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
**Table of contents**

Table of contents............................................................................................................................. 2
Semi-annual report information and submission instructions...................................................... 3
ACH contact information.................................................................................................................7
Section 1. ACH organizational updates........................................................................................... 8
  Attestations.............................................................................................................................. 8
  Documentation........................................................................................................................ 9
Section 2. Project implementation status update.......................................................................... 13
  Attachments............................................................................................................................ 13
  Documentation....................................................................................................................... 14
  Narrative responses................................................................................................................ 14
  Attestations............................................................................................................................ 44
Section 3. Pay-for-Reporting (P4R) metrics................................................................................. 45
  Documentation...................................................................................................................... 45
Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Achievement values

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

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

*Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period January 1 – June 30, 2021*

<table>
<thead>
<tr>
<th>Number of Projects in ACH Portfolio</th>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NC</th>
<th>NS</th>
<th>OCH</th>
<th>SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/support of Independent External Evaluator (IEE) activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Report on quality improvement plan (Replaced by COVID-19 Response)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total AVs Available</td>
<td>18</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>34</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>
Reporting requirements

The semi-annual report for this period (January 1 – June 30, 2021) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>Section 1. ACH organizational updates</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-8 Attestations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-11 Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Key staff position changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Budget/funds flow update</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2. Project implementation status update</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-13 Attachments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implementation work plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Partnering provider roster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Quality improvement strategy update</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 4. Pay-for-Reporting (P4R) metrics</th>
<th>Item num</th>
<th>Sub-section components</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-17 Narrative responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General implementation update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Regional integrated managed care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Scale and sustain update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Attestations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| SWACH | 5 | 4 | - | - | 5 | - | - | 4 | 18 |
| 26 |
| 18 |
| 26 |
| 18 |
| 26 |
| 18 |
| 26 |
| 18 |

There is no set template for the semi-annual report. All required elements are to be clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.
While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA’s webpage. See instructions for how to format the report below.

**File format**

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

- **Main Report or Full PDF**: ACH Name.SAR7 Report.08.02.21
- **Implementation work plan**: ACH Name.SAR7 Implementation work plan.08.02.2021
- **Partnering provider roster**: ACH Name.SAR7 provider roster. 08.02.2021
- **P4R metrics**: ACH Name.SAR7 P4R metrics. 08.02.2021

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

**Semi-annual report submission instructions**

ACHs must submit their completed semi-annual reports to the IA **no later than August 2, 2021 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/](https://cpaswa.mslc.com/).

**ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 7.”**

The folder path in the ACH’s directory is:

*Semi-Annual Reports → Semi-Annual Report 7.*

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

**Semi-annual report submission and assessment timeline**

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2021 – June 30, 2021.


Semi-annual reporting guidance

Reporting period: January 1, 2021 – June 30, 2021

Page 5
### ACH semi-annual report 7 – submission and assessment timeline

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period July 1 – December 31, 2020 to ACHs</td>
<td>IA</td>
<td>March 2021</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>August 2, 2021</td>
</tr>
<tr>
<td>4.</td>
<td>If needed, issue information request to ACHs within 30 calendar days of report due date</td>
<td>IA</td>
<td>August 25</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>August 26 – September 9, 2021</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>August 27 – September 24, 2021</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>October 2021</td>
</tr>
</tbody>
</table>

**Contact information**

Questions about the semi-annual report template, submission, and assessment process should be directed to [WADSRIP@mslc.com](mailto:WADSRIP@mslc.com).
ACH contact information

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

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>HealthierHere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Gena Morgan, Chief Operating Officer</td>
</tr>
<tr>
<td>Phone number</td>
<td>206.849.6262</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:gmorgan@healthierhere.org">gmorgan@healthierhere.org</a></td>
</tr>
<tr>
<td>Secondary contact name</td>
<td>Susan McLaughlin, Executive Director</td>
</tr>
<tr>
<td>Phone number</td>
<td>206.790.3709</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:smclaughlin@healthierhere.org">smclaughlin@healthierhere.org</a></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Primary care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

https://wahca.box.com/s/znfesjaldc5m1v6a0bhioun5xemoeh26
Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021   Page 8
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.*

**HealthierHere Response**

HealthierHere’s organizational chart as of June 30, 2021, is below.

Figure 1. **HealthierHere Organizational Chart (as of June 30, 2021)**

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.\(^3\)

- For payments not related to COVID-19 made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.\(^4\)

**HealthierHere Response**

The non-COVID-19 reconciliation spreadsheet is attached. During this reporting period, HealthierHere did not use Medicaid Transformation Project (MTP) funds to make any COVID-19-related payments outside the Financial Executive (FE) 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.

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.

**HealthierHere Response**

**Figure 2. Cumulative Accounting of Incentives to Assist Medicaid Behavioral Health Providers**

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditures</th>
<th>Fund Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Projected</td>
</tr>
</tbody>
</table>

\(^3\) 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](https://hca.wa.gov/assets/program/payment-reconciliation-template-covid.xlsx).

\(^4\) 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](https://hca.wa.gov/assets/program/payment-reconciliation-form-sar-5.0-noncovid.xlsx).
<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Amount</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds directed to contracted Medicaid behavioral health agencies (BHAs) to support infrastructure needs required for transition to IMC.</td>
<td>$3,955,078</td>
<td>$3,955,078</td>
<td>DY1: IMC</td>
</tr>
</tbody>
</table>
| HealthierHere is overseeing and maintaining training and technical assistance (TA). The ACH purchased systemwide training and TA for BHAs to help them transition to IMC and to support clinical models that will help make BHAs eligible for further incentives under HealthierHere’s bidirectional care project. Trainings included:  
  - Value-based payment (VBP) academy for 17 BHAs (the academy was offered to 28 BHAs)  
  - Managed care contracting TA for BHAs  
  - University of Washington (UW) Advancing Integrated Mental Health Solutions (AIMS) training for providers  
  - Comagine/Qualis and UW AIMS provider training and TA to support integrated care and VBPs | $461,850 | $461,850 | DY1: IMC |
| HealthierHere used incentive funding to support the King County Behavioral Health Organization (BHO) during the transition to IMC. Specifically, these funds were used for temporary staffing to support the King County Behavioral Health and Recovery Division in transitioning the BHO to the new Behavioral Health Administrative Services Organization. | $297,776 | $297,776 | DY1: IMC |
| **DY1 Subtotal**                                                           | **$4,714,704** | **$4,714,704** | **DY1: IMC** |
| HealthierHere is overseeing and maintaining training and TA. The ACH purchased systemwide training and TA for BHAs to help them transition to IMC and to support clinical models that will help make BHAs eligible for further incentives under HealthierHere’s bidirectional care project. Trainings included:  
  - Comagine/Qualis and UW AIMS provider training and TA to support integrated care | | | |
| **DY2 Subtotal**                                                           | **$127,198** | **$127,198** | **DY2: Project** |
| HealthierHere is overseeing and maintaining training and TA. The ACH purchased systemwide training and TA for BHAs to help them transition to IMC and to support clinical models that will help make BHAs eligible for further incentives under HealthierHere’s bidirectional care project. Trainings included:  
  - Comagine/Qualis provider training and TA to support integrated care | $313,119 | $313,119 | DY3: Project |
| **DY3 Subtotal**                                                           | **$313,119** | **$313,119** | **DY3: Project** |
HealthierHere allocated a portion of IMC funding to support COVID-19 partner relief funding. Allocated amounts and funds were:
- 2020 Clinical Partner Resiliency Fund
- 2020 Multilingual Response Fund

<table>
<thead>
<tr>
<th>Project</th>
<th>DY3 Subtotal</th>
<th>DY4 Subtotal</th>
<th>DY5 Subtotal</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 Clinical Partner Resiliency Fund</td>
<td>$1,925,080</td>
<td>$1,925,080</td>
<td>$589,200</td>
<td>$9,460,154</td>
</tr>
<tr>
<td>2020 Multilingual Response Fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DY3: Project</strong></td>
<td>$2,238,199</td>
<td>$2,238,199</td>
<td>$589,200</td>
<td>$14,859,062</td>
</tr>
<tr>
<td>2020/2021 approved IMC allocations: Testing models for whole-person</td>
<td>$1,681,339</td>
<td>$5,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>integrated care, training, and TA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthierHere is overseeing and maintaining training and TA. The ACH</td>
<td>$109,514</td>
<td>$1,000,000</td>
<td>$589,200</td>
<td>$14,859,062</td>
</tr>
<tr>
<td>purchased systemwide training and TA for BHAs to help them transition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to IMC and to support clinical models that will help make BHAs eligible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for further incentives under HealthierHere’s bidirectional care project</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainings included:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Comagine/Qualis and UW AIMS provider training and TA to support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>integrated care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DY4: Project</strong></td>
<td>$1,790,853</td>
<td>$6,000,000</td>
<td>$1,778,961</td>
<td></td>
</tr>
<tr>
<td>HealthierHere allocated a portion of IMC funding to support community</td>
<td>$589,200</td>
<td>$669,920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and clinical COVID-19 vaccination funds:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addendum 12: Clinical COVID-19 Vaccination Investment Fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addendum 14: Community COVID-19 Vaccination Investment Fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addendum 15: Community and Clinical Partnerships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance remaining</td>
<td>$0</td>
<td>$1,109,041</td>
<td>$589,200</td>
<td>$9,460,154</td>
</tr>
<tr>
<td><strong>DY5 Subtotal</strong></td>
<td>$589,200</td>
<td>$1,778,961</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cumulative Total</strong></td>
<td>$9,460,154</td>
<td>$14,859,062</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Addendum 12: Clinical COVID-19 Vaccination Investment Fund
Addendum 14: Community COVID-19 Vaccination Investment Fund
Addendum 15: Community and Clinical Partnerships
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 MTP. 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.

HealthierHere Response

The updated implementation work plan is attached.

13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation. To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in MTP 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 pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project

---

5 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 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.

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.6

HealthierHere Response
HealthierHere will not provide a quality improvement strategy update in this SAR. For HealthierHere’s current quality improvement strategy, please refer to the version submitted with SAR 6.

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).

HealthierHere Response
In this reporting cycle, HealthierHere began to shift its COVID-19-related work from crisis response and community stabilization to recovery. A summary of this work is provided below.

Supporting and Funding Vaccination Efforts. Since late 2020, HealthierHere has partnered with Public Health – Seattle & King County (PHSKC) to support the department in

6 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section
Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021

Page 14
developing and deploying a community-driven process for distributing COVID-19 vaccines. Initial efforts focused on working with partners and community members to better understand attitudes, beliefs, and structural barriers to accessing the vaccines. For example, in January 2021, HealthierHere assessed the vaccine-related needs of Federally Qualified Health Centers (FQHCs) in the region to determine where they needed support. Beyond lack of vaccine supply, FQHCs reported needs related to staff capacity, space, and support with reaching underserved communities. HealthierHere also held multiple meetings with the Indigenous Nations Committee, the Community and Consumer Voice Committee, and a community COVID-19 information sharing group to gather information on community needs and hesitancies around the vaccines. The following recommendations to address vaccine hesitancy arose from these meetings:

- Provide tribal elders and community leaders with relevant information, and celebrate them when they have received the vaccines.
- Provide direct, digestible, plain-talk communication materials in different languages and through different communication mediums.
- Have culturally competent in-language messaging and resources regarding the safety and efficacy of the vaccines.
- Address how the vaccines were developed so quickly and what to expect during the vaccination process, including side effects.
- Have Black, Indigenous, and other People of Color (BIPOC) communities represented in the materials.
- Use trusted relationships – existing provider/client and trusted community relationships – for outreach and engagement.

