates-june-30-what-to-know-today-about-covid-19-in-the-seattle-area-washington-state-and-the-world-2/. [Accessed on September 22, 2021.]
[3] Our World in Data. https://ourworldindata.org/coronavirus/country/united-states# [September 22, 2021.]

- **Health and Social Equity Impact.** Addressing equity is a pillar for MTP, and ACHs continue to take enhanced action, especially around vaccine equity:
    - The Kitsap Public Health District has a biweekly equity collaborative that looks at disparities in vaccine distribution and develops equitable mitigation strategies. OCH participates in the collaborative and has helped Kitsap County build a more accessible and equitable vaccine distribution process. A successful example was pop-up vaccine clinics at community hubs that did not require appointments and provided bi-lingual support.
    - HealthierHere reallocated funds to support King County's vaccination campaign for equitable access to the vaccines in King County. Project activities funded included pop-up vaccination sites, staffing support, developing culturally and linguistically relevant materials, outreach, transportation vouchers, and on-site interpreters.
    - North Sound COVID-19 activities shifted from COVID testing to vaccine equity in this reporting period. Their work with local health jurisdictions, community organizations, and partnering providers resulted in four vaccination sites reserving slots for underserved populations and three planned mobile clinics for farmworkers and their families.
    - SWACH is partnering with Southwest Washington Equity Coalition (SWEC) to apply for funding to increase access to COVID-19 vaccines. The grant will allow for the hiring and training of community health workers, integrated with HealthConnect, to expand vaccine information, engagement, and access for underserved communities.

  Recommendation: The majority of patients now requiring hospitalizations are unvaccinated individuals. Collaboration between ACHs and state partners on outreach efforts to reach underserved populations continues to be critical. Continued use of mobile clinics, pop-up vaccine clinics, resources such as transportation vouchers to ensure ready access, and the use of community health workers (CHWs) trained in vaccine efficacy to share trusted information is recommended. ACHs may wish to assess and follow emerging best practices, such as the strategies that North Sound employed with community leaders to support successful use of CHWs.

- **Escalating Behavioral Health Risks**. Due to the impacts of COVID-19, the behavioral health crisis among children and youth has continued to increase. In response ACHs indicated they have taken the following steps:
    - CPAA hosted the Children's Behavioral Health Task Force in May 2021 and a subcommittee is meeting weekly to draft a work plan and strategies to build engagement and improve care coordination for children's behavioral health.
    - GCACH distributed toolkits about behavioral health resiliency tools tailored for youth ages 5-12 and teens 13-18 to area schools. Fifty-eight school districts received printed toolkits and there were sixty-seven trainings conducted for schools, public health agencies, community-based organizations, and parent groups.
    - Elevate Health is working with local partners to develop a "Behavioral Health Workforce" strategic plan for the region.
    - North Central ACH worked with community partners and supported development of the Hope Squad model. The model supports suicide prevention and peer support for youth in local school districts. Funding has been used for training, curriculum, and a regional coordinator.

Recommendation: As the 2019 pandemic effects continue to be felt in 2021 and beyond, strategic plans should consider both short and long term needs. Budget preparation should consider prioritizing resiliency programs and supporting the workforce for an extended period. ACHs may wish to consider how partnering providers may sustain, expand, or support school-based counselors and related services into the future as part of ACH integration goals. A model may include BHT's School-Based Telehealth Access pilot that seeks to address equity gaps in community access and reduce barriers to care. BHT notes that nine schools will receive support, with three clinical sponsors already confirmed.

- **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 that 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	$8,355,396	$6,380,986	$9,006,298	$11,192,386	$13,331,240	$4,123,065	$11,853,517	$3,313,344	$5,791,304
Total Funds Distributed During Reporting Period	$3,877,447	$2,733,129	$3,911,116	$8,879,505	$5,673,194	$2,417,315	$6,756,581	$664,593	$3,600,169

- **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 two ACHs saw an increase in active partners (e.g. GCACH AND NCACH), CPAA saw a decrease of one partner, while all others reported the same number as SAR 6.

