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

Medicaid Transformation
Accountable Communities of Health
Demonstration Year 6 (DY6) Pay-for-Reporting (P4R) Report Guidance

DY6 P4R 1 Report

Updated Template Release Date: February 1, 2022

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Semi-annual report information and submission instructions

Purpose and objectives of ACH DY6 P4R report

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

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

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

Achievement values

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

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

Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for DY6 P4R 1 report

	BHT	CPAA	EH	GCACH	HH	NC	NS	OCH	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	4	6	8	6	4
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
Completion of all P4R metrics. This includes any current MeHAF assessments and CIAT support to providers.	2	2	2	2	2	2	2	2	2
Total AVs Available	14	20	14	14	14	20	26	20	14

Table 2. Potential P4R AVs for Project Incentives for DY6 P4R 1 report

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	4	3	-	-	4	-	-	3	14
Cascade Pacific Action Alliance	4	3	3	-	4	3	-	3	20
Elevate Health	4	3	-	-	4	-	-	3	14
Greater Columbia ACH	4	-	3	-	4	-	-	3	14
HealthierHere	4	-	3	-	4	-	-	3	14
North Central ACH	4	3	3	3	4	-	-	3	20
North Sound ACH	4	3	3	3	4	3	3	3	26
Olympic Community of Health	4	-	-	3	4	3	3	3	20
SWACH	4	3	-	-	4	-	-	3	14

Reporting requirements

This report includes the sections outlined below.

DY6 P4R 1 report requirements		
Section	**Item num**	**Sub-section components**
Section 1. Project implementation status update	1	Attachments - Partnering provider roster
	2 - 3	Narrative responses - COVID-19 - Scale and sustain update
	4 - 6	Attestations
Section 2. Pay-for-Reporting (P4R) metrics	7	Documentation

There is no set template for the DY6 P4R report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

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

File format

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

- *Main Report or Full PDF:* ACH Name.DY6 P4R 1 Report.04.08.22
- *Partnering provider roster:* ACH Name. DY6 P4R 1.Provider roster.04.08.22

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

DY6 P4R report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than April 8, 2022 at 3:00p.m. PST.**

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

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

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "DY6 P4R Report 1."

The folder path in the ACH's directory is:

P4R Reports → DY 6 P4R Report 1.

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

DY6 P4R report submission and assessment timeline

Below is a high-level timeline for assessment of the DY6 P4R reports.

ACH submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute DY6 P4R report instructions to ACHs	IA	January 2022
2.	Submit DY6 P4R report	ACHs	April 8, 2022
3.	Begin assessment of reports	IA	April 8, 2022
4.	If needed, issue information request to ACHs within 10 calendar days of report due date	IA	April 18, 2022
5.	If needed, respond to information request within 7 calendar days of receipt	ACHs	April 25, 2022
6.	If needed, review additional information within 7 calendar days of receipt	IA	May 1, 2022
7.	Issue findings to HCA for approval	IA	May 6, 2022

Contact information

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

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

ACH contact information

Include in the DY6 P4R report the contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's DY6 P4R report. If secondary contacts should be included in communications, also include their information.

ACH name:	HealthierHere
Primary contact name **Phone number** **E-mail address**	Gena Morgan, Chief Operating Officer 206.849.6262 gmorgan@healthierhere.org
Secondary contact name **Phone number** **E-mail address**	Susan McLaughlin, Chief Executive Officer 206.790.3709 smclaughlin@healthierhere.org

Section 1. Status update

The following sub-sections are required components of the ACH's DY6 P4R 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:

1. Partnering provider roster.

To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that reflect **all partnering providers** that are participating in efforts through the ACH under Medicaid Transformation.[2]

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

[2] 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). Nontraditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable health care services to Medicaid members (e.g., behavioral health organizations, community-based organizations, fire districts).

column(s) with Y/N.

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

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

Submit updated partnering provider roster.

HealthierHere Response

The updated partnering provider roster is attached.

Narrative responses

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

2. Challenges and mitigation activities

a) Provide an update on COVID-19 response and recovery activities, as well as any other relevant disaster declarations or similar crises in your region. Please describe ACH activities that emerged or evolved since January 1, 2022 (e.g., project management, communication and engagement, coordination of funding, etc.).

HealthierHere Response

Below is a summary of COVID-19 response and recovery activities that have emerged or evolved since January 1, 2022. These activities are focused on supporting providers in their COVID-19 stabilization efforts and expanding health care access and engagement in King County.