Based on the insights provided and input from committees and partners, HealthierHere reallocated $840,000 from the 2020 COVID-19 Emergency Response Funds to support the county’s vaccination campaign to resource a subset of partners, crucial to an equitable vaccine strategy, with startup funds for capacity building, information sharing, outreach and engagement, and development and implementation of partnerships to support equitable access to the vaccines in King County.

HealthierHere’s goal for this work was to amplify the strengths of its various partners and to enhance the efforts of PHSKC to roll out an equitable and accessible vaccination campaign in King County. The table below provides an overview of the various initiatives funded as part of the vaccination collaborative. (See Appendix A for a list of partners that received funding.) Funding applications are available upon request.
Figure 3. **HealthierHere COVID-19 Vaccination Investments, January 1, 2021 – June 30, 2021**

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Eligible Entities</th>
<th># of Partners Funded</th>
<th>Examples of Activities Funded</th>
<th>Amount of Funds Awarded to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccine Capacity Building</strong></td>
<td>FQHCs</td>
<td>4</td>
<td>- Staffing support and equipment costs for weekend, drive-thru, and pop-up vaccination clinic sites</td>
<td>$240,000 ($60,000 for each awardee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Staffing support for vaccination information sessions for community members</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Staffing support for call center specialists to be available to community members who are seeking vaccine appointments and vaccine-related information</td>
<td></td>
</tr>
<tr>
<td><strong>Information-Sharing Activities</strong></td>
<td>Community Practice Partners and Community Grants Alumni</td>
<td>14</td>
<td>- Hosting virtual conversations about the vaccines with community members</td>
<td>$211,003 (up to $10,000 for each awardee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Developing and distributing culturally and linguistically relevant materials</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Launching language-specific social media campaigns</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Deploying navigators and community health workers to share vaccine information with their communities</td>
<td></td>
</tr>
<tr>
<td>Vaccine Outreach and Engagement</td>
<td>Community Practice Partners and Community Grants Alumni</td>
<td>$230,997 (up to $15,000 for each awardee)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conducting outreach to community members to determine vaccine eligibility and supporting them in identifying vaccine sites and making appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Calling community members with appointment reminders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providing transportation vouchers (e.g., for Uber and Lyft)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providing on-site interpretation at vaccine clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community/ Clinical Vaccine Partnerships</th>
<th>FQHCs 3</th>
<th>$60,000 ($20,000 for each awardee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reserving blocks of vaccine appointments for special populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Providing staffing support and supplies to administer the COVID-19 vaccines at pop-up vaccination clinic events in the community</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See response 15f for additional details*

<table>
<thead>
<tr>
<th>Community Practice Partners and Community Grants Alumni</th>
<th>$98,000 (up to $15,000 for each awardee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providing staffing support to assist with filling vaccine appointments reserved by a partner FQHC for specific communities</td>
<td></td>
</tr>
<tr>
<td>• Hosting pop-up vaccine clinics at an accessible and trusted community site</td>
<td></td>
</tr>
</tbody>
</table>
Expanding Access to and Engagement with the Health Care System for the King County Region. On June 1, HealthierHere announced it will be expanding access and engagement services in King County through increased investment in community-based, non-licensed health care team members such as community health workers (CHWs), peer support specialists, cultural navigators, and recovery coaches. These community-based, non-licensed health care team members are a critical aspect of the health care delivery system, helping address stigma, bias, and health disparities. Through authentic engagement with individuals, and with ties to the culture and language of focus populations, they 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 achieve cost savings.

The HealthierHere Governing Board approved over $2.3 million to expand this critical workforce over the next 18 months. HealthierHere believes that these investments will help reconnect community members who were unable to access the health care system prior to the pandemic as well as those who have disengaged from the health and social services system during the pandemic. Community, clinical, and tribal partners can apply for up to $150,000 each, with award amounts varying depending on populations served and proposed scope of services. Examples of how funds may be used include the following:

- Increasing staff capacity for community-based positions such as Community Health Workers, Peer Support Specialists, Cultural Navigators, Community Navigators, and/or Recovery Coaches.
- Purchasing equipment or software that will support increased capacity to serve priority populations.
- Covering costs associated with enhancing capabilities to conduct remote outreach (e.g., internet and mobile phone voice/data plan).
- Staff training on supervising community-based, non-licensed staff.
- Staff training on enrolling and navigating public benefits/social services and how to use technology to offer these services while adhering to social distancing guidelines, as necessary.
- Consumer-facing education, communication, and other outreach activities that are designed to increase community member access to and/or engagement with the health care system and organizations that are addressing social determinants of health (SDOH) and raising awareness of available benefits and services. Materials and methods of communication will be presented in a manner that is culturally and linguistically responsive and appropriate to the needs of the focus population.

Applications for Access and Engagement funding were due to HealthierHere on June 23, 2021; awards are expected to be announced later this summer, and awardees will have through November 2022 to implement their interventions and expend funds.

Activated Community Partner Network to Distribute COVID-19 Testing and Safety Information. Recognizing the value of HealthierHere’s model for authentic community
engagement and its robust community partner network, Gates Ventures and PHSKC partnered with HealthierHere to fund and coordinate community-based and grassroots partner organizations to rapidly disseminate accurate COVID-19 testing and safety (e.g., social distancing and quarantining) information in local communities that are disproportionately impacted by COVID-19, including Black/African American, American Indian/Alaska Native, Latinx, and Native Hawaiian/Pacific Islander communities, and people in South King County. Thirty-two community partners were funded to spread COVID-19 testing and safety information in ways that are authentic, understandable, and culturally appropriate for the people they serve. While not the focus of the initiative, partners were also able to share information and knowledge on COVID-19 vaccination.

Community partners conducted outreach and engagement with more than 58,117 people (in 33 languages other than English) between December 2020 and March 2021; 23,308 people received personal protective equipment (PPE), and 5,408 people received a code for access to an at-home testing kit (as part of the Seattle Coronavirus Assessment Network (SCAN) study). HealthierHere, in partnership with PHSKC, conducted an evaluation of this work, focused on identifying key findings such as barriers faced by community members related to testing and safety protocols (see Figure 4) and successful strategies for information sharing and community engagement (see Figure 5). The work allowed HealthierHere and PHSKC to gather more information and strategies on how to best share information and engage the community and created an opportunity for PHSKC and community-based organizations (CBOs) to strengthen their relationship/build trust for potential future collaboration. The full report is included in Appendix C.

HealthierHere shared these results with its governance committees, partners, and other project stakeholders. Potential next steps include establishing a more formalized two-way communication channel between public health systems and community partners; creating a comprehensive, centralized source of resources; and leveraging HealthierHere's partner network to launch community-informed emergency preparedness plans. HealthierHere and PHSKC are also using these findings to inform communication and engagement activities for the ongoing vaccination campaign and future public health efforts.

Figure 4. Barriers Faced by Community Members Related to Testing and Safety

<table>
<thead>
<tr>
<th>Testing</th>
<th>Safe Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systemic Barriers</strong></td>
<td><strong>Limited awareness of testing options and locations</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Limited testing sites and open hours</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Lack of safe transportation options</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Challenges with digital access and familiarity</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Disruption to economic stability</strong></td>
</tr>
<tr>
<td>Service Provider Barriers</td>
<td>Social Barriers</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>- Lack of awareness of services</td>
<td>- Rapid spread of myths, misconceptions, and conflicting beliefs</td>
</tr>
<tr>
<td>- Lack of culturally and linguistically aligned services</td>
<td>- Distrust based on historical and current racism</td>
</tr>
<tr>
<td>- Unaddressed concerns about testing, safety, and accuracy</td>
<td>- Vaccination focus diminishing testing priority</td>
</tr>
<tr>
<td>- Fragmented resources available for families in quarantine and isolation (e.g., rent assistance, food delivery, PPE)</td>
<td>- Stigma of positive result</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 5. **Successful Information-Sharing and Engagement Strategies**

### Information-Sharing Strategies

- **Concise and visual messaging** reaches large audiences efficiently with the latest facts in an easy-to-understand way.
- **Culturally and linguistically aligned messaging** ensures accessibility and relevance to the community.
- **Sharing your personal experience with testing and safety protocols** helps strengthen the connection with individuals and can lessen their concerns.

### Engagement Strategies

- **Partnering with trusted messengers** builds additional trust and connections, increasing the likelihood the message will be heard and acted upon.
- **Listening with empathy and avoiding judgment provides** a safe space for individuals and keeps ongoing conversations open.
- **Social events/activities, with appropriate precautions**, increase engagement and provide needed emotional and social support for individuals.
Improving Health Literacy Among Racial and Ethnic Communities and Vulnerable Communities. HealthierHere and PHSKC were recently awarded nearly $4 million, over two years, 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. The grant is part of OMH’s Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 initiative, which aims to identify and implement best practices for improving health literacy related to COVID-19 vaccination and other mitigation practices among underserved populations and to tackle health disparities surrounding COVID-19 vaccination, testing, and treatment.

HealthierHere will work with its community partner network of over 120 CBOs and PHSKC’s CBO partners to support community-driven development and dissemination of information to keep people safe and healthy. CBOs will develop and implement a Health Literacy Plan; implement community-informed, culturally and linguistically appropriate health literacy strategies; and develop and provide training and practice coaching for public health providers, health care systems, and COVID-19 testing and vaccination providers to improve organizational health literacy in implementing COVID-19 mitigation strategies. CBOs will also develop and disseminate culturally appropriate COVID-19 materials to impacted communities in order to improve personal health literacy.

Distributed Mobile Phones to Connect Individuals to Telehealth and Community Resources. HealthierHere is partnering with HCA and Foundational Community Supports (FCS) providers to provide cell phones and/or tablets to certain 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, HealthierHere has distributed 120 phones to King County FCS providers for distribution directly to clients in need (tablets are still being procured by HCA). These efforts are not only helping mitigate the impact of the pandemic but also helping individuals obtain and maintain employment, housing, and social supports.

Provided Learning Opportunities in Behavioral Health and the Impacts of COVID-19. In partnership with the UW AIMS Center, HealthierHere offered several learning opportunities to promote whole-person care and address the mental health impacts brought on by the pandemic. On March 11, 2021, HealthierHere hosted a webinar, “Weaving Patient Activation into your Work with People with Depression,” featuring guest presenter Dr. Patrick Raue from the AIMS Center, who shared strategies for working with patients experiencing depressive symptoms exacerbated by the pandemic. Additionally, HealthierHere and the AIMS Center developed “Supporting the Medical Care of People Living with Serious Mental Illness,” an online, self-paced course for case managers working in BHAs. The course reviews the reality of increased premature mortality in people living with serious mental illness, explores the medical and social causes of this increased mortality as well as approaches to reducing it, and introduces some practical tools and approaches to improve health in the populations that case managers serve.