Table 3. Active Project Partnering Providers

Project	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
2A: Bi-directional Integration of Care	122	57	59	86	110	42	115	59	33
2B: Community-Based Care Coordination	124	35	91	•	•	47	8	•	14
2C: Transitional Care	•	35	•	87	97	46	109	•	•
2D: Diversions Interventions	•	•	•	•	•	47	112	59	•
3A: Addressing Opioid Use	120	59	47	89	103	56	150	59	14
3B: Reproductive and Maternal and Child Health	•	68	•	•	•	•	87	59	•
3C: Access to Oral Health Services	•	•	•	•	•	•	36	59	•
3D: Chronic Disease Prevention and Control	120	46	24	86	94	42	92	59	34

- **Scale and Sustain.** Many ACHs are reviewing their transformation project experience to make plans for sustaining improvements. They are using data, input from participating providers and community organizations, identified best practices, and opportunities for expansion to determine priorities for future transformation activities. ACHs noted their progress in sustaining and scaling their projects:
    - The sustainability planning process for BHT included reviewing their history, assessing strengths and initiatives, reviewing partner evaluations, and getting staff input. The board discussed service gaps in the region and has identified Equity, Anti-Racism, and Belonging, social determinants of health, and increased community-based care coordination capacity as high priorities.

- HealthierHere is using site visits to discuss effectiveness of project implementation, which projects demonstrate impact, and which projects will be or have the potential to be sustained and/or scaled. They use the site visits and reporting to determine current and future investments in partner activities as part of their strategy.
- Elevate Health has a multiyear strategic business plan that utilizes their subsidiary, OnePierce Community Resilience Fund, along with other funding sources to support equitable health improvement. The board of directors is focused on community health exchange governance, the care continuum network, and how to continue community engagement to ensure long-term success in the region.
- North Central researched ACH models across the country to determine best practices for structuring the organization going forward. From this research, a plan was developed for the future direction of the ACH and presented to the Governing Board for review. NCACH also received board approval of a set of priorities for 2022 including continued expansion in the following areas: Whole Person Care Collaborative with both outpatient primary care and behavioral health providers, regional Recovery Support Services through the Recovery Coach Network, and NCACH's Community Based Care Coordination efforts.

Recommendation: ACHs are increasingly building concrete approaches to regional sustainability after the waiver. Continued planning for coordinating across regions, sharing successes and making advances statewide is recommended.

6. Success Stories:

ACHs provided lessons learned or "success stories" that emerged during the response to the COVID-19 pandemic. Highlights include:

- **Better Health Together (BHT):** BHT shared a patient story around their community-based care coordination through Care Connect Washington: A COVID Care Coordination Hub. After being hospitalized for three months due to COVID, a man returned home with ports coming out of his chest and finding it difficult to walk. Due to his COVID diagnosis in March, he did not qualify for supports through the program. He wrote a letter of consideration to the care coordinator, who then worked with the Department of Health (DOH), and within an hour they were able to make reasonable accommodations and approve extended services. This situation highlighted that all cases won't necessarily fit into the standard COVID case and it will be important for the Hub to be well resourced to enable case-by-base review.

  BHT also noted that their Trusted Messenger strategy and COVID-19 Emergency Housing initiatives have shown the benefit of taking the time to build trusting relationships in the community. These relationships have allowed BHT to shift power to impacted communities through low-barrier, flexible dollars dedicated to organizations lead by and serving people impacted by oppression (e.g., BIPOC, justice involved, refugee/immigrant). The allocation of COVID-19 emergency housing assistance funds was determined by budgeting done by partner organizations.

- **Cascade Pacific Action Alliance (CPAA):** CPAA shared a patient story submitted by a partnering provider in their Q1 report. The client entered Care Coordination after fleeing from domestic violence and needed assistance with employment, food insecurity, and housing. She was making progress on sustainability goals when she became temporarily disabled due to contracting COVID-19. A community health worker delivered food boxes throughout the family's quarantine period and connected the family

to additional resources to help contain the virus. After quarantine, the CHW connected the client to employment resources and funding for car registration to assist with her job search. "The client and her family are now in stable housing with an ongoing housing voucher and the client has definitive planning in place to obtain her CNA licensing to be able to return to her chosen field of work."