Community Health Workers for COVID Response and Resilient Communities (CHW-CARE). HealthierHere was awarded $54,000 a year to join forces with Public Health – Seattle & King County (PHSKC), Center for MultiCultural Health, Healthy King County Coalition, International Community Health Services, Global to Local, and Seattle Children's Hospital to launch the CDC-funded initiative, CHW-CARE. The project aims to strengthen community resilience to fight COVID-19 through training, deploying, and increasing engagement/adoption of community health workers (CHWs).

Goals for this initiative include increasing vaccine uptake, decreasing illness and mortality due to COVID-19, providing support to youth experiencing mental distress due to the pandemic, addressing social determinants of health (SDOH), and addressing health disparities. To achieve these goals, HealthierHere and the other above-mentioned partners will focus their efforts on integrating CHWs into organizations and care teams and strengthening CHW knowledge, roles, and skills to prepare them to best support state and local efforts to address COVID-19.

The populations of focus for the CHW-CARE initiative include BIPOC (i.e., Native Hawaiians/Pacific Islanders (NHPIs), Hispanics, Blacks/African Americans, Asian Americans, American Indians/Alaskan Natives (AIANs)), and low-income populations who have been disproportionately impacted by COVID-19 in King County, Washington.

HealthierHere's role in this work includes facilitating conversations and sharing information about the project with managed care organization (MCO) partners, elevating project learnings

across stakeholders, and inviting clinical, community, and Tribal partners to participate in CHW training opportunities. HealthierHere is actively participating in governance activities and the communications workgroup and advising on project evaluation, which will track the strengths and challenges of implementing CHW-CARE-funded activities.

The project will continue through August 30, 2024. The governance team, consisting of the abovementioned organizations, may renew the project based on available funding and priorities.

This work will inform HealthierHere's approach for integrating CHW workforce strategies within other priorities, including the Connect2 Community Network and the care coordination landscape analysis (see SAR 8 for more details).

Improving Health Literacy Among Racial and Ethnic Communities and Vulnerable Communities. As reported in SAR 7 and 8, HealthierHere and PHSKC were awarded nearly $4 million over two years (2022-2023) by the U.S. Department of Health & Human Services (HHS) Office of Minority Health (OMH) to fight COVID-19 by improving health literacy among racial and ethnic communities and vulnerable communities in King County. During the two-year grant period, partners will implement culturally responsive and evidence-based organizational and personal health literacy strategies to mitigate the impacts of COVID-19. The development of strategies for health literacy system change will be community-centered and informed, using a shared process among partners, HealthierHere, and PHSKC.

HealthierHere released a request for applications in February 2022 in which community-based organizations (CBOs) and federally qualified health centers (FQHCs) applied for up to $40,000 to implement project activities (e.g., development and dissemination of COVID-19-related materials) and an additional $40,000 to participate in the project advisory group.

HealthierHere is in the process of reviewing applications and will award up to 26 project partners and 10 advisory group/project partners for a potential $1,840,000 across partners. Selected partners have until June 30, 2023, to complete project activities. Partners will submit quarterly progress reports, with the first report due July 2022, and the advisory group will meet monthly.

Distributed Mobile Phones to Connect Individuals to Telehealth and Community Resources. HealthierHere continues to partner with HCA and Foundational Community Supports (FCS) providers to provide cell phones to individuals enrolled in the FCS program in order to allow them to access telehealth and community resources to better navigate services during COVID-19. To date, and including distribution activities through this reporting period, HealthierHere has distributed a total of 330 phones to King County FCS providers with clients in need.

Access and Engagement Funding. In SAR 8, HealthierHere announced that it was investing $2.35 million across 18 organizations to grow and strengthen the community-based, non-licensed health care workforce (e.g., CHWs and peer support specialists). Through authentic engagement with individuals and ties to the culture and language of focus populations, community-based, non-licensed staff extend the reach of health care providers and can play an important role in improving access to care, health outcomes, and the patient experience while helping to achieve cost savings.

As of January 1, 2022, HealthierHere has issued payments totaling $735,000 and plans to distribute an additional $785,000 by February 2023 for partners' completion of narrative reports, which are used to track project progress. The first narrative report is due April 2022,

and the second narrative report is due January 2023 (see SAR 7 and 8 for an overview of the funding opportunity).

Continuation of Regional Vaccination Funding. HealthierHere continues to partner with 28 partners (four FQHCs and 24 CBOs) to increase vaccination rates in King County. Funded activities include vaccine capacity building, information sharing, outreach and engagement, and development and implementation of clinical and community partnerships (see SAR 7 and 8 for additional details on the scope of activities). In this reporting period, partners completed implementing project activities and met reporting requirements. HealthierHere distributed a total of $807,000 to partners for this work.

b) Related to the above, describe specific risks/issues, challenges, or other setbacks that emerged since January 1, 2022 (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.