Distributed PPE. Distribution of PPE continues to be a priority for HealthierHere. On January 29, HealthierHere, in partnership with HCA, donated 84,500 KN95 masks and 15,000 cloth face coverings to community partners to be distributed at a PPE pickup event. The donated
PPE was used by community-based and social services organization staff and clients to help ensure that all were equipped to do their part in protecting one another and decreasing the spread of COVID-19.

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?

**HealthierHere Response**

The following MTP-related activities and investments had notable changes during this reporting period:

**Discussions on Relaunching the Shared Care Plan Pilot.** HealthierHere launched the Shared Care Plan (SCP) workgroup and pilot in 2019 in response to partners’ calls for a single interoperable platform with complete and up-to-date patient information to facilitate coordinated and patient-centered care. Initially, the pilot was set to launch in early 2020, but HealthierHere suspended implementation to allow partners to focus on the pandemic. However, partners continue to express a desire for a SCP.

In this reporting period, HealthierHere had a series of discussions with partners on relaunching the SCP pilot, including reevaluating the needs of the region, reexploring how HealthierHere can help address those needs, and scoping out a potential pilot. As part of these discussions, HealthierHere is exploring how the Integrated Care Innovation projects could inform the pilot and/or evolve to include the pilot; three projects are currently developing and using their own shared registries and sharing that information across implementing partners. In addition, HealthierHere will continue to explore adding shared care planning functionality to the Connect2 Community Network over time, where clients and users from multiple organizations could contribute to a single, continuously updated plan - potentially leveraging use case work under development with the Connect2 Community Network (see the response to question 16a for more information on the Connect2 Community Network).

Relaunching the pilot would allow HealthierHere to learn what it would take to build a successful SCP (e.g., staff time, workflow changes, technology barriers and needed investments) and inform future funding requests/grants related to this type of work. Later this summer, HealthierHere will determine whether and how to proceed with the pilot.

**Continuance of Innovation Projects and Year 1 Evaluation.** 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 achieve pay-for-performance (P4P) metrics. Three investment areas have launched and are at varying stages of implementation: (1) Medication Assisted Treatment (MAT) Care Transformation – two projects; (2) Mobile Integrated Health (formerly known as Reducing Emergency Department (ED) Utilization through Community Paramedicine and Mobile Health Resources) – one project; and (3) Testing Models for Integrated Care – seven projects. (See previous SARs 5 and 6 for a detailed overview of each project.) For the MAT Care Transformation and Mobile Integrated Health innovations, implementing partners are eligible to receive up to $300,000 annually. For the Testing Models for Integrated Care innovations, partners are eligible to receive up to $500,000 annually. The projects and their status are described below in Figure 6. See Appendix B for a summary of the projects’ impacts on partners and the region to date.
HealthierHere is currently evaluating the projects and identifying opportunities to scale and sustain them. The evaluation includes surveys, interviews, focus groups, and document review. The goal is to identify workflow changes that are critical for success, assess the impact of the projects, and assess the feasibility of sustaining the projects at current participating partner sites and of scaling more broadly across King County. See the response to question 16a for more information on the evaluation.
### Figure. 6. **Ongoing Innovation Projects as of June 30, 2021**

<table>
<thead>
<tr>
<th>Project/Funded Partner(s)</th>
<th>Focus</th>
<th>Status</th>
</tr>
</thead>
</table>
| **MAT Care Transformation** | Connecting people who completed MAT induction in jails or EDs with community-based treatment | • CDCHCs continue in their second year of implementation, with the contract running through October 2021.  
  - See SAR 6 for an overview of year 2 scope.  
  • PHSKC was approved for a second year of implementation, with the contract running through December 2021.  
  - In year 2, PHSKC will expand its program to connect patients to MAT and support services. PHSKC continues to refine workflows and has launched a new partnership with the Seattle Drug & Narcotic Center (Seadrunar), a residential treatment program, to provide support and primary care services to Seadrunar patients. |
|  |  | • CDCHCs continue in their second year of implementation, with the contract running through October 2021.  
  - See SAR 6 for an overview of year 2 scope.  
  • PHSKC was approved for a second year of implementation, with the contract running through December 2021.  
  - In year 2, PHSKC will expand its program to connect patients to MAT and support services. PHSKC continues to refine workflows and has launched a new partnership with the Seattle Drug & Narcotic Center (Seadrunar), a residential treatment program, to provide support and primary care services to Seadrunar patients. |
| **Mobile Integrated Health**  
(Formerly known as “Reducing ED Utilization through Community Paramedicine and Mobile Health Resources”) | Responding to individuals who have activated 9-1-1 for low-acuity conditions | • SFD and ADS were approved for a second year of implementation, with the contract running through April 2022.  
  - In year 2, SFD and ADS will add a new mobile unit; they are exploring the use of the Connect2 Community Network to support the work. They are also looking to hire one data/analytics employee to oversee the development and monitoring of patient experience and outcome metrics. |
|  |  | • SFD and ADS were approved for a second year of implementation, with the contract running through April 2022.  
  - In year 2, SFD and ADS will add a new mobile unit; they are exploring the use of the Connect2 Community Network to support the work. They are also looking to hire one data/analytics employee to oversee the development and monitoring of patient experience and outcome metrics. |

---

Semi-annual reporting guidance  
Reporting period: January 1, 2021 – June 30, 2021  
Page 24
<table>
<thead>
<tr>
<th>Testing Models for Integrated Care</th>
<th>Addressing the lack of communication and shared protocols for people who visit multiple systems to meet their physical and behavioral health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• International Community Health Services and Asian Counseling and Referral Service</td>
<td></td>
</tr>
<tr>
<td>• Seattle Children’s Care Network and Seattle Children’s Hospital Psychiatry and Behavioral Medicine</td>
<td></td>
</tr>
<tr>
<td>• Virginia Mason Franciscan Health and Valley Cities Behavioral Health Care</td>
<td></td>
</tr>
<tr>
<td>• Downtown Emergency Services Center (DESC) and Harborview Medical Center (HMC)</td>
<td></td>
</tr>
<tr>
<td>• DESC, Community Health Plan of WA, PHSKC, King County Behavioral Health and Recovery Division</td>
<td></td>
</tr>
<tr>
<td>• HealthPoint Community Health Center and Valley Cities Behavioral Health Care</td>
<td></td>
</tr>
<tr>
<td>• The following partners are currently in negotiations for year 2 contracts:</td>
<td></td>
</tr>
<tr>
<td>o International Community Health Services and Asian Counseling and Referral Service</td>
<td></td>
</tr>
<tr>
<td>o Seattle Children’s Care Network and Seattle Children’s Hospital Psychiatry and Behavioral Medicine</td>
<td></td>
</tr>
<tr>
<td>o HealthPoint Community Health Center and Valley Cities Behavioral Health Care</td>
<td></td>
</tr>
<tr>
<td>o Virginia Mason Franciscan Health and Valley Cities Behavioral Health Care</td>
<td></td>
</tr>
<tr>
<td>• The following partners experienced challenges in year 1 (particularly around hiring behavioral health providers and capacity due to COVID-19) and have received no-cost extensions from HealthierHere:</td>
<td></td>
</tr>
<tr>
<td>o DESC and HMC (no-cost extension through October 31, 2021)</td>
<td></td>
</tr>
<tr>
<td>o DESC, Community Health Plan of WA, PHSKC, King County Behavioral Health and Recovery Division (no-cost extension through December 31, 2021)</td>
<td></td>
</tr>
<tr>
<td>o MultiCare Health System and Sea Mar Community Health Centers (no-cost extension through December 31, 2021)</td>
<td></td>
</tr>
<tr>
<td>Health Care</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>• MultiCare Health System and Sea Mar Community Health Centers</td>
<td></td>
</tr>
</tbody>
</table>
c) Describe any updates, new approaches, or new partnerships related to how your ACH has included Tribes/IHCPs in your COVID-19 response activities.

**HealthierHere Response**

HealthierHere continues to prioritize working with tribal nations and governments, Indian Health Services (IHS) facilities, Indian Health Care Providers (IHCPs), and tribal- and native-serving CBOs. Below are examples of how HealthierHere worked with and supported these partners during the reporting period:

- In the first quarter of 2021, HealthierHere met monthly with the Indigenous Nations Committee to gather information on community needs and hesitancies around the vaccines. HealthierHere also met monthly with the Community and Consumer Voice (CCV) Committee and COVID-19 information-sharing community group. (See the response to 15a for the recommendations that came out of these meetings.) These meetings informed the development of Vaccination investments, from which HealthierHere awarded $25,200 to three native-serving community partners: Unkitawa, Nakani Native Program, and United Indians of All Tribes Foundation. All three organizations were funded to develop and share information in a culturally responsive and relevant way, and one partner was funded to help community members schedule appointments, facilitate transportation, and remove emotional and other barriers to getting vaccinated.

- As part of the work with PHSKC and Gates Ventures on COVID-19 testing and safety information (described in question 15a), HealthierHere funded five native-led organizations, totaling $118,142: United Indians of All Tribes Foundation, Nakani Native Program, Tlingit and Haida, Unkitawa, and Headwater People.

- Through a series of meetings with tribal entities and native serving CBOs and consultation from a tribal data sovereignty expert, Dr. Desi Rodriguez-Lonebear, HealthierHere has developed a Connect2 Community Network privacy framework that includes specific considerations for the collection, use and sharing of tribal enrollment or affiliation information. HealthierHere also hosted a webinar on tribal data sovereignty on January 20, 2021 for staff and network partners. HealthierHere is currently working on establishing tribal and/or native serving CBO representation in the Connect2 Community Network Advisory Group. (For more information on the Connect2 Community Network see the response to question 16A below)

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

**HealthierHere Response**

**Clinical and tribal health care partners** continue to be able to earn incentive funds based on fulfilling semiannual reporting requirements, referred to as Pay for Progress. Over the course of the pandemic, HealthierHere has adjusted reporting expectations to both provide partners with additional capacity to respond to the pandemic and better measure progress given the impact of COVID-19 and other learnings to date.8

---

8 For example, beginning in the July 1, 2020 – December 31, 2020 reporting period, HealthierHere eliminated the improvement over self (IOS) requirement where partners had to demonstrate progress on select milestones. With all that partners are facing and the rapid evolution of their workflows, HealthierHere determined that measuring IOS was no longer relevant. Now, partners earn incentive funds based on fulfilling reporting requirements only.

**Semi-annual reporting guidance**

**Reporting period:** January 1, 2021 – June 30, 2021
In this reporting period, HealthierHere reduced the number of reporting metrics from eight to seven, eliminating the risk stratification metric and adding new questions to the equity reporting metric. See Figure 7 for a list of metrics and changes made during this reporting period. The January 1, 2021 – June 30, 2021 reporting workbook is available for review upon request.