- **Elevate Health (EH):** Elevate Health developed and implemented a COVID-19 Care Coordination model in December of 2020 to assess and address social determinant of health (SDOH) needs. The model is working with other community care coordination programs to increase workforce capacity for COVID-19 response and better accommodate CARES Act funding structures and audit requirements. The programmatic work, including the workflow developed for local CARES Act funding, has been included in the DOH Washington Care Connect contract signed in June of 2021. Elevate Health has also on-boarded North Sound ACH onto the software platform and shared their COVID-19 workflows and programmatic resources for use in their respective regions.

- **Greater Columbia ACH (GCACH):** Many GCACH practice transformation programs in Pullman came together as a community to tackle getting people vaccinated. Pullman Regional Hospital and clinics, Palouse Family Medicine, Palouse River Counseling, and other community members from Washington State University, pharmacies, emergency management services, and the Pullman fire department worked to put up vaccination hubs all over town. The group used their empanelment lists to contact patients and also started mobile vaccine outreach to access those without transportation. As of June 2021, Whiteman County reports some of the highest percentages of people vaccinated against COVID-19 in Washington.

  GCACH provided other examples of successful vaccination programs.

  - Kittitas Valley Healthcare (KVH) worked with Kittitas County, the Kittitas County Fire and Rescue Chief, and other groups to set-up, staff, and run vaccination clinics with zero vaccine waste. They worked after hours and on weekends to vaccinate all eligible individuals. Their outstanding work was recognized in an article by CNN[4].

  - The Providence Walla Walla Population Health Team coordinated the COVID-19 Vaccination efforts in Walla Walla County. The population health team provided support to the Health Department and collaborated with them to meet the demands of COVID vaccinations. The team uses The Mobile Outreach Service Team (MOST) RV to administer vaccinations out in the community for greater access.

- **HealthierHere (HH):** HealthierHere noted that COVID-19 served as a catalyst for creating new and strengthening existing clinical and community partnerships. This has allowed HealthierHere to test new ways of engaging with and activating its partner network to respond to community needs. A matchmaking event for federally qualified health centers (FQHCs) and community-based organizations (CBOs) was hosted by HealthierHere to help facilitate partnerships for using clinical/community vaccine partnership funds. Three FQHCs and seven CBOs were awarded $158,000 from the COVID-19 vaccination investments, specifically for partnering to implement pop-up vaccination clinics in the community. The clinics would also reserve blocks of appointments for special populations (e.g., Black or African American and Hispanic/Latinx communities). FQHCs are working with CBOs to ensure the special

[4] CNN. https://www.cnn.com/2021/01/25/health/kittitas-county-washington-covid-19-vaccine-trnd/index.html. (Accessed September 10, 2021)

populations have access to vaccination slots, while the CBOs are helping community members navigate vaccination appointment systems and confirm appointments. Examples shared include:

- Country Doctor and Recovery Café successfully vaccinated 16 individuals at a pop-up clinic who were hesitant about being vaccinated. Without the easy accessibility of the pop-up site and support provided by Recovery Café in getting to the appointment, the individuals likely would have not been vaccinated or delayed until a later date.
- Valley Medical contracted with six CBOs to provide community-based vaccination clinics serving communities disproportionately impacted by COVID-19. HealthierHere assisted by identifying and reaching out to potential partners, refining Valley Medical's scope of work and payment structure, and facilitating an introductory partner meeting. HealthierHere continues to provide technical assistance, guidance, and thought leadership to ensure partnership success.

- **North Central ACH (NCACH):** North Central ACH commented on the impact of the ongoing COVID-19 pandemic on youth in their region, noting statistics showing an overall decline in mental health and increase in suicide attempts among the age group. A $245,000 investment was received from Cambia Health Solutions to address urgent behavioral health needs intensified by COVID-19 in rural communities. NCACH worked with the Behavioral Health Provider Alliance to prioritize issues that could be addressed with the funding. Youth mental health and substance use, with an emphasis on teen suicide received the highest priority ranking. The proposed plan included implementation of a school-based, peer-to-peer model that addresses teen suicide, and a curriculum focused on mental wellbeing and building resiliency. NCACH contributed an additional $211,736, for a total of $456,736, to fund training and curriculum for all school districts in the region and a regional coordinator for four years. For the 2021/2022 school year, 21 school districts have implemented the program so far.