HealthierHere Response

The following two risks/issues have evolved since January 1, 2022:

Workforce Challenges. As reported previously, workforce challenges continue to pose a risk to delivery system transformation: critical workforce shortages exist across the delivery system, and the current workforce is not always representative of the populations being served. To combat these workforce challenges, HealthierHere is investing $5 million in 2022 in workforce capacity and development, focused on retaining and supporting the current health and social services workforce while building career pathways to attract and support the growth of a robust, diverse, and representative workforce. HealthierHere is considering investing in the following domains:

- Resources to prevent burnout and support the current workforce to increase job satisfaction and reduce turnover;
- Support to build the capacity of nontraditional positions (CHWs, peer support specialists, recovery coaches) to allow more creativity in staffing and sharing of work to maximize scope of practice;
- Capacity to expand and ensure access to supervision activities to accelerate licensure requirements;
- Programs that support career pathways for young people to enter into health and social services and advance in their health and social service careers; and
- Policy and advocacy to support sustainable funding for nontraditional positions, expedited licensure for individuals licensed in other states and other countries, and other policies that support an expanded workforce.

COVID-19 Recovery. Across the region, there continues to be a need for accurate dissemination of COVID-19 safety, testing, and vaccination/booster information. Many community members have expressed that they are confused and have received mixed messaging about how to maintain safety and what to do if they test positive. Additionally, community members and partners are seeking information on how to prepare for a potential surge of

infections. HealthierHere will continue to work with partners to ensure tailored messaging and accurate information are being distributed across the region. HealthierHere and the other ACHs can continue to support the state in COVID-19 recovery, including increasing access to accurate information and needed services/resources for community members and partners.

(See the response to question 3a for details on other 2022 investment areas.)

3. Scale and sustain update

a) Briefly describe the ACH's approach and activities related to sustainability of DSRIP investments, programs, projects, and any other planning taking place in this area.

HealthierHere Response

Through Medicaid Transformation project (MTP) investments and engagement with partners, HealthierHere has built a strong foundation for transformation to continue for years to come. HealthierHere's 2022 investment strategy will build on and amplify the below foundation (additional details on the 2022 investment strategy below):

- **Population Health Infrastructure.** HealthierHere's emphasis on advancing population health infrastructure through registries, risk stratification, and SDOH screenings helped the system become more responsive and adaptable to individuals' needs and more sophisticated at treating the whole person. HealthierHere's work supported partners in embedding these tools into new workflows. Over half of HealthierHere's clinical partners cite having registry capabilities embedded in their electronic health record (EHR) – which was not the case at the beginning of the MTP; many partners also have SDOH screening tools embedded within their EHR. Population health tools have helped partners improve their data and its usefulness. For example, the Asian Counseling and Referral Service (ACRS), a HealthierHere community partner, shared that HealthierHere's investment to help them build a registry allowed the organization to better identify and track individuals who need primary care services and connect them to those services.

- **Connect2 Community Network.** HealthierHere continues to partner with health and social services organizations to build the Connect2 Community (C2C) Network, a unified community information exchange that enables care coordination among physical health, behavioral health, Tribal, community, and social services organizations in King County. Partners continue to make progress in their use of the network: through the C2C Catalyst Fund, 49 partners receive funding and support to use the network to send and/or receive referrals on behalf of their clients. Thirty-five out of 49 Catalyst Fund partners have demonstrated significant progress in using the platform, achieving the final progress and payment milestone.[3] Originating from last year's RFP and a community-driven evaluation process, HealthierHere assessed vendors to build the C2C Unified Network Infrastructure (UNI) and brought technology vendor recommendations to the C2C

[3] The Catalyst Fund is structured around three milestones—(1) Engage, (2) Use, (3) Optimize – that reflect progress in using the platform, and upon achievement of each milestone, partners receive a payment.

Network Advisory Group in February 2022. Contract negotiations are underway with the "apparently successful bidder." Use cases have been identified by network partners, and future technology integrations will be explored. To date, HealthierHere has funded this work through a mix of MTP and other external funding sources. The Network is evolving as a "public utility" model that is supported and governed by the community of participants and stakeholders. Seeing the value of the C2C Network, health systems, MCOs, foundations, and other stakeholders have expressed interest in supporting its success and sustainability.

