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

Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 7.0

Reporting Period:

January 1, 2021 – June 30, 2021

DY5 Q1-Q2

Template Release Date: March 15, 2021

ACH contact information

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

ACH name:	Elevate Health
Primary contact name **Phone number** **E-mail address**	Alisha Fehrenbacher 253-370-9242 alisha@elevatehealth.org
Secondary contact name **Phone number** **E-mail address**	Jodi Castle 253-719-2592 jodi@elevatehealth.org

Section 1. ACH organizational updates

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

Attestations

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

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

[1] https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26

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

Documentation

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

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

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

    If applicable, include current organizational chart.

    Org Chart for SAR 7.pdf Org Chart Sar 7 HR Narrative .pdf

10. **Budget/funds flow.**

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

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

    - For COVID-19 related payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[2]

      No payments were made outside of the portal.

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

      No payments were made outside of the portal.

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

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

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

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

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

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

   iii. Description of use should be specific but concise.

Use of incentives to assist in the transition to integrated managed care		
Description of Use	**Expenditures ($)**	
	Actual	**Projected**
Allocation of integration incentive funds to Pierce County to be used to support projects around integration, transitions of care and crisis/diversion	4,485,000	120,000
Transition support incentives to behavioral health providers	1,000,000	-
Regional investments in IMC Learning Network	685,000	200,000
Direct technical assistance from Strategic Improvement Team	2,230,000	600,000
Sponsorship and management of the Whole-Person Care Collaborative for primary care and BH clinic teams	573,000	-
Investments in centralized technical assistance and data tools for behavioral health	1,150,000	-
TOTAL	**10,123,000**	**920,000**

Section 2. Project implementation status update

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

Attachments

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

12. Implementation work plan

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

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

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

Elevate Health is not submitting an updated implementation plan during this reporting cycle due to the extra focus on COVID-19 response efforts in the community with partners and providers.

13. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.[4] To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should use the template provided by the IA to indicate:

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

   ii. When the partnering provider site starts and ends engagement in transformation

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

activities according to project area by indicating the quarter and year.

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

Submit updated partnering provider roster.

Documentation

The ACH should provide documentation that addresses the following:

14. Quality improvement strategy update

The reporting requirements for the quality improvement strategy updates are temporarily replaced with COVID-19 related responses in the "Narrative Responses" section. The submission of quality improvement strategy updates are considered ***optional*** for this reporting period but are encouraged to the extent the ACH has an updated quality improvement strategy to keep HCA and the IA apprised of quality improvement activities and findings. If submitting updates, ACHs may determine the format to convey this information.[5]

Elevate Health will not be submitting a Quality Improvement Strategy update this reporting period.

Narrative responses

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

15. COVID-19

a) Provide an update on COVID-19 activities. If applicable, please describe any support of vaccine efforts, or other ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., PPE, project management, communication and engagement, coordination of funding).

Positioned at the intersection of public health, social services, and health delivery systems, Elevate Health and OnePierce Community Resiliency Fund (OnePierce) have continued to adapt and respond to critical community needs in the evolving climate of the COVID-19 pandemic. Elevate Health has continued to leverage the Care Continuum Network's (CCN) care coordination programs to scale its approach to meet public health ends and provide support to the most vulnerable populations during the ongoing COVID-19 crisis in our community. Additionally, OnePierce has leveraged and invested funding to support providers, both fiscally and transactionally, and enhance housing capacity. Many ACH activities have pivoted to address new needs or slowed/paused due to partners' involvement in emergency pandemic response.

OnePierce Community Resiliency Fund (OnePierce) Activities: On Track, Expanded

OnePierce Community Resiliency Fund, the investment arm of Elevate Health, has continued to remain agile in accomodating COVID-19 pandemic demands by means of: 1) Responsive community bridge loans for rental assistance providers, 2) Local investment for creation of additional housing units, and 3) Development of a capacity building program to aide providers with technical and financial back office services supports.

1. ***Community Bridge Loans:*** *In addition to Elevate Health's funding for partners during COVID-*

19, OnePierce Community Resiliency Fund – the investment arm of Elevate Health – revolved community loans to support rental assistance providers. In February 2021, OnePierce received repayments of bridge loans from human services providers contracted to Pierce County for CARES funds. In March, OnePierce approved a second bridge loans program. By June, OnePierce had disbursed $2.63M in loans to community providers delivering rental assistance to families and individuals in need.