- **North Sound ACH (NSACH):** One "bright spot" that North Sound ACH observed during this reporting period as a result of COVID-19 was strengthened relationships of community-based organizations that serve the farmworker, immigrant, and refugee communities. Providing access to personal protective equipment (PPE) resources allowed the ACH to work with community organizations to bypass appointment scheduling systems and arrange culturally and linguistically accessible and welcoming vaccine sites. The community organizations have also been jointly applying with the ACH for federal grants. One vaccine equity grant from All in Washington helped support and promote community health workers (CHWs) across the region as this workforce is essential to advancing vaccine equity. Co-developing strategies with community leaders to support CHWs has been the "brightest spot" during the reporting period.

- **Olympic Community of Health (OCH):** OCH commented that as COVID-19 vaccine distribution became a top priority for many OCH partners, the opportunity to learn, collaborate, and take action regarding health equity emerged as a "bright spot". In April, OCH convened a call with partners across the region to connect organizations and Tribes, discuss current challenges regarding vaccine hesitancy and barriers to access, and tangible next steps to have better outreach. Participating providers paired strategies with each hesitant group, identified areas of strength, and then created commitments to address vaccine hesitancy and barriers to access in their communities. OCH partners have been implementing these equitable distribution strategies and outreach methods. Examples shared include:

- First Step Family Support Center, along with the county health department, and other community organizations partnered to support equitable vaccine access, address vaccine hesitancy, and encourage vaccine acceptance. A program manager shared, "Our first vaccine pop-up event […] was the most successful pop-up event to date in Clallam County by double, according to the health department. In addition to the funds awarded to us by OCH, we have been able to secure funds from All In Washington to support vaccine equity work. We are connecting with various community partners to support vaccination efforts, pop up events, incentives, education and outreach."
- Kitsap Public Health District (KPHD) held no appointment needed pop-up clinics at farmers markets, breweries, food banks, libraries, and local events. They also started a collaborative that meets biweekly to discuss vaccine access with the community.

- **SWACH:** SWACH, in partnership with Clark County Public Health, Klickitat County Public Health and Skamania County Community Health, launched the Care Connect WA (CCWA) program on January 11, 2021. The existing HealthConnect community-based infrastructure and partnerships allowed SWACH to train and deploy a Culturally Appropriate Response and Engagement (CARE) Cohort of Community Health Workers to support COVID-19 impacted community members and households. They have already seen many positive outcomes including 4,235 food/care kits delivered in the SWACH three county region and contracted partnerships with eight CBOs and clinical partners to recruit/hire/train and support culturally diverse community health workers to deliver CCWA.

  SWACH noted examples that highlight the best practice of leveraging the HealthConnect infrastructure to support community COVID-19 response. During the reporting period, HealthConnect partnered with community organizations at local events to support food kit distribution for COVID-19 impact communities. SWACH and HealthConnect also partnered with the Southwest Washington Equity Coalition for Health Resources & Services Administration (HRSA) funding to increase BIPOC vaccine uptake through community engagement, information, and access to the vaccine.

7. Summary Recommendations for Payment of Incentives

Tables 4 through *7* below provide an overview of ACH projects, AVs, and incentives that ACHs can earn for achieving project milestones for the reporting period January 1, 2021 to June 30, 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 4.

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, January 1, 2021 – June 30, 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 January 1 – June 30

	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 7.

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		**$6,883,875**

8. COVID-19 Observations by ACH

In addition to the overall response themes identified in Section 5 across ACHs, *Tables 9 through 35* provide ACH-specific observations of regional resiliency and vulnerability in handling the pandemic response. 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.[5] 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.