- **Tribal Engagement in Transformation Efforts.** Throughout the MTP, HealthierHere prioritized working with Tribal nations and governments, Indian Health Services (IHS) facilities, Indian Health Care Providers (IHCPs), and Tribal and native-serving CBOs on transformation efforts. HealthierHere engaged with, listened to, and learned from Tribal partners on what the needs/gaps were for supporting American Indian/Alaskan Native/Indigenous (AI/AN/I) people. Tribal partners contributed and supported transformation efforts in myriad ways, including elevating the urgent need for access to traditional medicine, herbs, and culturally responsive care. As a result, HealthierHere launched the Traditional Medicine Fund, first in direct response to COVID-19, and in 2022, HealthierHere is investing $1.1 million through partnership with five native-led native-serving organizations (Cowlitz Indian Tribe, Seattle Indian Health Board, Nakani Native Program, Unkitawa, and United Indians of All Tribes Foundation) for 18-month projects from July 2021 through December 2022. These investments will support the provision of traditional medicine(s) focusing on equitable, culturally appropriate, and culturally relevant and responsive activities that support the physical, mental, emotional, and spiritual well-being of the AI/AN/I people. As part of this work, HealthierHere conducted a request for applications and selected Headwater People to conduct an evaluation of the models, methodology, and sustainability options through both traditional insurance and other non-health care payers.

- **Enhanced CBO Capacity.** HealthierHere remains committed to building capacity for CBOs to participate in health care system and transformation work. Throughout the MTP, HealthierHere involved CBOs in transformation planning and decision-making, and worked to create opportunities for CBOs to expand their reach. For example, HealthierHere created CBO-specific funding opportunities and in partnership with the Non-Profit Finance Fund, provided technical assistance to CBOs focused on enhancing organizational business structures and systems to support long-term provision and promotion of SDOH services. HealthierHere envisions building off this work and finding new ways to bring CBOs into health care efforts (e.g., brokering partnerships among clinical health care providers, CBOs, and MCOs; supporting contracting on behalf of CBOs; and providing training, technical assistance, and other infrastructure supports).

- **Primary Care and Behavioral Care Integration.** As reported in SAR 8, partner responses to the Maine Health Access Foundation (MeHAF) site integration self-assessment survey, collected semiannually since July 2019, indicate that the median level of integration has increased across hospitals, FQHCs, and behavioral health

agencies (BHAs); the average level of integration (across partner types) moved from 5 in July 2019 to 7 by December 2021. Investments in population health infrastructure, described above, have played a large role in these achievements, as has HealthierHere's efforts to increase and optimize the use of Collective Medical. Partners cite Collective Medical as a highlight of HealthierHere's system-wide integration work, allowing them to track patient emergency department (ED) utilization and hospital transitions. HealthierHere has also helped partners build more integrated care teams. For example, Seattle Children's Care Network, a clinical partner, cited that with HealthierHere's support, they were able to embed behavioral health professionals in six practices and will have embedded behavioral health professionals in 12 out of their 14 practices in two years. With HealthierHere's initial investment to integrate these professionals, Seattle Children's Care Network is working on sustaining the integration through traditional reimbursement channels, such as Collaborative Codes and value-based payment (VBP) contracting.

As previously reported, the Statewide Integration Assessment Work Group recommended the adoption of the Washington Integrated Care Assessment (WA-ICA) to develop and standardize a statewide infrastructure and process to assess outpatient primary care and behavioral health providers' level of integration, and support advancement of integration through ongoing training, technical assistance, practice coaching, and other strategies. HealthierHere continues its work with the Statewide Work Group comprised of MCOs, ACHs, and HCA representatives to advance implementation of the WA-ICA. HealthierHere has been contracted, over the next six to eight months in 2022, to work with the Statewide Integration Assessment Work Group partners and stakeholders to finalize the assessment tool and process, develop training materials, and implement training on completing the new assessment for an initial cohort of providers. HealthierHere will also develop a set of reports describing the state of integration based on the data submitted by provider sites completing the WA-ICA.

- **Health Equity and Anti-Racist Practices in Care Delivery.** Throughout the MTP, HealthierHere has focused on advancing equity and anti-racist practices across the region, including working with partners to complete an equity assessment and develop an equity action plan. HealthierHere's work has created equity implementation and accountability mechanisms that will continue post-MTP. Out of 22 clinical partners:
    - Sixteen launched/revamped their Diversity, Equity, and Inclusion (DEI) committee.
    - Eleven created new DEI roles in their organizations.
    - Nineteen offered equity trainings to staff.
    - Seventeen incorporated equity elements within their hiring practices.

- **Innovative Care Models.** HealthierHere established its "Tests of Innovation" in 2019 to support partner-led innovations that establish or expand advanced care models, improve community-clinical linkages, and help achieve pay-for-performance (P4P)

metrics. HealthierHere has launched eight innovations across three focus areas.[4] Many of these models show promise and have been extended for a second contract year (see Appendix A).