2. ***Community Capacity Building Program:*** *OnePierce also began a capacity building program during this period by referring community partners to business support services and by developing technical assistance frameworks. This activity is a response to the needs of organizations highlighted by COVID-19 in our community.*
3. ***Community Investment for Supportive Housing Units:*** *To support the creation of additional units of housing, OnePierce re-committed $250,000 to a local church intending to re-develop its property into 42 units of affordable and supportive housing.*

Care Continuum Network (CCN) Activities: On Track, Expanded

The CCN consists of three care coordination programs (Pathways, CHAT, and Health Homes) that support vulnerable populations by addressing both health and socio-environmental needs. The services Elevate Health has continued to offer through care coordination have become critical as our community addresses the enhanced biopsychsocial needs of individuals who are at high-risk for contracting COVID-19, as well as those exposed to, and positive for the virus.

1. ***Department of Health Washington Care Connect Program Contract:*** *During this reporting period, Elevate Health contractually partnered with the Washington State Department of Health (DOH) to continue providing COVID-19 specific care coordination support to Pierce County. Elevate Health's Washington Care Connect program was founded on the work we completed in December 2020 with CARES Act funding, where a COVID-19 program was developed, to include a specific needs assessment and care coordination workflow within our software platform. Elevate Health was able to successfully work with the DOH to utilize our existing software tools versus a new system for case management documentation, saving the State both time and money. As such, Elevate Health revised and improved the electronic workflows to create a more streamlined documentation experience for the care coordinator and align with all data requirements set forth by the State.*

   In order to accomplish the work set forth by the DOH contract, Elevate Health partnered closely with the Tacoma Pierce County Health Department (TPCHD) to create custom dashboards and operationalize referral workflows from their ArcGIS platform. TPCHD facilitated the flow of COVID-19 positive referrals directly from TPCHD Case and Contact Investigation Teams to Elevate Health for identified care coordination needs. Elevate Health partnered with five network agencies to perform the care coordination work in this program, to include SeaMar Community Health Centers, Viriginia Mason Franciscan Health, Korean Women's Association (KWA), Hope Sparks Family Services, and Casteele, Williams, and Associates (CWA). Many of these partners were selected for their ability to provide culturally specific care coordination services to a wide variety of populations within Pierce County, including (but not limited to) the local Latinx community, the East Asian community, and the Black and African American community. Within our network of care coordinators, 7 of the 10 are bilingual, offering in-culture services for Spanish, Vietnamese, and Korean speaking clients.

Care Coordinators selected for this program were formally trained on software workflows and assessments on May 6, 2021. Elevate Health began formally accepting referrals on May 7, 2021. As of the end of June, Elevate Health referred 369 clients to partner organizations for care coordination, with 192 individuals and family members enrolled and served through the program. In May and June, Elevate Health distributed approximately $13k in partner payments and $14K in funding to assist 63 individuals and families with utilities, housing payments, and fresh food assistance. The majority of referred individuals are those who've tested positive for COVID versus exposed.

2. ***Cross-Use of DOH Funding for Washington Care Connect for Tacoma Pierce County Health Department:*** *Elevate Health was contractually required to distribute the first wave of Washington Care Connnect program dollars on a very short timeline (from May 7 through June 20, 2021). In an effort to utilize this funding to the fullest extent for community benefit, Elevate Health also contracted with Tacoma Pierce County Health Department (TPCHD) to support ongoing COVID-19 efforts. Elevate Health, with DOH approval, contracted with TPCHD to provide $200k of additional funding for cell phones, rental assistance for the wareshousing of care and non-perishable food storage kits, and deliveries of these and other necessary resources for maintenance of isolation and quarantine.*

3. ***Request for Funding Assistance (RFA) and Budget Workbook Submission for Y2 DOH Washington Care Connect funding:*** *During this reporting period, Elevate Health also submitted a new RFA and budget workbook for Y2 regional hub funding in the amount of $2M. As part of this budget, Elevate Health will allocate $18k per month to the Tacoma Pierce County Health Department to continue to pay warehousing rental fees for necessary personal care and food kits.*

4. ***Personal Protective Equipment Distribution Activities: On Track, Ongoing:*** *Elevate Health has continued to support the warehousing and distribution of PPE throughout the Pierce County community during this reporting period. Sourced through the Washington State Emergency Operations Center, Elevate Health has distributed 199,655 pieces of PPE to community partners and organizations over the past 6 months.*