**Figure 7. 2021 Clinical and Tribal Partner Pay-for-Progress Metrics and Changes**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Changes Made This Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maine Health Access Foundation (MeHAF)</td>
<td>None</td>
</tr>
<tr>
<td>2. Opioids Survey (which contains the state’s Project 3A pay-for-reporting metrics)</td>
<td>None</td>
</tr>
<tr>
<td>3. Whole-Person Care Screenings/Assessments</td>
<td>None</td>
</tr>
<tr>
<td>4. Use and Optimization of Collective Ambulatory Platform</td>
<td>None</td>
</tr>
<tr>
<td>5. Registry Functionality</td>
<td>None</td>
</tr>
<tr>
<td>6. Risk Stratification</td>
<td>Removed – HealthierHere determined that risk stratification was no longer relevant as a stand-alone metric because partners’ risk stratification efforts and capabilities were not substantially changing over reporting cycles. Instead, HealthierHere decided to incorporate a question on risk stratification in the equity metrics to identify how partners are risk stratifying to identify and address health disparities.</td>
</tr>
<tr>
<td>7. Equity</td>
<td>HealthierHere added the below new categories to better understand equity-related needs in the region:</td>
</tr>
<tr>
<td></td>
<td>• Organizational Leadership Composition. Partners were asked to report on whether their organization identifies as “BIPOC-led,” meaning having 51% or more of board members and staff leadership identifying as being a member of the BIPOC community.</td>
</tr>
<tr>
<td></td>
<td>• Annual Operating Budget. Partners were asked to report on the 2019 and 2020 operating budgets.</td>
</tr>
<tr>
<td></td>
<td>• Risk Stratification. Partners were asked to describe how they are risk stratifying to</td>
</tr>
</tbody>
</table>
**Metric** | **Changes Made This Reporting Period**
---|---
**8. Quality Improvement** | *identify and address health disparities.*

**Community partners** earn payments for meeting transformation benchmarks and milestones specified in their contracts along with agreed-upon deliverables and deadlines. See Figure 8 for a summary of 2021 requirements.

**Figure 8. 2021 Clinical and Tribal Partner Pay-for-Progress Deliverables/Requirements**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Reporting Period</th>
<th>Summary of Deliverables/Requirements</th>
<th>Deliverable Due/Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative 1</td>
<td>1/1/21 – 4/30/21</td>
<td>• Narrative report describing progress toward advancing transformation activities within the organization</td>
<td>By 6/22/21</td>
</tr>
<tr>
<td>Narrative 2</td>
<td>5/1/21 – 9/30/21</td>
<td>—</td>
<td>By 10/13/21</td>
</tr>
<tr>
<td>Screen and Refer 1</td>
<td>1/1/21 – 4/30/21</td>
<td>• Conduct screenings for physical, behavioral, and/or SDOH needs and refer to appropriate service providers • Partners must submit screen tools used and report on number of people screened/referred to services</td>
<td>By 6/22/21</td>
</tr>
<tr>
<td>Screen and Refer 2</td>
<td>5/1/21 – 9/30/21</td>
<td>—</td>
<td>By 10/13/2021</td>
</tr>
<tr>
<td>Access and System Navigation Training 1</td>
<td>1/1/21 – 4/30/21</td>
<td>• Participate in at least four training sessions to help community members access the types of care and support that they need and/or build organizational capacity to provide/sustain SDOH services</td>
<td>By 6/22/21</td>
</tr>
<tr>
<td>Access and System Navigation Training 2</td>
<td>5/1/21 – 9/30/21</td>
<td><em>(HealthierHere is working to offer five more training opportunities in various topic areas (e.g., Native/Indigenous, gender/trans-affirming care, equity, data visualization) in the upcoming year.)</em></td>
<td>By 10/13/2021</td>
</tr>
</tbody>
</table>
| Equity Action Plan Narrative 1 | 1/1/21 – 4/30/21 | • Attend HealthierHere-sponsored equity training  
• Submit an equity action plan for advancing equity within the organization to help reduce health disparities | By 6/22/21 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity Action Plan Narrative 2</td>
<td>5/1/21 – 9/30/21</td>
<td>• Provide an update on equity action plan implementation progress</td>
<td>By 10/13/21</td>
</tr>
</tbody>
</table>

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.

**HealthierHere Response**

In SARs 5 and 6, HealthierHere reported the pandemic had exacerbated many of the underlying risks to delivery system transformation – and many of these remain valid for this reporting period. Mitigation strategies have been updated to reflect current activities. HealthierHere is also adding a new risk of COVID-19 amplifying racial and health inequities. HealthierHere is working to mitigate these issues and investing in systemic changes to prevent their negative long-term impacts. HealthierHere is also interested in participating in statewide solutions and approaches to these issues.
Figure 9. **COVID-19 Issues and Mitigation Strategies for King County, Clinical Providers, and CBOs**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Mitigation Strategies</th>
<th>Impacted Subpopulations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amplification of Ethnic/Racial Disparities</strong></td>
<td>• In May 2021, HealthierHere released a report from the Consumer Voice Listening Project, where in 2018 and 2019, 34 grassroots and CBOs surveyed 2,860 individuals from over 40 different communities in King County on health conditions, barriers to accessing care, patient experience, and how health care experiences could be improved. The data collected includes the voices of those who are often not heard by government, mainstream media, and large institutions. HealthierHere is using this data to elevate identified disparities across government, partners, and other stakeholders.</td>
<td>• BIPOC</td>
</tr>
<tr>
<td>• HealthierHere’s <a href="#">Equity Dashboard</a> shows known disparities in the King County Medicaid population prior to COVID-19.</td>
<td>• HealthierHere approved investments/projects to support PHSKC and partners in rolling out an equitable, accessible vaccination campaign in King County (see response to question 15a).</td>
<td>• Communities experiencing health disparities</td>
</tr>
<tr>
<td>• King County’s <a href="#">COVID-19 Dashboard</a> shows that cases over the course of the pandemic have been higher for communities of color, with the rate of positive cases being highest for Native Hawaiian/Pacific Islander, Hispanic/Latinx, Black, American Indian/Alaska Native, and Asian residents.</td>
<td>• HealthierHere approved investments to expand access and engagement to health care services through increased investment in community-based, non-licensed health care team members for communities already experiencing health inequities (see response to question 15a).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HealthierHere released a <a href="#">public statement</a> on the January 6 insurrection, denouncing white supremacy and racism and voicing solidarity with</td>
<td></td>
</tr>
</tbody>
</table>

---

Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021   Page 31
<table>
<thead>
<tr>
<th>Issues</th>
<th>Mitigation Strategies</th>
<th>Impacted Subpopulations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BIPOC, and shared an outline of the organization’s commitments to embed antiracism in its work.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HealthierHere is partnering with the Public Health Institute’s Population Health Innovation Lab (PHIL) in support of the Aligning Systems for Health (AS4H) research project, which seeks to better understand how ACHs leverage cross-sector alignment and collaboration to advance health equity and improve outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HealthierHere provided equity training for staff and HealthierHere’s community partners to identify and address systemic barriers that contribute to health disparities. A total of 25 community partner organizations participated along with the entirety of HealthierHere’s staff.</td>
<td></td>
</tr>
<tr>
<td>Surge in Behavioral Health Needs Across the Region</td>
<td>• HealthierHere continues to support providers in their journey to integrate physical and behavioral health, including through the Innovation and Access and Engagement investments.</td>
<td>• BHAs and FQHCs and the populations they serve, including individuals with behavioral health needs (depression, anxiety, isolation, acute stress, suicide, substance use disorder (SUD))</td>
</tr>
<tr>
<td></td>
<td>• HealthierHere received $40,000 out of a $2 million investment by Cambia Health Solutions to expand and enhance programs that provide behavioral health care and supports to adults and youth, with a special focus on culturally, linguistically, and trauma-informed care for individuals and families disproportionately impacted by the pandemic in rural areas of King County, including Enumclaw (in partnership with Valley Cities Behavioral Health Care) and Vashon Island (in partnership with Vashon Youth and Family Services).</td>
<td>• Incarcerated individuals with mental health, SUD, medical, or other social needs</td>
</tr>
</tbody>
</table>

King County established a [dashboard](#) to track behavioral health needs and service utilization; anxiety and depression were at an all-time high at the end of 2020 and beginning of 2021.

The Washington State Department of Health’s COVID-19 [Behavioral Health Impact Situation Reports](#) track, on a weekly basis, the impact that COVID-19 is having on behavioral health and related
<table>
<thead>
<tr>
<th>Issues</th>
<th>Mitigation Strategies</th>
<th>Impacted Subpopulations</th>
</tr>
</thead>
</table>
| Health Care Workforce Capacity and Burnout Providers | • HealthierHere is helping clinical partners and CBOs augment current staff in community-based, non-licensed health care teams via investments.  
• HealthierHere continues its partnership with the King County Integrated Care Network (KCICN), giving HealthierHere insight into behavioral health providers’ workforce needs.  
• See response to question 17a for a description of HealthierHere’s work with the Healthcare Industry Leadership Table (HILT) and Behavioral Health Institute to build up the behavioral health workforce pipeline.  
• HealthierHere welcomes opportunities to work with the county, state, and other stakeholders on developing strategies to build a robust, diverse, culturally relevant, pipeline of healthcare talent. For example, HealthierHere is considering launching a learning action network to focus on these and other issues. | • Populations served by clinical providers, including individuals with SUDs and other behavioral health needs |
| Lack of Access to Care | • HealthierHere is supporting community-based, non-licensed health care team members who can extend the current reach of clinical, community, | • Individuals with:  
  ○ Limited English |
<p>| • Lack of access to accurate, relevant, culturally appropriate, | | |</p>
<table>
<thead>
<tr>
<th>Issues</th>
<th>Mitigation Strategies</th>
<th>Impacted Subpopulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>and in-language information and care.</td>
<td>and tribal health care partners in service of whole-person integrated care and health care reform to ensure that individuals get connected to the right resources, through investments in Access and Engagement.</td>
<td>proficiency</td>
</tr>
<tr>
<td>• Increased need for SDOH services and supports without increased capacity to deliver such services and supports.</td>
<td>• HealthierHere has been partnering with the Behavioral Health Institute to conduct a regional survey on telehealth’s impact on the collection of SDOH information and broadband availability and to develop a strategy to address identified needs.</td>
<td>o Chronic disease diagnoses</td>
</tr>
<tr>
<td></td>
<td>• HealthierHere has partnered with HCA and FCS providers to distribute 120 cell phones to certain FCS participants to enable them to access telehealth and community resources.</td>
<td>o COVID-19</td>
</tr>
<tr>
<td></td>
<td>• HealthierHere continues to discuss these issues with housing providers and other stakeholders, elevating issues and exploring opportunities to support housing providers and individuals.</td>
<td>Low-income BIPOC families, particularly undocumented Latinx families</td>
</tr>
<tr>
<td></td>
<td>• HealthierHere is facilitating conversations between CoLEAD and managed care organizations (MCOs) around supporting and expanding CoLEAD’s JustCare program, an intensive case management program that supports finding temporary housing and providing wraparound services for individuals in need of behavioral health support, income stabilization, and basic needs during the pandemic. The program currently supports over 170 individuals with behavioral health conditions who have experienced long-term homelessness and have histories of justice involvement.</td>
<td>Individuals experiencing unemployment and housing instability</td>
</tr>
<tr>
<td></td>
<td>• On June 9, 2021, HealthierHere hosted a learning</td>
<td>Housing providers</td>
</tr>
</tbody>
</table>

**Housing Instability**

- Affordable housing continues to be an issue in King County.
- Housing costs are a barrier to recruiting and retaining a robust health care workforce.
- Many individuals are still experiencing loss of or reduced employment.
- Many individuals are struggling to pay deferred rent/mortgage.
<table>
<thead>
<tr>
<th>Issues</th>
<th>Mitigation Strategies</th>
<th>Impacted Subpopulations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>session for Connect2 Community Network partners on resources available in the region to help clients prevent evictions. Meeting notes can be found <a href="#">here</a>.</td>
<td></td>
</tr>
</tbody>
</table>
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.