One project, Mobile Integrated Health (MIH), has successfully transitioned to sustainable funding, with support from the city of Seattle. Over the past two and a half years, HealthierHere invested $488,500 in improving outcomes for some of the most marginalized residents of King County by funding the Seattle Fire Department (SFD) and Aging and Disability Services (ADS) to develop a model that successfully reduces unnecessary ED visits. Under the MIH project, a multidisciplinary team, including firefighters and a case manager, responds to individuals who have activated 911 for low-acuity conditions; the team provides short-term case management to direct individuals to the appropriate intervention/resources (provided by other project partners). Over the course of the project, the MIH team has responded to more than 2,000 calls and served more than 2,300 unique individuals, on scene or remotely. Average service time during the initial encounter is approximately 40 minutes, which is about twice as long as a standard basic life support call, which allows for more comprehensive assessment and linkages to care and social supports. Case management and follow-up support may extend over several weeks. To elevate the learnings and explore opportunities for scaling the project to other areas, HealthierHere hosted a webinar with the MIH team on March 22, 2022. The team shared an overview of the model, with a focus on successes, challenges, opportunities to address barriers, and insights for others interested in implementing similar models of care. Many representatives from local governments across the state, interested in this program model, joined this webinar. More information about the project can be found in an article from the *Seattle Times* from December 2021: https://www.seattletimes.com/seattle-news/how-a-health-one-is-setting-up-a-model-for-alternative-911-response-in-seattle/

HealthierHere's 2022 investment strategy, approved by the Governing Board in February 2022, provides $20 million in funding across four key investment areas that build on the above work:

- **Leverage Foundational Infrastructure to Advance Health Equity ($6.5 million).** To support clinical, community, and Tribal partners in applying principles of Targeted Universalism to identify, address, and reduce health disparities within populations served, expanding access to whole-person care that is culturally and linguistically appropriate and responsive.
- **Coordinate Care through Clinical, Community, and Tribal Linkages ($7 million).** To improve client access and quality of care by enabling clinical, Tribal, and community organizations to share information and coordinate care more effectively.
- **Scale and Sustain Learnings from Innovations and System Transformation**

[4] The three focus areas include (1) connecting people who completed the induction of medication-assisted treatment (MAT) in jails or an ED with community-based strategies; (2) reducing ED utilization through mobile, integrated health care; and (3) testing and advancing models for integrated whole-person care.

($1.5 million). To facilitate learning, networking, and sharing opportunities to scale, spread, adopt, and adapt learnings from HealthierHere's Tests of Innovation to include best practices, workflows, and tools that support whole-person integrated care, improved coordination of care, and addressing social drivers of health.

- **Workforce Development and Capacity ($5 million).** To retain and support the current workforce while building career pathways to attract and support the growth of a robust workforce in health and social services that is as diverse as HealthierHere's communities and representative of the King County region.

(See Appendix B for additional details on potential investments within each area.)

HealthierHere's work throughout the MTP and COVID-19 has demonstrated its value as a neutral convener that can activate its network to deploy a coordinated response to regional needs based on a shared vision. Looking beyond the MTP, HealthierHere will continue to serve as a hub for the King County region, leveraging its network and resources to:

- **Address long-standing systemic inequities and complex problems** that no organization or sector can solve on its own;
- **Champion community and Tribal-driven solutions** that reflect the needs and cultures of those HealthierHere serves;
- **Mobilize and respond** to urgent public health needs and crises; and
- **Build capacity and transform systems** to improve population health.

Post-MTP, HealthierHere will work to sustain its role by securing ongoing government funding, grants, and other resources that align with the organization's mission, vision, and priorities. HealthierHere established 2022/2023 Policy Priorities (available here, page 32) that build on the work done throughout the MTP and continue to advance the region's system transformation goals that include:

- Improving access to integrated, whole-person care.
- Building and strengthening community and clinical partnerships.
- Promoting health equity for all, by all.
- Advancing community- and Tribal-driven health solutions.
- Achieving organizational excellence and accountability.

b) Briefly describe any changes to the funding and financing of partnering providers and community initiatives in DY6 (and beyond, if applicable), compared with DY1-5. This could include provider contracts and relationships, scope, project transitions/project sustainability, etc.

HealthierHere Response

HealthierHere's 2022 investment strategy (see 3a above) provides a similar level of support to partners as in years past, and HealthierHere continues to contract with the same roster of MTP

partners (see attached roster). To date, MTP partners have been eligible to earn payment for completing semiannual reports, which included reporting on and/or achievement of certain targets. Additionally, many partners have been contracted for other activities (e.g., Tests of Innovation and COVID-19 response) where they draw down funds for completing deliverables/activities specified in their contracts.