5. ***Data Technology Initiatives; On track, Expanded Innovaccer Population Health and Care Coordination Product Development:*** *In effort to overcome technological silos, which fail to facilitate timely, equitable, cohesive, integrated, whole-person care, Elevate Health has continued active collaboration efforts with our data platform partners at Innovaccer. The COVID-19 pandemic environment has cast a spotlight on rapid data sharing and systems interoperability as an imperative to public health; effective community health interventions require collaborative data enterprises. To this end, Elevate Health has maintained a primary focus on shared data innovations as a primary pillar of our work. Once such investment has been Innovaccer as our primary data platform. Innovaccer offers an infrastructure which allows multiple organizations to work together on the same platform by means of robust API interoperability and utilizes advanced analytics to create a 360-degree view of a client/patient on a micro level and a comprehensive view of community health on a macro-level. This technology gives decision-makers the information necessary to drive responsive, community-centered interventions and draft policies that address gaps in care.*

Together with Innovaccer, Elevate Health has architected several electronic workflows during the past 6 months to support ongoing care coordination program activities, many of which directly and/or indirectly serve those affected by COVID-19. During this reporting period, Elevate Health utilized the COVID-19 workflow developed Q4 of 2020 to continue care coordination endeavors under the DOH Washington Care Connect Program. Moreover, Innovaccer aided Elevate Health in developing Potentially Preventable Hospitalizations Heart Failure and Mobile Integrated Health Care workflows to help support and launch care coordination partnership pilots in the community. With the assistance of Innovaccer, additional product development work was executed to optimize our Health Homes program workflows for HCA compliance and configure interoperational billing structures to support program activites. Moreover, Innovaccer and Pathways Community Hub Institute have worked alongside Elevate Health staff to create a new build for PCHI's recently published 2.0 model, which is ongoing.

In addition to product development work, Innovaccer has partnered with Elevate Health to further engage with contracted care coordination organizations to develop birdirectional data feeds with their respective Electronic Health Records (HER) systems. As partner care coordination data is entered into Elevate Health's Innovaccer instance, these bidirectional feeds further break down silos and allow providers to view care coordination activities and interventions at point of service from their EHRs. Conversely, these data channels will also allow select data streams into Innovaccer for care coordinators to access while working with clients. Elevate Health has engaged both a local Federally Qualified Health Care Center (FQHC) and regional health care system in these collaborations.

6. ***Community Health Information Exchange (CHIE); On Track, Progressing***
To the end of developing a more robust care delivery infrastructure by leveraging data resources, Elevate Health hired a team of subject matter experts to drive project planning, technological architecture, and strategy development for a multi-sector community health information exchange (CHIE) as a legacy asset. While this effort is not yet meeting an immediate pandemic need, Pierce County Human Services recognized the importance of this work for public health emergency management with a CARES Act funding grant Q4 of last year. During this reporting period, Elevate Health has been actively engaged with local county council members regarding additional funding for futher expansion efforts. Elevate Health is also involved in early collaborations with United Way/211 for CHIE planning with a Common Spirit Grant award.

Elevate Health has mapped the cloud-based infrastructure for the CHIE's cloud-based environment, has performed due diligence in vetting vendors within the architecture, and is presently engaged in contract execution with chosen vendors for this technical integration enterprise. Elevate Health has been in conversations with the community for discovery around use case development. By Q3, Elevate Health anticipates having the preliminary activation structures established with data landed.

b) During this reporting period, has your ACH made any notable changes or decisions related to your DSRIP activities? For example, are there updates regarding your region's balancing of COVID-19 response and activities that were already in motion?

During this reporting period, Elevate Health advanced progress around previously forestalled DSRIP initiatives, while simultaneously attending to the unique regional challenges presented by

COVID-19. Please refer to Section 15 above for progress around COVID-19 related activites. While assisting with communal COVID response, Elevate Heath experienced successes in reinstituting iniatives such as the Pierce County Opioid Task Force, Trueblood Activities, Emergency Medical Services Collaboration, and Medical Respite. Additionally, we launched two care coordination pilots, which include a TPCHD Potentially Preventable Hosptializations pilot in partnership with Community Health Clinic, as well as the Mobile Integrated Health Care pilot with Multicare Health System and Sea Mar Community Health Center. Please see Section 17 below for updates on these specific projects.

c) Describe any updates, new approaches, or new partnerships related to how your ACH has included Tribes/IHCPs in your COVID-19 response activities.