**HealthierHere Response**

COVID-19 has served as a catalyst for creating new and strengthening existing clinical and community partnerships, allowing HealthierHere to test new ways of engaging with and activating its partner network to respond to community needs. For Vaccination investments, HealthierHere structured the application process such that clinical and community partners were incentivized to partner together to codesign vaccination initiatives to better serve communities that are disproportionately impacted by COVID-19 and are experiencing disparities in vaccination rates (see King County’s COVID-19 Race and Ethnicity and Vaccination dashboards). HealthierHere hosted a matchmaking event for FQHCs and CBOs to meet informally and brainstorm potential plans for using clinical/community vaccine partnership funds. Following this event, HealthierHere released a funding opportunity, where partners that attended the event were invited to submit short proposals to partner with each other to make the vaccine more available to community members.

In total, HealthierHere awarded $840,000 as part of its COVID-19 vaccination investments, with $158,000 awarded to three FQHCs and seven CBOs specifically for partnering to implement pop-up vaccination clinics in the community, with reserved blocks of appointments for special populations (e.g., Black or African American and Hispanic/Latinx communities). Additionally, one FQHC agreed to self-fund a new partnership with CBOs, forgoing HealthierHere funding. FQHCs are using funds to create new or expand existing vaccination clinics and are working with one or more CBOs to ensure the special populations have access to vaccination slots. CBOs are working to fill the reserved vaccination appointments by helping community members navigate vaccination appointment systems and confirm appointments; CBOs are also locating and providing resources to help community members overcome barriers to attending appointments (e.g., transportation to appointments).

Without the urgency in responding to COVID-19 and distributing vaccines, these types of partnerships would likely have taken longer to solidify. In the short term, the partnerships are helping make the vaccine more accessible for communities that are disproportionately impacted by COVID-19 and/or are harder to reach. In the long term, these partnerships will likely evolve and continue to be a mechanism for addressing community needs.

Partners will continue to implement this work through November 15, 2021. Early successes are highlighted here:

- Country Doctor and Recovery Cafe shared that they successfully vaccinated at a pop-up clinic 16 individuals who were hesitant about being vaccinated and likely would have gone without being vaccinated or delayed their vaccination until a later date had it not been for the easily accessible pop-up site and support provided by Recovery Cafe in getting to the appointment.
- HealthierHere assisted Valley Medical Center in partnering with CBOs to co-host community-based vaccination clinics serving communities disproportionately impacted by COVID-19. In total, six CBOs are contracting directly with Valley Medical to provide these services. HealthierHere assisted in identifying potential partners, refining Valley Medical’s scope of work and payment structure, reaching out to potential partners, convening and facilitating an introductory meeting with the partners, and finalizing the
list of participating partners. HealthierHere continues to informally monitor progress within the partnership and provide technical assistance, guidance, and thought leadership to ensure the success of the partnerships.

16. 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.

HealthierHere Response

Below is an update on activities and investments that HealthierHere envisions continuing post MTP, including efforts taken during this reporting period to promote sustainability.

Evidence-Based Models. Partners continue to make progress in adopting and embedding the use of evidence-based models and strategies into their practices, as evidenced through the below.

Semiannual Reporting. As part of their semiannual reporting requirement, clinical partners complete the MeHAF Site Self-Assessment survey to assess and advance their level of primary care and behavioral care integration (Project 2A) and report on whether they follow the Bree Collaborative Model (Project 2A), Agency Medical Directors’ Group/Washington State, and/or Centers for Disease Control and Prevention (CDC) opioid prescribing guidelines (Project 3A). Additionally, the semiannual reporting includes domains that are foundational to system and service delivery transformation and are congruent with the evidence-based models identified by HCA in the project toolkit. For example, partners are required to report on their use of whole-person screenings/assessments, use of chronic disease registries, improvement on care transitions, and reduction of returns to the ED and/or hospital through use of the Collective Medical platform.

Site Visits. The ACH team also organizes site visits to engage directly with partner organizations and determine the extent to which projects are being effectively implemented, demonstrate impact, and will be or have the potential to be sustained and/or scaled. Using the information gathered through the reports and site visits, HealthierHere makes determinations regarding whether to renew or modify its investments in partner activities as part of future years’ investment strategies. HealthierHere has planned the next round of site visits for fall 2021.

Innovation Projects. Partners are also advancing evidence-based models in their implementation of the Innovation Projects, which are helping advance the goals of Domain 1 (specifically population health and VBP) and projects 2A, 2C, 3A, and 3D by:

- Connecting people who completed induction of MAT in jails or an ED with community-based strategies
- Reducing ED utilization through mobile integrated health care
• Testing and advancing models for integrated whole-person care

For these tests of innovation, HealthierHere has contracted with PHSKC to conduct an evaluation of the Innovation projects, which includes surveys, interviews, focus groups, and document review. The goal is to identify workflow changes that are critical for success, assess the impact of the projects, and assess the feasibility for sustaining the projects at current participating partner sites and for scaling more broadly across King County. The evaluation is in progress and will conclude in early 2022. The evaluation seeks to answer the below key questions; HealthierHere will provide a summary of the evaluation results in the next SAR:

1. To what extent were the projects implemented as intended? Why?
2. What were the successes and early learnings of the projects?
3. What factors would need to be considered for the projects to work sustainably on a larger scale and in different contexts?

Below is a summary of implementation challenges and early learnings (across all projects) based on partner webinars, where partners shared their experiences implementing the projects, and HealthierHere’s ongoing assessment of the evaluation. This information and the final evaluation results will help inform the spreading and scaling of similar projects across the region. HealthierHere will also use the evaluation findings to inform the development and implementation of new projects (dependent on available funding). HealthierHere will work with MCOs and state, county, and other potential funders to identify funding streams to support scaling of existing initiatives and testing of new innovations.

See Appendix B for a detailed overview of project successes and impacts to date.

Figure 9. Innovation Project: Crosscutting Implementation Challenges and Early Learnings

<table>
<thead>
<tr>
<th>Implementation Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difficulty Hiring/Retaining Staff</strong>, e.g., dually credentialed mental health/SUD providers</td>
</tr>
<tr>
<td><strong>Impact of COVID-19</strong>, e.g., competing priorities, lack of in-person interactions, lack of organizational capacity</td>
</tr>
<tr>
<td><strong>Organizational Challenges</strong>, e.g., changes in organization leadership</td>
</tr>
<tr>
<td><strong>Data Sharing/Health IT/Interoperability</strong> – implementing partners had incompatible IT systems</td>
</tr>
<tr>
<td><strong>Substantial Time and Resources</strong> needed to plan for and implement projects (e.g., optimizing workflows)</td>
</tr>
<tr>
<td><strong>Increased Need for Interagency Coordination</strong>, e.g., shared decision making, overcoming differences in organizational models and cultures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies for Success</th>
</tr>
</thead>
</table>

Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021
• Identify Organizational Champions and Secure Buy-in. Identify strong champions from each partner organization and ensure organizational leadership support of the project.

• Conduct Robust Planning. Developing a detailed project plan will help identify milestones and enable tracking of progress. Each partner will need to assess its workflows for how they will need to be updated.

• Establish Clear Documentation/Information Exchange Processes. Keep records of patients served and referrals; incorporate documentation processes into existing workflows; ensure information can be exchanged across team members and partners.

• Understand and Honor Organizational Differences. Identify, acknowledge, and honor differences in organizational models and cultures, especially between CBOs and clinical providers.

• Hold Regular Partner Meetings. Regular partner meetings are useful in working through crosscutting and systems issues, e.g., IT and data issues. Remote meetings are essential for multi-organization projects.

• Maintain Maximum Flexibility. Unexpected challenges will arise.

• Have Written Policies and Procedures for Project Staff. This includes day-to-day responsibilities and expectations for documenting work and tracking outcomes.

• Develop Standardized Training for Project Staff. Standardized training will help project staff understand their roles and implement the project as envisioned.

• Implement Mitigation Strategies for Staffing/Hiring Issues. Consider targeted recruitment and enhanced salaries for difficult-to-fill positions.
**Foundational Technology Platforms.** HealthierHere continues to work toward optimizing partners’ use of the Collective Medical platform and building a community information exchange (CIE), with the goal of continuing to advance these initiatives post MTP. HealthierHere believes that these technologies will enhance the coordination and delivery of care across the region by helping critical information flow to the entities that need it to deliver whole-person, high-quality care.

*Collective Medical.* Over the course of the MTP, HealthierHere has supported partners’ use of various population health tools, including Collective Medical. In SAR 6, HealthierHere reported on how partners have embedded Collective Medical and other tools into their organizations. HealthierHere continues to work with partners to optimize their use of Collective Medical. In this reporting period, HealthierHere led the Statewide Care Coordination Platform Standards Workgroup and published *Washington State Care Coordination Platform Standards: Sharing Care Information on the Collective Platform* to help providers delineate roles and responsibilities in entering care coordination information into the platform, ensure consistency in the scope of information entered, and reduce duplication of efforts among participating providers. In February 2021, HealthierHere hosted a webinar to launch the standards with 135 stakeholders, including primary care facilities, hospitals, and BHAs. HealthierHere and the workgroup are now focusing their efforts to assess barriers to use the standards, assessing the need for tools and other materials to aid in the implementation of the standards, and forming focused groups to further the implementation of the standards.