HealthierHere has continued with the above approach for the first few months of 2022 but is actively exploring how to evolve partner contracting and funding moving forward. Many of the contracts and investments, including the Tests of Innovation, will be winding down during 2022. HealthierHere remains focused on making investments that support ongoing sustainability and prepare providers and the region for the evolution of the organization and the work (including under any potential renewal of the 1115 Medicaid waiver).

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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
4. 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	
5. The ACH supported WA-ICA communication and technical assistance as requested by HCA (see Section 2, Pay-for-Reporting)	X	
6. The ACH sent the requested physical and behavioral health partnering provider information on or before the due date as instructed by HCA	X As required by HCA, HealthierHere will send the requested physical and behavioral health partnering provider information in late April 2022.	

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 2. Pay-for-Reporting (P4R) metrics

Documentation

7. P4R Metrics

Refer to the attestations in Section 1.

The Washington Integrated Care Assessment (WA-ICA) will replace the Maine Health Access Foundation (MeHAF) tool that had been used under the Medicaid Transformation Waiver Project 2A to advance bi-directional integration of physical and behavioral health services. The collection of data using the WA-ICA will be a requirement for partnering providers beginning in 2022. ACHs will no longer be required to collect MeHAF data from partnering providers beginning in 2022.

To help with a smooth transition, each ACH will inform partnering physical and behavioral health providers who have ever completed the MeHAF under Project 2A that:

- the HCA is transitioning from the MeHAF to the WA-ICA; and
- these partnering providers will be required to complete the WA-ICA instead. The WA-ICA will be completed once during Q3 2022.

More guidance will be shared related to communication and technical assistance by HCA in Q1 2022.

Appendix A. Tests of Innovation: Success and Impact to Date

Project	Implementing Partner	Project Impact and Success to Date
MAT Care Transformation	County Doctor Community Health Centers (CDCHCs) **(ongoing, in second-year contract)**	• Created the first Saturday clinic providing medication for opioid use disorder (MOUD) in King County. Visits at the Saturday clinic increased from 1-2 per Saturday in 2020 to 3-4 in 2021. • Expanded day-of-release/discharge access to MOUD intakes for vulnerable populations at high risk of overdose death. • Developed and optimized referral workflows with feedback from project and jail/ED referral partners. • Created "Healthcare for People with Opioid Use Disorder" posters and handouts with locations, hours, and a menu of services offered. • Established direct phone lines to nurse care managers and Health Insurance Portability and Accountability Act (HIPAA)-compliant cell phones for CHWs. • Hired a Reentry CHW to do intakes, support patients, and make referrals to SDOH services. • Throughout 2021, there was a steady increase in referrals from jails and intakes through established partnerships. • Had a breakthrough in relationship with King County Jail, with referrals happening in real time.
MIH	SFD and ADS **(ended 2/28/2022)**	• From December 2019 to December 2020, the program saw 1,355 non-duplicated individuals who received five or more responses, accounting for 19% of all emergency medical services records during that time. • In 2020, the unit received nearly 500 "vulnerable adult reports" where the program provided some level of case management; an additional 450 non-duplicated clients were contacted via HealthONE responses or the high-utilizer program.

		• Prior to the COVID-19 emergency, 87% of HealthONE encounters did not require transport to a hospital or an ED. This number dropped to 75%-80% during COVID-19 but is expected to rise again. • Formed an integrated care team within the MIH program that cuts across the three subprograms: high utilizers, vulnerable adults, and the HealthONE response unit. • Expanded and launched the HealthTWO response unit in April 2021. • Designed a nurse triage service that will assess incoming 911 calls to help route callers to appropriate interventions. A vendor has been identified, and it has developed protocols and is working on connections back to services. • Fostered excellent working relationships with external partners, leading to improved flow of information and an increased number of closed-loop referrals. • Improved patient experience: firefighters and case managers are highly skilled at implicit assignment of on-scene tasks, from building rapport with the client to interviewing family members or other firefighters to beginning telephone referrals. • In March 2022, HealthierHere showcased this innovation in a public webinar, reaching dozens of local government stakeholders interested in implementing similar models in their own jurisdictions.
Testing Models for Integrated Care Innovations	Virginia Mason Franciscan Health and Valley Cities Behavioral Health Care **(ongoing, in second-year contract)**	• Built a successful model by identifying a physician champion who maintained continuous process improvements for the program. • Hired and onboarded a behavioral health provider for the Des Moines test clinic quickly and on schedule. • Des Moines behavioral health provider continues to build his caseload – has 140 patients as of February 2022, surpassing the benchmark of 60-80. • Forty-one percent of active patients in treatment for at least 10 weeks have decreased their Patient Health Questionnaire (PHQ)-9 score by at least 50%.