The Nurse Family Partnership Program funded by Elevate Health to improve maternal-child outcomes with the Puyallup Tribe has remained operational, with staff conducting visits and follow-ups with clients utilizing telephonic and virtual technologies. During the course of this reporting period, 26 tribal families have been enrolled in the Nurse Family Partnership program. Elevate Health has provided ongoing support to the Tribe in the provision of face masks acquired from state and local resources. Elevate Health has also initiated conversations with the Puyallup Tribe to provide funding to embed an in-culture community health worker as part of integration efforts with the Nurse Family Partnership program. The Care Continuum Network (CCN) provided a Pathways Community Hub Institute (PCHI) presentation to the Tribe in March and has continued outreach since that time to engage Tribal partners in this initiative.

d) Specific to partnering providers, describe any updates, new approaches regarding provider contracts, reporting, type of providers engaged, support provided, and/or payment strategies.

Provider/Partner Contracts: *During the last reporting period, Elevate Health loosened contractual reporting requirements for partner organizations given capacity and funding limitations to support standard operations in the pandemic environment. Unfortunately, Elevate Health did not achieve anticipated milestones and received a reduction in funding as a result of these responsive accomodations. Elevate Health achieved 41% of the State's calculated pay for performance (P4P) measures, which impacted the requisite conditions of existing Binding Letters of Agreement (BLA). Elevate Health subsequently collaborated with community partners to reassess and revise BLAs consistent with identified needs in community-based care coordination, community information exchange, whole-person care, and/or workforce development. Elevate Health staff worked closely with partner organizaions to identify metrics and deliverables to both maximize funding opportunities and meet P4P goals. Finally, in order to create greater opportunity and flexibility for multiple partnerships, Elevate Health determined to move forward with single-partner agreements only.*

Engagement with BIPOC Providers: *In recognition of the growing disparities in BIPOC communities as a result of COVID-19, Elevate Health concertedly outreached organizations serving Latinx, Asian, Black, and Pacific Islander Communities. During the reporting period, Elevate Health funded a Care Coordinator position with Casteele, Williams and Associates, an*

organization serving the Black community. Elevate Health funded the position, aided in writing job descriptions, and provided laptops and training in COVID-19 and Pathways programs through the CCN. The Care Coordinator through Casteele, Williams, and Associates has been able to provide in-culture services to support COVID-19 needs in Tacoma's Black community. We also liaised between Casteele, Williams and Associates and the Tacoma Pierce County Health Department around ensuring vaccine availability for the Black community in Southeast Tacoma. Elevate Health also conducted outreach to Black Infant Health Program through the Tacoma Pierce County Health Department and initiated discussions regarding potentially funding a Care Coordinator position for COVID-19 response and integrated care. Elevate Health has continued engagement work with the Puyallup Tribe and began conversations with Samoan Nurses of Washington (SNOW) to determine how best to partner around in-culture COVID-19 supports.

e) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access), including any notable impacts to specific providers or communities. Also highlight any mitigation strategies or activities that shifted as a result, if applicable.

Elevate Health and OnePierceElevate Health and OnePierce have recognized a number of risks and challenges since the emergence of COVID-19, which continue to evolve and change the landscape of service demands in Pierce County. During this reporting period, specifically, Elevate Health has assessed community need and engaged in interventional efforts around the following:

1. ***Provider Requests for Bridge Loans:*** *OnePierce noted an increase in the number of healthcare and human services provider organizations requesting bridge loans to fund the upfront work of County contracts. With the influx of federal and state funds into our community, many providers do not have access to the capital they are required to spend prior to seeking reimbursement for their work under County contracts. OnePierce approved and disbursed $2.63M in the first half of 2021 to six providers of rental assistance contracts. These funds are enabling the providers to allocate rental assistance and draw down their full contract amounts. It is an example of public-private partnership work that OnePierce has undertaken with Pierce County and the local philanthropic community.*
2. ***Business Intelligence Supports with Federal Funding Streams:*** *An additional risk that continues with the flow of federal funds into our county is the capacity of providers to manage the personnel and finances associated with the award amounts. Capacity building and technical assistance are required for many providers to scale up their back office operations to manage the funds.The provision of back-office supports to community providers continues to be a primary strategy of Elevate Health's sustainability plans.*
3. ***Stable and Affordable Housing Needs:*** *We have also identified risks in Pierce County, as in all other Counties, around housing affordability and stability during the COVID recovery period. To support the creation of additional units of housing, OnePierce re-committed $250,000 to a local church intending to re-develop its property into 42 units of affordable and supportive housing.*
4. ***Scarcity of Behavioral Health Service Provider Resources:*** *Behavioral health service needs have increased significantly as a result of the COVID-19 pandemic. In recognition of this substantial need, Elevate Health has been working together with local partners, 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.