[5] 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 find better ways to serve the Compact of Free Association (COFA) Marshallese communities. They are developing cultural trainings to be required for all care coordinators working on the project. • Rural Counties Workforce: Many rural counties saw their services reduced during the pandemic. They used this time to reassess their equity projects and determine how they wanted to move forward. As in-person events were canceled, counties shifted to creating de-stigmatizing advertisements, social media campaigns, and distributing behavioral health resource information. Stevens County shifted the focus to increasing availability of quality childcare. They combined Department of Commerce dollars with Equity Project dollars to start the process toward a childcare facility. • School-Based Telehealth Access: BHT convened a group of community partners and stakeholders to develop a program for school-based urgent and basic primary care and continuity of care by looping back to an established provider when applicable. The goal is to address equity gaps in community access, and reduce barriers to care including transportation, parental work schedules, and lack of medical home. A model has been selected and they are working toward a fall launch date. The pilot will roll out in nine schools, with three clinical sponsors confirmed. • Cell Phone Distribution: BHT received 737 cell phones from HCA/Amerigroup and set up a tracking system to distribute the phones to providers for their enrollees. So far 442 phones have been distributed.	• Disparities with access to resources: Through stakeholder meetings, it was identified that BIPOC, non-English speaking, and undocumented communities were less likely to complete or slower to complete the status quo funding opportunities so funds were not getting to high-need communities. The high burden of reporting requirements and low reimbursement also hindered small community organizations from applying. BHT is partnering to apply for funding as a fiscal sponsor on behalf of the organizations to address these disparities. • Workforce burnout and shortages: Increased stress continues to be a workforce issue. Reasons include moving to telehealth so quickly, dealing with personal challenges due to the pandemic, turnover, and the existing workforce shortage. These all put additional pressure on the remaining staff. • Access to resources: Through the COVID Care Connect Hub, BHT found that many people were unable to submit documentation for household assistance payments on time. Reasons included having no access to technology, being too sick to complete timely, and language/trust barriers. BHT has requested that DOH consider extending the allowed timeframe to submit household financial assistance documentation. The Hub's team of Community Health Workers is working case-by-case to help make reasonable accommodations.

Table 8. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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 9. 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**
• Care Coordination: CPAA's Community CarePort further expanded its care coordination services by partnering with the DOH's WA Care Connect program. Through this partnership, CPAA has increased caseloads and resources to reach more clients that required isolation or quarantine assistance. Examples of support included 373 care kits distributed, 496 food kits distributed, and $152,845.18 in financial relief for over 277 household bills through the Household Assistance Request process. • Vaccine Assistance: Vaccine assistance continues to be a focus for CarePort as additional resources are acquired through combined funding and resources from the CDC foundation. • Health Disparities: In April, CPAA released an open call for proposals to implement strategies to promote health equity. Each applicant would receive up to $10,000. Implementation of projects has begun for 17 partners. The initiative has built new partnership with community-based organizations and offers ACH the opportunity to expand its reach and support in the region. CPAA project managers are providing technical support and project monitoring to identify challenges and provide platforms for mutual learning, solution generation, and sharing of evidence-based best practices and success stories.	• Behavioral Health Crisis: CPAA is working with stakeholders in the region to find sustainable solutions to the ongoing children and youth behavioral health crisis across the ACH region. More than 120 stakeholders met in May to address concerns including the following: - Strain on families attempting to cope with the pandemic and behavioral health crisis among children - Community support systems hit particularly hard by COVID-19 - Inadequate access to local mental health professionals to deal with an increased need for behavioral and mental health services The group developed seven recommendations with commitment to continue engagement and come up with specific action steps. CPAA continues to convene and facilitate a weekly call around the topic.

Table 10. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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 11. 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 fund has continued to be responsive to the COVID-19 pandemic by providing community bridge loans for rental assistance providers, local investment for creation of additional housing units, and development of a capacity building program to help providers with technical and financial services supports. • Care Coordination: Elevate Health has contracted with the DOH to continue providing COVID-19 coordination support to Pierce County. They partnered with multiple agencies to create dashboards, operationalize referral workflows, and facilitate the flow of referrals to identify care coordination needs. The partnering providers chosen were able to provide "culturally specific care coordination services to a wide variety of populations." Between May 7 and June 30, 369 clients were referred to partner organizations for care coordination and 192 were enrolled and served through the program. • Data Technology Initiatives: Elevate Health continues to work with Innovacer and has built and improved electronic workflows to improve care coordination and optimize workflows for the Health Homes program. They are also working together with contracted care coordination organizations to link EHR systems for bidirectional information sharing. • Community Health Information Exchange: Progress is being made on the multi-sector community health information exchange (CHIE). Elevate Health has worked on the cloud-based infrastructure, vetted vendors, is executing contracts with chosen vendors, and working with the community for case development. They plan to have preliminary activation structures established, with data, in the next reporting period.	• Provider Requests for Bridge Loans: Provider organizations were increasingly requesting bridge loans to fund the upfront work of County contracts. Providers do not have access to capital required to spend prior to seeking reimbursement for work under County contracts. OnePierce is disbursing funds to enable providers to allocate rental assistance and draw down their full contract amounts. • Health Disparities for People of Color: The COVID-19 pandemic has only served to worsen health-care disparities in economically suppressed communities of color. - Elevate Health has engaged with the African American Faith community to develop strategies that will address the pandemic's impact on residents of Tacoma's Hilltop district, which has historically been a low-income neighborhood impacted by rapid gentrification. • Behavioral Health Resources: There is a continued increase in behavioral health needs due to the COVID-19 pandemic. Elevate Health is working with local partners to develop a "Behavioral Health Workforce" strategic plan. • Business Intelligence Supports: Many community providers are having difficulty managing the personnel and finances associated with federal funding streams. Elevate Health continues to help build capacity and provide technical assistance to scale up their back office operations to manage the funds.