*Connect2 Community Network.* HealthierHere continues to partner with health and social services organizations to build the Connect2 Community Network, a unified CIE that enables care coordination between physical health, behavioral health, tribal, community, and social services organizations in King County. HealthierHere envisions the Connect2 Community Network as a unified network of cooperating technology platforms (CIE platforms, referral systems, electronic health records, care management systems, etc.), each serving one or more organizations (i.e., a network of networks). For the remainder of the MTP and beyond, HealthierHere is focusing its CIE-related efforts on building a critical mass of users and investing in interoperability across platforms. The CIE advances MTP population health goals and is aligned with projects 2A and 2C milestones related to technology to support integrated care activity and bidirectional communication.9

CIE achievements during the current reporting period include the following:

- Launched a new website for the Connect2 Community Network: [https://www.connect2.org/](https://www.connect2.org/).
- Selected 49 social services and health organizations to receive funding from HealthierHere’s Connect2 Community Network Catalyst Fund. The awards will enable the organizations to send to and receive from other Connect2 Community Network partners electronic closed-loop referrals via the Unite Us technology.
  - With the addition of the 49 Catalyst Fund awardees, the network is comprised of 114 organizations in King County.

---

9 2A: Obtain technology tools needed to create, transmit, and download shared care plans and other health information exchange (HIE) technology tools to support integrated care activities. 2C: Implement bidirectional communication strategies/interoperable HIE tools to support project priorities.
• Designing a request for proposal (RFP) to procure the services of one or more vendors to implement and operate the technical solution for the Connect2 Community Network. For more details, see the RFP background information document located here. The RFP is to be released in August 2021.

• Launched regular meetings of a 23-member multisector advisory group.

• Continued regular monthly network partner meetings and tribal and community engagement.

• Hosted a webinar, “A Discussion on Sovereignty, Equity, and the Health of Indigenous Peoples,” with guest presenter Dr. Desi Rodriguez-Lonebear, where network partners were invited to learn about Indigenous data sovereignty and governance principles and practices and how they can be applied to help address the intersection of health disparities and data justice in King County.

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?

ii. What types of entities are those funds obligated to?

iii. Will the ACH retain some of this funding for post-2021 admin?

iv. Are providers receiving any of these funds for P4P or for future deliverables?

**HealthierHere Response**

No updates. HealthierHere will develop its 2022 investment strategy and present it to the Governing Board for review and approval this fall. To support that process, HealthierHere estimates P4P incentives and uses the following rubric to guide funding allocation across partner types:

- Medicaid Providers – 41.5%
- CBOs – 36.6%
- Tribal – 11.2%
- Reserve/Unallocated – 10.7%

HealthierHere expects to retain a portion of DY4 and DY5 P4P incentives to support post-2021 administrative expenses, such as those associated with disbursing 2022 and 2023 incentives to partners.

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.

**HealthierHere Response**
No updates. Upon Governing Board approval of the 2022 investment strategy, HealthierHere will begin implementing those recommendations and executing contracts with partners.

17. **Regional integrated managed care implementation update**

   a) 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?

**HealthierHere Response**

HealthierHere continues to actively support the King County government and BHAs in integrated managed care (IMC) implementation. As described in previous SARs, HealthierHere participates in the KCICN governance committees and works to ensure HealthierHere’s projects and investments are aligned with IMC goals. Through HealthierHere’s involvement in the IMC transition and partnerships with BHAs, HealthierHere is aware of the challenges BHAs are facing. The greatest challenges BHAs continue to face are summarized below.

**Workforce Shortages and Capacity.** King County continues to experience severe health care workforce shortages, especially for behavioral health practitioners. BHAs are unable to fill vacant positions and retain staff. Additionally, existing behavioral and physical health staff are experiencing burnout due to the physical and emotional toll caused by the pandemic. HealthierHere is exploring ways to partner with the HILT and support its work to build the pipeline of health care professionals in the region, starting with middle and high school students, and to identify and address the biggest challenges facing behavioral health providers today. Areas of alignment and potential partnership include advancing equity and antiracism in the health care workforce (e.g., via trainings and webinars) and identifying and implementing strategies to recruit and retain diverse staff. HealthierHere is also exploring options to support employers’ participation in a behavioral health apprentice program to train local residents to become behavioral health technicians and peer support specialists, which is sponsored by Service Employees International Union (SEIU) and supported by the HMC Behavioral Health Institute.

**BHA Capabilities.** BHAs continue to need support with adapting their care models and strengthening their capabilities to advance integration. The KCICN has launched a learning collaborative for BHAs focused on continuous quality improvement, and HealthierHere is exploring how to support this work, including leveraging its relationship with Comagine Health. HealthierHere collaborates with Comagine Health to provide quality improvement practice coaching to BHAs, including implementing Plan-Do-Study-Act cycles in service of developing workflows for Collective Medical.

   b) 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?

**HealthierHere Response**

Semi-annual reporting guidance
Reporting period: January 1, 2021 – June 30, 2021
HealthierHere continues to actively participate in and support local, regional, and statewide partners in designing and implementing strategies in response to IMC implementation.

- Locally, HealthierHere continues to work to ensure its projects and investments advance IMC goals – notably, through its Testing Models for Integrated Care Innovations.

- Regionally, HealthierHere participates in the KCICN governance committees.

- At the statewide level, HealthierHere continues to lead the statewide discussion among ACHs, MCOs, and HCA regarding standardized measurement and reporting on clinical integration. See below for additional details.

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

**HealthierHere Response**

HealthierHere has identified two statewide challenges tied to measurement and assessment and looks forward to continuing to work with HCA and other stakeholders to mitigate these issues:

- **Lack of a Standardized Integration Assessment Approach.** One of the greatest challenges identified is that clinical practices across the state are completing physical and behavioral health integration assessments for multiple stakeholders, often with different tools and at inconsistent and potentially redundant frequencies. Not only is this burdensome for providers but also it does not allow for a clear way to compare progress and develop a statewide picture of how providers are doing on integration efforts. The Clinical Integration Assessment Work Group (CIAWG), consisting of HealthierHere, HCA, all five MCOs, and two other ACHs, is working to address this issue. Following a review of seven tools and/or frameworks, the CIAWG recommended that the state adopt the *Continuum-Based Framework for Behavioral Health Integration into Primary Care* and the *Continuum-Based Framework for General Health Integration into Behavioral Health*, a complementary set of tools not currently used in the state.

To help inform and advance the adoption of these new tools, HCA contracted with HealthierHere to conduct a field test in March 2021, with six pilot partners representing diverse perspectives and organizational types: Consejo Counseling and Referral Service, Ideal Option, Sea Mar Community Health Centers, Skagit Pediatrics, Quality Behavioral Health, and Valley Medical Center. Pilot partners assessed the tools’ clarity and applicability and provided insights into resources needed to ensure a successful statewide implementation.

The pilot ended June 30 and based on the outcomes of the pilots and ongoing learnings, HealthierHere and the CIAWG recommend that HCA support statewide adoption of a common Clinical Integration Assessment Tool (CIAT) to assess providers’ levels of integration. The full report and set of recommendations were submitted to the HCA at the end of June and will inform ongoing work to develop an implementation roadmap.

- **Insufficiency of MeHAF Data.** Available MeHAF data may not provide the state with a comprehensive and accurate view of the current state of integration. With the state reducing ACH reporting obligations during the COVID-19 pandemic, there may be insufficient data points to identify and understand trends. Additionally, ACHs are only
collecting data from a sample of all behavioral health and primary care sites in their regions, thus results and trends from available data may not be representative of integration across the state. As the state evolves its approach for measuring integration (see below), it should seek to ensure that the above issues are mitigated to help capture as comprehensive a view as possible.

**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 backup documentation related to the attestations provided.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. 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:</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

19. P4R Metrics

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

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

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets](https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121).
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under “ACH pay for reporting metrics.”

Instructions:

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

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

Format:

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

HealthierHere Response

See the attached P4R workbook.

Narrative responses:

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

HealthierHere Response
HealthierHere is providing updates on the MeHAF this reporting period and has done so throughout the pandemic.

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

**HealthierHere Response**
No additional context to report. See the attached P4R workbook for a summary of responses collected from partners.

*Optional: The ACH may submit P4R metric information.*
APPENDIX A. List of Partners That Received 2021 COVID-19 Vaccination Program Funding

<table>
<thead>
<tr>
<th>Partner</th>
<th>Capacity Building</th>
<th>Access and Engagement Fund</th>
<th>Community/ Clinical Partnership Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arms Around You</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Association of Zambians in Seattle, Washington</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Center for Human Services</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Chinese Information and Service Center</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Congolese Integration Network</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Consejo Counseling and Referral</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Country Doctor</td>
<td>Y</td>
<td>-</td>
<td>Y</td>
</tr>
<tr>
<td>El Centro de la Raza</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>HealthPoint</td>
<td>Y</td>
<td>-</td>
<td>Y</td>
</tr>
<tr>
<td>Hepatitis Education Project</td>
<td>-</td>
<td>-</td>
<td>Y</td>
</tr>
<tr>
<td>Interim CDA</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>International Community Health Centers</td>
<td>Y</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Living Well Kent</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Lutheran Community Services Northwest</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother Africa</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Nakani Native Program</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Neighborhood House</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Pamoja Christian Church</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Peer Seattle</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Recovery Café</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Sea Mar Community Health Centers</td>
<td>Y</td>
<td>-</td>
<td>Y</td>
</tr>
<tr>
<td>Sisters in Common</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Somali Health Board</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Southwest Youth and Family Services</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>SSKANA</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>United Indians of All Tribes Foundation</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Unkitawa</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Villa Communitaria</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
</tbody>
</table>
**APPENDIX B. Innovation Project Impacts and Successes to Date**

<table>
<thead>
<tr>
<th>Project</th>
<th>Implementing Partner</th>
<th>Project Impact and Success to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT Care Transformation</td>
<td>County Doctor Community Health Centers (CDCHCs)</td>
<td>• Created the first Saturday clinic providing medication for opioid use disorder (MOUD) in King County.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expanded day-of-release/discharge access to MOUD intakes for vulnerable populations at high risk of overdose death.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Developed and optimized referral workflows, with feedback from project and jail/ED referral partners.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Created “Healthcare for People with Opioid Use Disorder” posters and handouts with locations, hours, and a menu of services offered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Established direct phone lines to nurse care managers and Health Insurance Portability and Accountability Act-compliant cell phones for community health workers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased linkages to behavioral health services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provided trauma-informed treatment for staff with lived experiences.</td>
</tr>
<tr>
<td>Public Health – Seattle King County (PHSKC)</td>
<td></td>
<td>• Reduced barriers to link patients to behavioral health services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supported patients with finding employment, finding housing, and reengaging with families and friends.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengthened care coordination via increased data sharing/information flow.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased organizational capacity to address social determinants of health (SDOH).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facilitated a new referral relationship with a residential substance use disorder treatment provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Changes due to COVID-19 response provided new ways to connect with Department of Public Health Jail Health Services.</td>
</tr>
</tbody>
</table>
| **Mobile Integrated Health (MIH)** | Seattle Fire Department (SFD) and Aging and Disability Services (ADS) | • Strengthened linkages/collaboration between PHSKC and Navos mental health clinics.
• Promoted whole-person care.