5. ***Worsening Health Disparities for People of Color:*** *The COVID-19 pandemic has only worsened health-care disparities in economically suppressed communities of color. To address this concern, 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.*

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

OnePierce: *OnePierce finalized a $2M investment from CommonSpirit Health to blend and braid into its funding available to fulfill Elevate Health's mission.*

Care Coordination through the Care Continuum Network (CCN): *Elevate Health developed a COVID-19 Care Coordination model for assessing and addressing SDoH needs; this model was implemented in December of 2020 with ongoing use into this reporting period. This model was developed to be utilized with any other community care coordination programs to increase workforce capacity for COVID-19 response with an agnostic workflow and better accommodate CARES Act funding structures and audit requirements. Please see Section 15.a) for additional details. The programmatic work, to include the workflow developed for local CARES Act funding, has also been instituted with our DOH Washington Care Connect contract signed in June of 2021. Notably, Elevate Health also onboarded North Sound Accountable Community of Health onto our software platform instance and shared our COVID-19 workflows and programmatic resources for use in their respective service regions.*

Scale and sustain update

a) In SAR 6.0, ACHs reported on activities and/or conversations regarding the sustainability of DSRIP funded infrastructure, activities, and/or evidence-based models. Please describe relevant updates from the reporting period. These could include (but are not limited to) board decision regarding priority ACH investments and projects, strategic planning results, community/partner engagement, sustainability planning TA or coordination, etc.

Elevate Health's Board of Directors, Community Advisory Council, and staff have been working on sustainability of the accountable community of health. The Board, committees, staff, and partners have continually engaged formally and informally in workgroups, planning sessions, and board meetings to use data, experiences, and common values to ensure the regional table allows for transparency, innovation, shared and leveraged resources, and opportunities for strategic partnership. The organization and its subsidiary, OnePierce Community Resiliency Fund, have developed a multiyear strategic business plan that braids and blends funding from contracts inside and outside of the healthcare space to support equitable health improvement. Work continues to progress at the board level focused on governance around the community health information exchange, care continuum network and the overall community engagement strategies and activation table ensuring long-term coalition building and collaboration for equitable health and economic vitality within the region.

b) In SAR 6.0, some ACHs reported that P4P incentives for DY4 and DY5, to be paid out in 2022 and 2023, had been obligated, and others reported they had not been obligated. Please provide any updates based on this reporting period, or simply indicate "no updates" as applicable.

   i. Have P4P incentive funds for DY4 and DY5 (to be paid out in 2022 and 2023) been obligated? *No updates.*

   ii. What types of entities are those funds obligated to? *No updates*.

   iii. Will the ACH retain some of this funding for post-2021 admin? *No updates.*

   iv. Are providers receiving any of these funds for P4P or for future deliverables? *No updates.*

c) If applicable, describe how any other P4R or P4P funds (already earned or to be earned before the end of the DSRIP period) have been obligated for ACH or provider payments post-2021. *No updates.*

16. Regional integrated managed care implementation update

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

As Elevate Health continues to work with both providers and managed care organizations, we have assessed and addressed integrated managed care challenges in the following ways:

Challenge: *We have no place for shared-client data.*

Means of Address: *We have encoureaged providers to incorporate Collective Medical. Collective Medical presented to the IMC Learning Network. We are meeting with individual agencies to discuss the benefits of using Collective Medical and promoting the MCOs financial support with this collaboration.*

Challenge: *Providers have reported that payment is still delayed by certain payers. Payers have requested that providers reach out to them directly to address payment concerns. Additionally, providers have reported initial information provided for authorization impacts delays or denials in authorization. Furthermore, providers cite that denials are laborious and costly in that the back-forth utilization review process and second level review requires additional staffing and time investments.*