Table 12. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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 13. Greater Columbia ACH (GCACH) COVID-19 Observations

Findings for Greater Columbia ACH (GCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Health Workforce: GCACH implemented a CHW internship program to increase the adoption and capacity of care coordination within GCACH primary care organizations. The decision to implement the program was accelerated by the pandemic and need for improved outreach for services. They worked with Providence St. Mary Medical Center in Walla Walla to demonstrate the value of CHWs as part of a primary care team. This advocacy was needed to help providers see the financial savings and value-add of this position since it is not a reimbursable service. So far, eleven organizations were awarded $50,000 contracts in May, and another round will be offered in January, 2022. • Diversity, Equity, and Inclusion: GCACH established a new diversity, equity, and inclusion (DEI) program. A new social justice, equity, diversity, and inclusion (JEDI) specialist position will start a pilot program in partnership with the Tri-Cities Regional Chamber of Commerce's Inclusion Council to bring DEI groups together to discuss racism, disparities, and inequities within the region. GCACH plans to scale the program in 2022. • Social Determinants of Health (SDOH): The distribution priorities for $1.4 million budgeted for 2021 to address SDOH were changed due to the pandemic. The changes prioritized behavioral health, housing, food insecurity, and domestic violence that were elevated due to COVID-19. • Community Resiliency Campaign: GCACH launched a regional media and educational campaign, "Practice the Pause", geared to specifically address the "disillusionment" phase of the COVID-19 pandemic when you typically see increases in depression, acute stress, increases in domestic violence, and post-traumatic stress disorder. GCACH worked with Field Group marketing agency to develop toolkits in English and Spanish that have been distributed to school districts, skilled nursing and assisted living facilities, community colleges, domestic violence agencies, faith based organizations, food banks, public health districts, and behavioral health providers.	• Workforce Shortages: GCACH highlighted many risks and issues surrounding workforce issues. They include the inability to recruit, retain, and offer competitive wages to staff including primary care doctors at internal medicine sites, behavioral health specialists, substance use disorder counselors, care coordinators, and certified medical assistants. It was also noted that providers are unable to get applicants for positions such as registered nurses, certified nursing assistants. GCACH noted barriers to change of low reimbursement from MCOs, decreased supply of new MA graduates due to suspension of clinical training due to COVID-19, current workforce conditions, and personal life issues such as childcare and parental supervision for virtual schooling. Mitigation strategies GCACH is implementing include the Behavioral Health Internship and Training Fund, and the Community Health Worker Internship Program.

Table 14. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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 15. HealthierHere COVID-19 Observations