		• Forty-one percent of active patients in treatment for at least 10 weeks have decreased their General Anxiety Disorder (GAD)-7 score by at least five points. • Testing billing of collaborative care codes as a potential sustainability strategy.

	HealthPoint and Valley Cities Behavioral Health Care
	(ongoing, in second-year contract)
		• As of February 2022, 137 patients served (goal is 150 patients).
		• Established significant data-sharing capabilities (shared patient registry) and successful workflows, expanding access to the psychiatric advanced registered nurse practitioner (ARNP) and ultimately making significant progress in truly integrating care teams.
		• Discovered integration strategies and ways to connect teams that weren't previously apparent.
		• Developed a highly successful model for care conferences, now a regular practice among HealthPoint care coordinators and Valley Cities care managers, where they convene, reconcile various information, share updates, and coordinate care and follow-up.
		• Met or exceeded many clinical outcome goals in the first year of the program:
		  ○ Exceeded goal for lowering PHQ9 scores (goal of 30% and achieved 62%
		  ○ Exceeded goal for controlling hypertension (goal of 70% and achieved 76%).
		  ○ Exceeded goal for follow-up primary care visits after a hospital stay or ED visit (goal of 80% and achieved 96%).
		  ○ Exceeded goal for screening patients for SDOH needs (goal of 90% and achieved 100%).
		• In the second year of the innovation, the follow-up visit rate continues to be as high as 93%. The hypertension metric continues to improve, and patient activation measure (PAM) scores are also showing sustained improvement, indicating a continued increase of activation and engagement, which should translate into improved health outcomes.

	Seattle Children's Care Network (SCCN) and Seattle Children's Hospital Psychiatry and Behavioral Medicine
	(ongoing, in second-year contract)
		• Six practices are participating in the second cohort of the learning collaborative. The first learning collaborative session for Cohort 2 was held in November 2021.
		  ○ In December, the Cohort 2 Practices participated in the first Pediatric Integrated Care Collaborative (PICC) training on Trauma-Informed Care.
		• Seven practices participated in the first cohort of the learning collaborative.
		  ○ All participating practices have either started seeing behavioral health patients for the first time or expanded/enhanced the behavioral health services they provide.
		  ○ Cohort 1 completed a total of 73 trainings, webinars, and clinic implementation calls in the first year of the innovation.
		  ○ While launching Cohort 2, SCCN continues to support Cohort 1 through individual monthly coaching meetings, operational support for behavioral health providers, and family advocate affinity meetings. In addition, SCCN continues to work with Cohort 1 Practices to collect outcome data.
		• High partner engagement throughout 2021.

	Downtown Emergency Services Center (DESC) and Harborview Medical Center (HMC) **(second-year contract launched 1/1/2022; ongoing)**	• In 2022, partners will apply lessons learned from the first year of the innovation to build a care coordination model on a broader scale at a new co-located clinic set to open in 2022, also known as the Hobson Clinic. • In the first year of the innovation, partners developed a formal care coordination strategy between DESC and HMC. This included care coordination team members becoming familiar with HMC's Pioneer Square Clinic, building new relationships with a greater range of care team members, establishing a care coordination liaison between institutions, developing an informatics strategy, and creating and testing care coordination workflow best practices. • The partners developed a shared client registry in DESC's EHR. They navigate compliance and technical barriers to develop a process to match data and identify shared clients on a quarterly cadence.

		• They created a full-circle experience around coordination. The team is able to receive a referral, contact HMC, schedule appointments, take clients to appointments, and follow up with HMC and DESC case managers regarding the next steps.
	DESC, Community Health Plan of Washington (CHPW), PHSKC, King County Behavioral Health and Recovery Division **(ongoing, second-year contract launched 3/1/2022)**	• The partners worked together over the first year of the innovation to identify a bundle of services critical to the provision of extremely low-barrier MAT for DESC's patient population. Currently, the direct services are funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) grant, but that is not sustainable long term. • The partners met regularly throughout 2021 to better understand the current payment model, services provided, staffing model, population served, and member data to test the feasibility of a low-barrier MAT payment model. • Once the payment prototype was developed and tested, they discovered that inpatient hospital stays and ED visits were lower for the group receiving DESC services, and primary care and behavioral health outpatient utilization were higher. In summary, DESC engagement appears to have a greater impact on reducing high service expenses (inpatient) and increasing engagement in services that support penetration rates and member sustainability for our chronically homeless members (i.e., primary care physician (PCP) visits and behavioral health outpatient services). • In their 2022 contract, DESC and CHPW are contracting with each other directly to test the bundled payment model for 26 CHPW members over 12 months, with payment delivered through the bundled negotiated rate and achievement of quality measures, such as retention in MAT services and increased numbers of outpatient primary care, behavioral health, and substance use disorder (SUD) visits. ○ In 2022, DESC and CHPW have also committed to expanding the advocacy piece of their innovation. They will be having system change discussions with entities like the HCA on how to overcome barriers and prevent Medicaid from paying for low-barrier essential services, such as outreach and engagement. This is a significant unmet need in Washington and is necessary for sustaining and scaling this model.