Means of Address: *Elevate Health addressed these issues by bringing concerns forward during joint monthly meetings. Elevate Health provided a neutral space and mediated concerns, facilitating an environment of open communication. Elevate Health also modified its approach to these monthly meetings, and divided them to allow time for providers to discuss concerns without payers present. This allowed more space for providers to problem solve together. When payers join the meeting, providers can share a more comprehensive list of concerns and propositions for solution-focused work.*

Challenge: *Pierce County is experiencing a behavioral health crisis. A severe workforce shortage and COVID-19 have only exacerbated that crisis. For pediatric emergencies, on average, parents have to make 26 phone calls and wait weeks to months to get their children the help they need. For adults, finding the requisite support to manage behavioral health and medical health care is also very difficult.*

Means of Address: *Pediatrics - Elevate Health convened Pediatrics Northwest and HopeSparks to form an integrated, collaborative care partnership with children and their families. The Bridge of Hope model has successfully imbedded Behavioral Health Case Managers in Pediatrics Northwest primary care clinic to work closely with primary care providers and psychiatric consultants to provide brief, evidence-based interventions for depression, anxiety, ADHD, and other presenting behavioral challenges. The model offers patient-centered multidisciplinary assessment, measurement-based treatment, evidence-based practices, population-specific care, and accountable outcomes. During this reporting period, Hope Sparks and Elevate Health have been engaging healthcare system providers and managed care organizations around the spread and scale of this model. Since January 2021, Bridge of Hope has graduated 842 chilren and youth from treatment, with an average of 69% of clients showing an improvement in diagnostic symptomology.*

Means of Address: *Adults - Elevate Health is leading an integration pilot project with MultiCare Health System (MHS) and Sea Mar Community Health Clinic specific to the seriously mentally ill (SMI) population cohort. The pilot objective is to identify and address SDoH needs in a pre-identified SMI population with the integration of Communty-Based Care Coordination services within the Mobile Integrated Primary Health Care model asserted by MHS. The MHS mobile medical van travels to identified sites to provide adaptive primary care to patients at several of their mental health facilities. At point of service, clients are screened for SDoH challenges and barriers by the medical ARNP, who is then referring clients for care coordination services through SeaMar. Community Health Workers (CHW) performing care coordination services are utilizing the Pathways Community HUB model as evidence-based practice. As of the writing of this report, the pilot is active, with data collection ongoing.*

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

Community Communication and Facilitation: *Elevate Health continues to bridge the communication and information sharing gaps between the providers and payors of Pierce County. Elevate Health also has invited additional providers to the table to learn the services and processes of our MCO partners. Elevate Health's Director of Clinical Integration and Transformation is responsible for this work with local, regional, and statewide partners. She has a clinical background and experience working with various healthcare, behavioral health, and managed care organizations.*

We host regular 1:1 meetings with providers and payers to openly engage conversation about improvements of the IMC meeting with the goal of addressing challenges. Ongoing relationship building and collaboration is a key tactic for Elevate Health as we move through 2021.

The Elevate Health IMC Facilitator (Director of Clinical Integration and Transformation) also engages in meetings with WA State ACHs and MCOs to improve processes and build standard practices. We have also begun the process of reinstituting the Provider Integration Panel and forming work groups to address identified gaps/barriers focusing on solutions.

Medical Respite Initiative: *One glaring gap in Pierce County is the lack of transitional medical care for patients who continue to challenge the health system with lengthy hospital stays and emergency department utilization. These patients are medically stable for discharge to a lower level of care in the*

continuum, but lower level of care to facilitate healing and prevent hospital readmissions currently exists. Elevate Health convened key stakeholders to conduct a landscape assessment of data, learnings from previous endeavors, and current state of need. As a result of this work, Elevate Health has formed a Medical Respite Steering Committee and has obtained a commitment from Community Health Care to be the onsite medical, dental, and behavioral health care provider.