Findings for HealthierHere	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• FQHC Vaccine Support: HealthierHere worked with regional FQHCs on vaccine supply, staff capacity, space, and support for underserved communities. Through meetings with the FQHCs, the Indigenous Nations Committee, and the Community and Consumer Voice Committee, they made recommendations and then reallocated $840,000 from COVID-19 Emergency Response Funds to support the vaccination campaign and roll out an equitable and accessible vaccination campaign in King County. • Access and Engagement Services: HealthierHere has approved $2.3 million to expand community-based, non-licensed health care team members (e.g., CHWs, peer support specialists, cultural navigators, recovery coaches). Community Partner Network: HealthierHere worked with Gates Ventures and PHSKC to fund and coordinate 32 community partners to spread COVID-19 testing and safety information in local communities disproportionately impacted by COVID-19. The partners engaged more than 58,117 people (in 33 languages other than English) between December 2020 and March 2021. An evaluation of the project was conducted and focused on identifying barriers related to testing and safety protocols and successful strategies for information sharing and community engagement. The findings are being used to determine best practices for information sharing and community engagement going forward.	• Amplification of Ethnic/Racial Disparities: The pandemic highlighted and validated that communities of color see greater disparity in health outcomes and access to care. King County's COVID-19 Dashboard showed that the rate of positive cases was highest for Native Hawaiian/Pacific Islander, Hispanic/Latinx, Black, American Indian/Alaska Native, and Asian residents. HealthierHere is making investments to expand access and engagement to these populations. • Behavioral Health Needs: A dashboard was developed to track behavioral health needs and service utilization. The dashboard shows that anxiety and depression were at an all-time high from the end of 2020 through beginning of 2021. HealthierHere continues to make investments for providers to integrate physical and behavioral health, and to focus on families disproportionately impacted by the pandemic. • Workforce Shortages: The loss of staff and the insufficient supply of behavioral health professionals to meet increased demand for services (now and in the future) are considered risks to the health care system. • Access to Care: HealthierHere noted the following risks to access: - The lack of access to accurate, relevant, culturally appropriate and in-language information and care. - The increased need for SDOH services and supports without increased capacity to deliver such services and supports. • Housing Instability: HealthierHere noted the following risks due to housing instability: - Housing costs affect workforce shortages as they are a barrier to recruiting and retaining staff. - COVID-19 has resulted in loss of or reduced employment and many individuals are struggling to pay their rent or mortgage.

Table 16. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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

Table 17. North Central ACH COVID-19 Observations

Findings for North Central ACH (NCACH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Community Partner Engagement: There has been an increase in engagement from community partners through Community Based Care Coordination funding, the Coalitions for Health Improvement Imitative Funding, and expansion of Recovery Coaching efforts. CBO agencies increased from 27% of NCACH contracts for SAR6 to 49% for SAR7.	• Recovery Coach Program: COVID-19 delayed the Recovery Coach pilot program serving individuals leaving incarceration as in-person components of the service depends on high touch between Recovery Coach and the person seeking recovery support. Once restrictions were relaxed, the initial pilot with the Chelan County Regional Justice System was launched. The program is not planned for expansion in Grant and Okanogan Counties. • Behavioral Health: Rural areas are showing a strong correlation between mental health issues exacerbated by pandemic-related isolation and a surge in the opioid epidemic increasing both overdose and suicide rates. NCACH is working on initiatives to address the issue. - Expanding Recovery Coach trainings and will continue promoting recovery coaching with local partners. - Partnering with agencies that do homeless outreach to get Narcan directly into the hands of the individuals who need it. - Formed partnership with Beacon Health Options and placed two Narcan vending machines for low-barrier access to Narcan in strategic locations without needing a medical facility. - Worked with community partners to develop the Hope Squad model which supports suicide prevention and youth peer support in local school districts.

Table 18. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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

Table 19. North Sound ACH COVID-19 Observations

Findings for North Sound ACH	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Vaccine Access and Equity: Weekly meetings are held with local health jurisdictions, participating providers, and community organizations to push for equitable COVID testing access. The vaccination effort has now pivoted to vaccine equity. • Care Coordination: North Sound is the regional lead for the Washington State DOH's Care Connect Program. They connected 53 referrals impacted by COVID to resources including food and assistance with rent and utilities. • Communication: North Sound partnered with PeaceHealth and other community-based groups to provide greater access to multi-lingual COVID-19 education and materials. The group recorded testimonial videos, "Why I got vaccinated" which included members of the North Sound tribal communities. The videos were recorded in Spanish, Mixteco, Tagalog, Korean, Punjack, Vietnamese, and ASL. • COVID-19 Response Activities: North Sound served as Strategic Planning Unit Lead and Volunteer Section Chief for the Whatcom County's Unified Command Structure (WUC) COVID-19 response. Efforts developed included Whatcom County's medical surge plan, weekly surveillance reports, and staffing support for testing, vaccinations, and food distribution.	• Behavioral Health Shortages: - There are on-going and heightened workforce shortages, especially in behavioral health. - The largest behavioral health provider in the region closed several rural satellite clinics and no longer accepted new referrals for most of the reporting period. • Vaccine Access: Challenges of vaccine access include identifying providers with available supply, continually changing vaccine eligibility criteria, and getting vaccines to populations with accessibility barriers (e.g., language, work time restraints, transportation, and technology). • Social Determinants of Health: Accessing health services continues to be a challenge due to inadequate transportation, especially in rural areas. The pandemic also increased disparities in food access. Food access points saw disruption due to local shut-downs, decreases in sufficient stock and donations, staffing shortages, and funding decreases.