- From December 2019 to December 2020, the program saw 1,355 nonduplicated individuals who received five or more responses in that time period, 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 nonduplicated 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 sub-programs: high utilizers, vulnerable adults, and the HealthONE response unit.
- Adapted quickly to the onset of COVID-19 with minimal disruption to the current service model. Because every staff can take on any case, there were efficiencies such as a same-day HealthONE response to a high-utilizer referral from that morning.
- Fostered excellent working relationships with external partners, leading to improved flow of information and 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.

| **Virginia Mason Franciscan Health and** | **Achieved a quality score of 99.2% for the Des Moines clinic.**
• Built a successful model by identifying a physician champion who maintained continuous process improvements for the program. |
<table>
<thead>
<tr>
<th>Testing Models for Integrated Care Innovations</th>
<th>Valley Cities Behavioral Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Hired and onboarded a behavioral health provider for the Des Moines test clinic quickly and on schedule.</td>
</tr>
</tbody>
</table>
| HealthPoint and Valley Cities Behavioral Health Care | • 63+ patients served, 45 care conferences, and 12 psychiatric evaluations by a psychiatric advanced registered nurse practitioner (psych ARNP).  
• Established significant data-sharing capabilities (shared patient registry) and successful workflows, expanding access to the psych 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:  
  o Lowered PHQ9 scores (62% toward goal of 30%).  
  o Exceeded goal for controlling hypertension (76% toward goal of 70%).  
  o Exceeded goal for follow-up primary care visits after a hospital stay or ED visit (96% toward goal of 80%).  
  o Exceeded goal for screening patients for SDOH (100% toward goal of 90%). |
| International Community Health Services (ICHS) and Asian Counseling and | • Converted their in-person training curriculum on diabetes management for peer support specialists to virtual due to COVID-19.  
• Met hiring goals for six part-time peer support specialists (though there has been turnover throughout the year).  
• Started weekly case conferences between the peer support specialists, their ACRS supervisors, and the ICHS care team. This has been very effective in coordinating care. |
| Referral Service (ACRS) | • 14 patients enrolled so far. They speak six different languages (the most common being Vietnamese).  
• Longtime partners ICHS and ACRS grew closer via a dedicated and detailed program design process. Despite their history of collaboration, they needed to gain a better understanding of the other’s workflows and approach to data sharing. |
|---|---|
| Seattle Children’s Care Network and Seattle Children’s Hospital Psychiatry and Behavioral Medicine | • Seven practices participated in the first cohort of the learning collaborative.  
  o *All participating practices have either started seeing behavioral health patients for the first time or expanded/enhanced the behavioral health services they provide.*  
• Every practice has officially brought on a family advocate to be a part of their Core Integrated Behavioral Health (IBH) Team.  
  o *Family advocates have lived experiences and support SDOH needs.*  
• Cohort 1 has completed 73 trainings, webinars, and clinic implementation calls in total.  
• High partner engagement. |
| Downtown Emergency Services Center (DESC) and Harborview Medical Center (HMC) | *Partners were delayed in year 1 implementation and received a no-cost extension (see Figure 6).*  
*Partners experienced various challenges, including difficulty recruiting behavioral health professionals, limited organizational capacity due to COVID-19, and data-sharing and HIE integration challenges.*  
*HealthierHere will report on project impact and successes at a later date.*  
DESC, Community Health Plan of WA, PHSKC, |
<table>
<thead>
<tr>
<th>King County Behavioral Health and Recovery Division</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MultiCare Health System and Sea Mar Community Health Centers</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C. Community-Led COVID-19 Information Sharing Project
(see next page)
COMMUNITY-LED COVID-19 INFORMATION SHARING PROJECT

A partnership with HealthierHere, Community-Based Organizations, and Public Health-Seattle King County. Funding for this project was provided by Gates Ventures.

June 2021
Summary

The Community-Led COVID-19 Information Sharing Project, a collaboration between Public Health – Seattle & King County (PHSKC), HealthierHere, and 32 community partners was designed to improve access to information about COVID-19 testing and safety among Black, Indigenous, and People of Color using a variety of community-grounded information sharing strategies. Evaluation was incorporated into the implementation of the project to understand to what extent and how community-led, rapid information sharing strategies were shared as well as successes and barriers (Aim 1), and whether this partnership was a promising model to rapidly engage communities (Aim 2).

During a four-month period, community partners shared information about COVID-19 safety and testing, including access to free at-home testing through the University of Washington Seattle Coronavirus Assessment Network (SCAN). Information about vaccinations was incorporated after the start of the project in response to community interest. We used formative evaluation that was adaptive to the partner feedback and shifting needs in response to the rapidly evolving pandemic. **Aim 1** metrics included reach (# partners engaged), adoption (# people engaged), and effectiveness of partners’ strategies to share information (successes and barriers). **Aim 2** assessed the value of the partnership, interest in future collaboration among partners, and factors to support sustainability through partner surveys and focus group discussions. Quantitative data were summarized descriptively, and qualitative data were analyzed for themes. Community partners reviewed and contributed to the interpretation of all evaluation findings throughout the project.

We highlight key findings in the figure below.

In summary, the Community-Led COVID-19 Information Sharing Project used a combination of strategies, promoted ongoing engagement, and responded rapidly to community questions. This partnership model was effective in engaging communities in rapid information sharing with potential to adapt for future COVID-19 response efforts and other public health emergencies. Partners valued this model for its rapid, open communication, capacity to respond rapidly to community needs, and trust-building that came from diversity of PHSKC staff reflecting the diversity of community partners. All partners wanted to continue collaborating despite funding uncertainties. More investments in partners’ digital and human resources and establishment of two-way communication between PHSKC and partners would support sustainability.
Key Findings

- From December 2020 to April 2021, 32 (100%) community partners shared information with 58,117 people, personal protective equipment (masks) with 23,303 people, and SCAN testing codes with 5,408 people – 13 people used the SCAN project code to access a COVID-19 test kit.

- **Barriers** to testing and safety practices included limited access to transportation, demands of essential and high-exposure work, and pandemic fatigue, among others.

- The use of a **combination of community-designed information strategies**, rather than a single ‘one-size-fits all’ approach, was effective to reach multiple communities most impacted by COVID-19. Community partners reached community members quickly through numerous contact points that were familiar, including social media, trusted messengers, and service delivery events. Clear, concise, and visual tools were used.

- Effective information sharing about COVID-19 was more than a one-time event but a **process of ongoing engagement with community members** to respond to questions, help navigate resources, and offer a safe space for listening to fears and concerns. Community partner organizations played a key role in interpreting information from trusted sources (e.g. PHSKC, WA State Department of Health (DOH), and CDC) in ways that community members could meaningfully receive, considering appropriate language, format, tone, and frequency.

- **The adaptability of this project design** enabled real-time response to the continuously evolving pandemic and information needs of community members. This includes pivoting the work to address community concerns about vaccines through question-and-answer time during community partner meetings and via “FAQs.”

- The partnership was **highly valued and there was interest in continuing partnering** by all partners. This was attributed to potential for impact on inequities, the flexibility of the partnership structure, and the existing relationships and trust built by HealthierHere with community partners.
Background

Washington state had the first confirmed case and King County had the first reported deaths from COVID-19 in the country.\(^1\) Since the beginning of the pandemic in March 2020, the county’s COVID-19 epidemic has disproportionately affected immigrants, migrants, and communities of color.\(^2\) More than one year later, populations of Black, Indigenous, and People of Color continue to experience disproportionately high rates of COVID-19, and COVID-19 positivity continues to be highest in South King County where testing rates have been low compared to other KC regions.

Early disparities underscored the urgency for Public Health – Seattle & King County (PHSKC) to partner with trusted community entities to rapidly scale and disseminate messaging about when, where, and how to get a COVID-19 test and what to do to stay safe. To address the need to increase COVID-19 testing among the most impacted populations, PHSKC and HealthierHere (HH), a local Accountable Community of Health, designed a community-partnered approach to increase COVID-19 testing and promote COVID-19 safe behaviors (e.g. mask use, social distancing, when and how to isolate and quarantine) among disproportionately affected populations in KC.

In October of 2020, Gates Ventures expressed an interest in supporting community engagement activities to increase COVID-19 testing and safe behaviors among highly impacted communities. There was also interest in evaluating the partnership and community-led approach to understand best practices for rapid outreach and dissemination of health messages to highly impacted communities. Lessons learned from this project will inform community outreach and education for other local programs to address COVID-19.

Between December 2020 and April 2021, PHSKC, HealthierHere – the Accountable Community of Health for the King County Region – and 32 community-based organizations (CBOs) partnered to: 1) rapidly disseminate existing information about COVID-19 testing (including SCAN priority codes) and safe behaviors to Black, Indigenous, and People of Color (including Black/African American/African-born, American Indian/Alaska Native, LatinX, and Native Hawaiian/Pacific Islander communities) and people in South King County, identify barriers to testing and COVID-19 safe behaviors, and 2) evaluate this as a model for community outreach and education, including assessing partnering agencies' interest and ability to sustain this work, and factors that contribute to sustainability.

Methods

For this project, HealthierHere convened 32 CBOs (community partners), with whom they routinely engage for community health work, to rapidly disseminate health messages. These trusted CBOs have long-standing relationships with communities highly impacted by COVID-19, especially in South King County. HealthierHere and PHSKC project team members met weekly to prepare activities to engage community partners throughout the project period. Participating community partners were provided funding to support their ongoing activities to share information about COVID-19 with members of their communities.

The project team worked with an Advisory Group of six CBOs to collaboratively adapt the evaluation approaches that would be used to learn to what extent the messages were shared, how well messages resonated, and identify structural and individual level barriers/facilitators to COVID-19 safe behaviors.
Over the four-month project period, HealthierHere convened five Advisory Group (AG) meetings and four Community Partner (CP) meetings. Advisory Group meetings were typically 90 minutes and CP meetings were three hours. The AG guided the evaluation approach and structure of each community partner meeting and helped interpret findings collected by the PHSKC evaluation team. PHSKC and HH drafted CP meeting agendas, presentation materials, and evaluation questions for AG input prior to each CP meeting. Early in the project period (December 2020), the AG advised the project team to focus on promoting information about COVID-19 safe behaviors and testing options, and not to discuss vaccines. The advice came at a time when no COVID-19 vaccines were authorized for use in the United States and was in response to community concerns and trepidation about the topic. A few weeks into the project, the AG informed the project team that they were ready to talk about vaccines, that community members had burning questions, and that the project needed to shift focus to allow time during CP meetings to address questions and share information from the public health department. Project activities were adapted to meet this need.

To evaluate the rapid outreach work (Aim 1), we used the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework as a guide.4 Data from community partner surveys and reports (media buys, SCAN codes) were summarized as frequencies including Reach (number of community partners providing information) and Adoption (number of community members who received information and PPE, and a priority SCAN code). We coded and analyzed qualitative data, which consisted of community partner meeting minutes, responses in Zoom chats, and open-text responses from surveys.5 Community partner meeting notes were reviewed for key themes according to the RE-AIM framework, including Effectiveness of outreach events, and Implementation barriers and strategies to sharing information about COVID-19 testing and safety (Table 1). Preliminary findings were shared with community partners for co-interpretation after each analysis.