Potentially Preventable Hospitalizations (PPH) CHF Pilot: *The Potentially Preventable Hospitalizations initiative targets community-based interventions for those regions with the highest state-wide rates of PPH. With a focus on population health cohorts within the six highest-risk zip codes in Pierce County, Elevate Health launched a pilot in May, supported by the Tacoma Pierce County Health Department to assess the efficacy of care coordination interventions with CHF patients with Community Health Clinics in the 98444 zip code. During the previous reporting period, Elevate Health developed the pilot logic model, identified key performance indicators, engaged partners, developed CHF in-scope curriculum for community health workers, formalized a specialized model and workflow within Innovaccer, and completed all necessary operational documents (policies and procedures, training materials, and consents). At the writing of this report, Tacoma Pierce County Health Department is working on a second contract with Elevate Health to financially support his work though the PPH Collaborative. In less than 2 months, 15 clients were enrolled in the program, with 23 medical referrals made, 23 medical appointments facilitated, and 12 social service referrals initiated.*

Mobile Integrated Healthcare Clinic: *Elevate Health is leading an integration pilot project with MultiCare Health System (MHS) and Sea Mar Community Health Clinic specific to the seriously mentally ill (SMI) population cohort. The pilot objective is to identify and address SDoH needs in a pre-identified SMI population with the integration of Communty-Based Care Coordination services within the Mobile Integrated Primary Health Care model asserted by MHS. The MHS mobile medical van travels to identified sites to provide adaptive primary care to patients within their mental health system. At point of service, clients are screened for SDoH challenges and barriers by the medical ARNP, who is then referring clients for care coordination services through SeaMar. Community Health Workers (CHW) performing care coordination services are utilizing the Pathways Community HUB model as evidence-based practice. As of the writing of this report, the pilot is active, with data collection ongoing.*

The Pierce County Opioid Task Force: *The Pierce County Opioid Task Force (OTF) is a group of local and state stakeholders who actively work to find real and sustainable solutions to the opioid epidemic. Elevate Health operates in close collaboration with the Tacoma Pierce County Health Department (TPCHD) as a convening agent, thought partner, educator and driver of forward progress. During the COVID-19 pandemic, the frequency of task force meetings was reduced from weekly to monthly and the TPCHD OTF Coordinator exited his position; as such, this work was significantly forestalled. During this reporting period, Elevate Health has made great gains in reinstating this initiative. Elevate Health aided TPCHD with hiring activites for another OTF Coordinator and engaged in strategic planning. Additionally, Elevate Health planned, organized, funded, and hosted the 3rd Annual Pierce County Opioid Summit for the community on March 3,2021. The OTF Summit successfully registered 153 participants and included guest speakers from The Greater Spokane Substance Abuse Council, Safe Streets Tacoma, and Alchemy Skateboarding.*

Multidisciplinary Health and Education Center: *Elevate Health is a participant and funding partner for a large medical-dental school primary care integration project. Elevate Health is presently sponsoring*

salary costs for both a medical doctor (MD) and doctor of dental surgery (DDS) as primary project consultants. The proposed Multidisciplinary Health and Education Center is a partnership between Elevate Health, Sea Mar Community Health Centers, MultiCare Health System, Yakima Valley Farmworkers Clinic and Pacific Northwest University of Health Sciences. The project serves two purposes: to develop medical health and dental workforce in an equitable way and to bring more medical and dental professionals to rural and underserved areas.

PNWU has established an accelerated Doctor of Osteopathic medicine program with proven success in sending their graduates to serve in these areas. Now, they will expand that program to include a new College of Dental Medicine that will produce "primary care dentists" who will commit to serve in underserved areas. They are doing this by combining the medical and dental students in the same classes for the first year of training. For the second year, 12 dental students will be placed with Sea Mar and 24 with Yakima Valley Farm Workers Program (2 sites). Each year, 12 more students will be added to the clinics. All students will be trained in the Federically Qualified Healthcare Center (FQHC) multidisciplinary model of delivering whole person care with exposure to a unified electronic health record.

Once the project is well advanced, Elevate Health will also play a role as a conduit for faciltiative integration between these clinics by providing the care coordination for patients with SDoH needs. The multidisciplinary health and education center will provide the clinical site for training, both didactic and practicum. The goal is to bring all healthcare disciplines to this center to provide clinical training for the healthcare student in a multidisciplinary clinic serving the large Medicaid population in our area. This is the only model of its kind in the nation.