Table 20. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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 21. Olympic Community Health (OCH) COVID-19 Observations

Findings for Olympic Community Health (OCH)	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Behavioral Health Resources: - The Olympic Region Behavioral Health Report was released and presented to local government, the Board of Directors, and other regional community leaders. The report included the impact of COVID-19 on mental health needs in the region and suggested mitigation strategies. - OCH compiled a behavioral health resource packet, including creative strategies and example materials, to address behavioral health needs at the same time as COVID-19 vaccination. St. Michael Medical Center and Kitsap Public Health District have adopted the resources. • Relief Funds: OCH approved $399,000 in funding for seven COVID-19 project proposals supporting issues such as: vaccination access (home, mobile, and mass sites), outreach to vaccine hesitant populations, reducing homelessness and other social needs, and expansion of a tiny home village on the Makah Reservation. • Resilience Campaign: The "Plant Hope, Grow Resilience" campaign encourages individual, professional, and community resilience during the pandemic. OCH hosted a poster contest to encourage hope and resilience with 22 students submitting poster designs. The posters were made available to OCH partners for distribution in their communities.	• Workforce: Health care providers continue to report difficulty in recruiting and retaining staff. This is especially true among behavioral health and SUD providers.

Table 22. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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**

SWACH

Table 23. SWACH COVID-19 Observations

Findings for SWACH	
Examples of Pandemic Response Resiliency	**Examples of Pandemic Response Vulnerability**
• Partnerships: SWACH collaborated with multiple partners during the reporting period on COVID-19 outreach: - Worked with the Slavic Engagement Collaborative and its partners to build trusted relationships in the Slavic community to increase vaccine confidence. - Held community events with NAACP, LULAC, PICA, Odyssey World International, and others to distribute food kits to COVID-19 impacted households. - Coordinated with PeaceHealth and BIPOC community leaders to align HealthConnect food kit distribution with testing events prioritizing BIPOC. • Care Coordination: The Care Connect WA Program (CCWA) was launched with the DOH through the HealthConnect community-based care coordination infrastructure. The resources provide an immediate connection to community health workers who provide COVID-19 information and effective Q&I strategies, along with fresh food and financial support for housing costs (e.g., rent, mortgage, utilities) • Regional programming: SWACH partnered with WSU-Extension Clark County to develop and promote consistent regional evidence-based self-management programming for this calendar year. Programs include: Chronic Disease Self-Management Program (CDSMP), Chronic Pain Self-Management Programs (CPSMP), and Diabetes Prevention Program (DPP) which also supports COVID-19 recovery and Long-Haul effects.	• Delayed Service Provision: There is a continued need for timely household assistance payments as part of the CCWA program. SWACH is working with DOH to develop high efficiency payment systems to support COVID-19 quality improvement. • Delayed Referrals: SWACH was seeing delayed referrals into HealthConnect for Care Connect WA services. A workflow was built to support positive referrals from the Washington Disease Reporting System (WDRS) directly into HealthConnect hub to quickly send referrals. • Accessing Services: Partners were not utilizing the Hub due to multiple coordination barriers. This meant critical resources were not reaching impacted households. Mitigation strategies were implemented including complementary/alternative referral networks leveraging community based and clinical organization partnerships. HealthConnect will be a referral point for COVID-19 positive households going forward.

Table 24. Achievement Values and Earned Incentives for Reporting Period January 1, 2021 – June 30, 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	