	MultiCare Health System and Sea Mar Community Health Centers **(second-year contract launched 3/1/2022; ongoing)**	• In year 2 of this innovation, MultiCare and Sea Mar are expanding to a second site, a pediatric MultiCare clinic in Auburn. They will be adjusting their collaborative care model to support a pediatric population and plan to develop a custom screening tool for pediatric patients under 12. ○ The MultiCare and Sea Mar pediatric team will be joining the SCCN trainings as appropriate to make sure the lessons on the nuances of pediatric collaborative care are scaled across multiple innovations. • The partners continue to meet weekly on process improvement for data and registry systems. MultiCare has been working with its IT department team to build a shared registry in EPIC, creating episodes of care, and building out collaborative care management codes. The episode of care tracks minutes spent on the patient. The episode of care captures minutes of care team activities, which are helpful for billing collaborative care codes.

Appendix B. 2022 Investment Strategy

Investment Area	Goal	Potential Investments	Amount
Leverage foundational infrastructure to advance health equity	To support clinical, community, and Tribal partners in applying principles of targeted universalism to identify, address, and reduce health disparities within populations served, expanding access to whole-person care that is culturally and linguistically appropriate and responsive.	• Incentives to Tribal, community, and clinical partners to maintain and increase access to and engagement with health and social services that improve health outcomes • Incentives for implementing or advancing organizational policies, practices, and/or procedures to promote whole-person integrated care • Incentives for implementing or advancing organizational policies, practices, and/or procedures that promote equity and reduce health disparities within their focus population served • Resources to maintain and/or expand access to traditional medicine and telemedicine • Policy and advocacy to support payment reform and value-based care	$6.5M
Coordinate care through clinical, community, and Tribal linkages	To improve client access and quality of care by enabling clinical, Tribal, and community organizations to share information and coordinate care more effectively.	• Implement a unified network infrastructure that enables data sharing across technology vendors • Design and build a comprehensive resource directory that is aligned with statewide efforts and tailored for our region • Advance C2C Network partner priorities related to relationship building, language access, capacity building, community member engagement, and Tribal data sovereignty across the network	$7M

		• Improve care coordination structure following recommendations from Landscape Analysis • Enhance community-based care coordination in south King County by enabling CHW workforces to share information and coordinate care • Support clinical and community partners using electronic referral technologies • Enhance and expand Shared Care Plan functionally following learnings from current pilot	
Scale and sustain learnings from innovations and system transformation	To facilitate learning, networking, and sharing opportunities to scale, spread, adopt, and adapt learnings from HealthierHere's Tests of Innovation to include best practices, workflows, and tools that support whole-person integrated care, improved coordination of care, and addressing social drivers of health.	• Resources to partners for adopting and/or adapting learnings from innovations and other system transformation work • Policy and advocacy around convening partners and identifying sustainable funding for system transformation, including payment reform • Continued evaluation and elevation of new learnings from ongoing innovations • Capacity for participation and teaching in learning/sharing best practices • Training and teaching assistance for spread of learnings to Tribal, community, and clinical partners	$1.5M
Workforce Development and Capacity	To retain and support current workforce while building career pathways to attract and support the growth of a robust workforce in health and social services that is as diverse as HealthierHere's	• Resources to prevent burnout and support the current workforce to increase job satisfaction and reduce turnover • Support to build capacity of nontraditional positions (CHWs, peer support specialists, recovery coaches) to allow more creativity in staffing and sharing of work to	$5M

	communities and representative of the King County region.	maximize scope of practice • Capacity to expand and ensure access to supervision activities to accelerate licensure requirements • Programs that support career pathways for young people to enter into health and social services and advance in their health and social service careers • Policy and advocacy to support sustainable funding for nontraditional positions, expedited licensure for individuals licensed in other states and other countries, and other policies that support an expanded workforce	