Emergency Medical Services Fire Districts: *In 2020, Elevate Health partnered with seven (7) EMS Fire Districts on a plan to reduce avoidable 9-1-1 calls and EMS transports. This collaborative aimed to develop best practices and strategies in accomplishing the goal of reducing avoidable EMS service usage. Initial goals set forth in collaboration with the Fire Districts around the implementation of telehealth services were derailed because of the COVID-19 crisis. As such, Elevate Health met with each of the Fire Districts during this past reporting period to outline individual and collective DSRIP goals and write contracts. In addition to these activities, Elevate Health received a $250k Cambia Foundation grant in December 2020, and received funding to bolster behavioral health (to include SUD) efforts in rural communities as a responsive intervention in the pandemic and post-pandemic environments. Elevate Health is working actively with rural Fire Districts in Key Peninsula, Orting and Graham, as well as with Comprehensive Life Resources' Mobile Community Intervention Response Team (MCIRT). Together with the MCIRT team, the aims of this project include providing community-based education to address stigma, crisis management, managing stress during COVID, and promoting connection to services to support wellness.*

*For **all regions**, what challenges or opportunities has the ACH identified during the reporting period tied to clinical integration measurement and assessment?*

Measuring integration continues to be a challenge in our region. To remedy this, our Director of Integration and Transformation has remained active in the Integration Assessment Work Group to build an assessment tool that will work for MCOs and providers and reduce redundancy in assessing levels of integration. The tool is being piloted and is set to be released for general use soon.

Attestations

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

	Yes	No
17. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to: • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.	X	

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

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

Documentation

18. P4R Metrics

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

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.[6] Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

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

Instructions:

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

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

Format:

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

Narrative responses:

19. If the ACH **is not** providing updates on the MeHAF this reporting period, please describe what, if anything, the ACH is doing instead to assess partnering provider implementation progress at a clinic/site level?

Elevate Health is doing a number of things to assess partnering provider implementation progress at the clinic/site level.

1. *Our CCN Director of Clinical Integration and Transformation continues to meet 1:1 with our partners to assess their integration progress and strategize how we might partner around increased integration. For example, we are in the process of negotiating BLAs with an FQHC and a behavioral health clinic to bring mental health professionals into their clinical space for*

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

ease of patient access. We have also helped them establish a referral process to get patients into behavioral health treatment at accelerated rates.

2. *We have begun pilot projects with partners to assess the effects of care coordination on integration. See our MIHC and Potentially Preventable Hospitalizations pilot projects mentioned above.*
3. *We continue to lead the Integrated Managed Care meetings for our partners and the MCOs to provide a space for networking, information sharing, and integrations assessment.*

21. If the ACH **is** providing updates on the MeHAF this reporting period, please provide any additional context if applicable.

Optional: The ACH <u>may</u> submit P4R metric information

Elevate Health is not submitting P4R metric information during this reporting cycle.

Elevate Health

January 1-June 30, 2021

Cumulative snapshot	
Funds Earned	$ 79,015,322.55
Funds Distributed	$ 60,391,780.60
Funds available	$ 18,623,541.95

Table 1: Incentive Funds earned

	Q1	Q2	Q3	Q4	Total
Project 2A	$ -	$ 3,220,060.00			$ 3,220,060.00
Project 2B	$ -	$ 2,080,376.00			$ 2,080,376.00
Project 3A	$ -	$ 408,021.00			$ 408,021.00
Project 3D	$ -	$ 736,653.00			$ 736,653.00
VBP	$ 250,000.00	$ 150,000.00			$ 400,000.00
Bonus pool/High Performance Pool		$ 2,161,188.00			$ 2,161,188.00
Total	**$ 250,000.00**	**$ 8,756,298.00**			$ 9,006,298.00

Table 2: Interest accrued for funds in FE portal

	Q1	Q2	Q3	Q4	Total
Interest accrued	$ -	$ -			$ -

Table 3: Incentive funds distributed, by use category

	Q1	Q2	Q3	Q4	Total
Administration	$ 200,000.00	$ 500,000.00			$ 700,000.00
Community health fund	$ -	$ -			$ -
Health systems and community capacity building	$ 584,630.00	$ 897,593.52			$ 1,482,223.52
Integration incentives	$ -	$ -			$ -
Project management	$ -	$ -			$ -
Provider engagement, participation, and implementation	$ 684,050.02	$ 794,842.51			$ 1,478,892.53
Provider performance and quality incentives	$ -	$ 250,000.00			$ 250,000.00
reserve/contigency fund	$ -	$ -			$ -
Total	**$ 1,468,680.02**	**$ 2,442,436.03**			$ 3,911,116.05

Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on July 21, 2021 to accompany the seventh Semi-Annual Report submission for the reporting period January 1 to June 30, 2021.