To evaluate the partnership model (Aim 2), PHSKC partnered with a University of Washington Master of Public Health Capstone student to gather perspectives from key partners on the value of the collaboration, CBO interest in continued use of this model of partnership, interest and likelihood of continuing the work, resources needed, and factors that contribute to sustaining this work (e.g. community interest, funding, organizational mission). Between March 2021 and April 2021, data were collected using an online survey with 32 community partners and three focus group discussions with representatives from the AG, HH, and PHSKC by videoconference. Preliminary findings were shared with participants for review and feedback was incorporated accordingly.

Results | Aim 1: Rapid Dissemination of Information and Outreach

Through the partnership structure and approach (Figure 1), government and community partners were able to jointly discuss rapidly changing COVID-19 information, share insights, and adapt evaluation methods. Community partners identified six community-grounded strategies that were most effective for them to engage and share information.
How and Where COVID-19 Information was Shared
Collectively, 32 community partners achieved the following key outcomes (Table 1):

- Over 58,000 people reached with COVID-19 information
- 13 community partners (41%) distributed personal protective equipment (face masks) to over 23,000 people across and outside King County*
- 13 community partners (41%) shared information about SCAN and the SCANCBO priority code to 5,408 people*
- More than 80% of community partners reported working with communities in South King County and South Seattle
- Ethnic media buys focused on Latinx and Native Indigenous populations reached more than 380,000 individuals

* Sharing PPE (face masks) and SCAN codes were optional activities.

Community partners shared information about COVID-19 risks, safety practices, and testing options using technology, outreach events, and direct conversations with community members. This included
social media, video, and email, one-on-one or group activities, storytelling, and events held in person and online. As a result of government restrictions on gathering, virtual outreach strategies were prioritized. The most common formats and platforms that partners reported using were social media, printed materials, and electronic communications such as newsletters and email (Figure 2).

![Platforms used by community partners (n=32) to share information about COVID-19](image)

**Figure 2. Platforms used by community partners (n=32) to share information about COVID-19**

**Barriers to Accessing COVID-19 Information & Resources**

Partners serving different cultural and geographic communities within and outside of King County reported several common barriers – very few were unique to a specific community. A predominant theme heard from community partners was that COVID-19 messages coming from national and local public health institutions were not reaching many communities at highest risk of COVID-19 exposure, illness, and death. Inequitable access to the internet, complex messages, lack of messages available in appropriate languages and literacy levels, and uncertainty about where to go for trusted information impeded community members’ ability to access the information they needed to make informed decisions about testing and safety. We organized findings by system, service, social, and individual/family levels using an adapted ecological framework.  

**Systemic barriers**

For this project, *system level barriers* were those related to transportation systems, employment, and information systems. Systemic barriers to accessing COVID-19 testing included limited safe and affordable transportation options. Community partners reported that some community members who wanted to get tested could not because they either did not have their own transportation, did not feel comfortable asking friends/family to drive them, or were afraid of COVID-19 exposure from public transportation.

Partners described that many of their community members are essential workers. High exposure jobs and the lack of paid time off contributed to barriers to safe behaviors. The limited operating hours of many testing locations was a challenge.
Accessing information online about testing locations or scheduling appointments was difficult for community members without internet access or limited familiarity with navigating online systems. For example, partners reported that one of the main challenges to sharing information about SCAN testing, especially among older adults, was the lengthy online registration system, the only option for getting the SCAN test.

**Service barriers**

*Service level barriers* are those related to provider-client interactions and care coordination. Partners highlighted the lack of culturally and linguistically appropriate services and strategies, as well as fragmented resources as key barriers to accessing information and support. Partners emphasized that information delivered by institutions and individuals from outside the community was less likely to be valued or trusted. In most communities, it was important for messages to be communicated through trusted leaders, elders, or health experts from the community.

A key challenge was the fragmented system of providing resources for community members. Partners noted difficulty connecting families to available resources for isolation and quarantine, such as rental assistance, food delivery, gift cards, home visits, and/or isolation and quarantine centers. This was due in part to confusion about what services exist and how to access them, including answering calls from contact tracers.

**Social barriers**

*Social level barriers* refer to broader community and social norms and relationships that influence behavior. Partners highlighted challenges associated with sharing COVID-19 information while managing constantly changing messaging from Public Health. They described the tension of balancing conversations about the consequences of testing positive with the idea of testing as a tool for safety until they were ready to get vaccinated. Community members feared loss of employment or being asked about their immigration status. Some were reluctant to reveal their COVID-19 status to outreach staff, which made it difficult for community partners to identify who in their communities needed support for isolation and quarantine or other resources. For example, some community members were reluctant to engage with contact tracers, who are a primary source of information about supportive resources, because they worried what would happen if their contacts and employers knew. Some also had concerns about the SCAN test—what if a neighbor saw the kit being delivered/picked up?

Community partners described that some community members felt a false sense of safety. They described a sense of safety with family and friends, and so masks and social distancing weren’t used. As the pandemic progressed, partners shared that community members were already well-informed about COVID-19 testing and safety practices and weary of hearing these same messages again. They were ready to talk about vaccines. As more people got vaccinated, some community members began to doubt whether they still needed to mask and socially distance. It became a challenge, though important, to find new ways to engage community members with messages about safety behaviors.

“When we talk about SCAN...a lot of the [community] members are not technologically savvy, and the conversation doesn’t go [anywhere]. The younger generation might be able to, but not the older generation.”

- Community Partner

“Vaccine talk has replaced any question or concern about prevention, so I feel stuck because we’re supposed to respond to the needs of community, ...they think the need is the vaccine and are forgetting the need for prevention.”

- Community Partner
Individual & family barriers

Individual/family level barriers are related to personal context and perceptions, which are tied to historical context. Partners emphasized that families in multi-generational or shared households faced multiple challenges to practicing safe behaviors, including how to isolate when they lacked space and/or the ability to take time away from work or caring for other family members. As schools started to re-open for in-person learning, families faced the challenge that children might come home with COVID-19 and expose vulnerable members of the household.

Community partners raised the persistent concern of fear and distrust of government, health, and research agencies. Community partners shared that historical and ongoing systemic racism has a significant impact on perceptions of health information and health behaviors. This includes hesitancy to seek care or testing, or to trust medical advice, scientific studies, or innovations such as vaccines.

Community members also described the challenge of meeting emotional needs to socially connect, to grieve, gather, and celebrate. Partners noted this was especially challenging for isolated older adults and among young people who were seeking contact with peers.

Effective Strategies for Sharing COVID-19 Information and Engaging Communities

Community partners shared six overall strategies they found to be effective, which were often used in combination to share COVID-19 information in meaningful ways and to engage with community members on an ongoing basis.

Strategies for Sharing Information

Keep messages clear, concise, and visual

Early in the project, members of the project Advisory Group mentioned that messages from Public Health were often too complicated to understand or follow, so partners spent time creating simple messages and tools they could share. Nearly all partners used social media to rapidly reach large audiences with updated information. This was a key approach that enabled partners to adapt to continuously changing information, which sometimes contradicted prior information. Some partners used Facebook and messaging apps such as WhatsApp and WeChat for regular communication, which allowed people to comment and re-share. Many partners shared infographics, maps of new testing sites, and brief summaries that directly answered the questions raised by the community. Community partners also combined social media, flyers, and in-person discussions to disseminate information about COVID-19. A couple of partners provided updated information on their websites.

Ensure messages are culturally and linguistically aligned

Community partners emphasized the importance of involving community-based organizations in the design and delivery of messages and tools to ensure that information was communicated in ways that are appropriate and relevant to community members. The main features of making information culturally and linguistically aligned involved developing, translating, interpreting, and vetting information with the intended audience, as well as responding to concerns being heard. Tools are best disseminated through trusted messengers and in settings where people are comfortable gathering – online or in-person with appropriate safety guidelines. Community partners working with American Indian/Alaska Native/Indigenous communities, for example, often used traditional storytelling to convey messages through online platforms and found safe ways to deliver resource baskets to community members. Some partners held virtual meetings through WhatsApp and Facebook groups or online
cooking classes, while others delivered information through their existing relationships with schools, places of worship, local restaurants, and cultural centers. This work was resource-intensive and presented challenges for organizations with limited outreach staff.

**Include personal experiences and model safe behaviors**

Having community members share their personal experiences with COVID-19 was especially useful when talking about difficult decisions such as vaccination and/or isolation and quarantine. Whereas simply sharing facts could feel impersonal, partners saw more interest from community members in hearing from someone in their community about their firsthand experience contracting COVID-19 and quarantining, getting tested, or receiving their vaccine. Community partners applied this strategy by conducting radio interviews, creating videos with individuals and families sharing their stories, and hosting small group discussions. Some partners also sought out firsthand experience by ordering their own SCAN test or using COVID-19 testing sites so they could explain the process to others during outreach.

**Strategies for Engaging Communities**

**Involve trusted messengers**

Partners emphasize that testing and safety messages were more likely to be received when delivered by trusted and respected messengers. Trusted messengers are individuals who are viewed as sources of credible information because they have strong and long-standing relationships with community members. Many are religious leaders, elders, youth leaders, community health workers, medical professionals, and radio hosts, among others. Because community partners are deeply embedded in their communities, they are poised to identify and engage trusted messengers to elevate COVID-19 information and address community concerns. These messengers played a key role in distributing concise, culturally appropriate messages and assisting with scheduling appointments for testing and/or vaccination. Because they are community embedded, trusted messengers also played a key role in fostering sustained community engagement and were especially effective in working with community members who shared doubts and fears about the pandemic and response. Importantly, trusted messengers were effective at sharing rapidly changing information. Partners could, for example, share new updates through social media then follow up through trusted messengers with more extended conversations to address on-going questions and concerns.

**Communicate with empathy and without judgement**

“Having someone who has [been tested] before to talk you through the process is more comforting than blindly going on your own....”
- Community Partner

“For communities that do not rely on the news but rely on word of mouth, messaging needs to be shared with elders, leaders, matriarchs, patriarchs... Otherwise people don’t take it seriously.”
- Community Partner
Partners highlighted that effective COVID-19 information sharing went beyond a single brief interaction and required open, ongoing dialogue where community members felt listened to and not judged. This was especially important in conversations with community members who had unanswered questions, fears, doubts, and frustration. When community members voiced concerns about whether to test, vaccinate, or gather with loved ones, partners offered them information and resources needed to make informed decisions while intentionally not pushing them towards one decision or another. Partners who worked with youth also stressed that maintaining an open dialogue was critical to keeping them engaged. Inviting young people to discuss their personal challenges allowed them to come up with solutions for how to connect socially in ways that allowed them to stay safe.

**Combine information sharing with activities and services**

Partners found that an important way to engage community members in COVID-19 information was to integrate it into social events and activities that helped meet needs for personal connection while also providing items that people needed to keep healthy and safe. This approach provided opportunities for community members to connect and uplift one another while taking part in fun activities such as games and raffles with prizes. Some partners described these events as a critical way to connect community members to resources such as food bags, at-home play kits for children, or PPE while also sharing information about testing, safety, and vaccines. Online events were used by some partners to allow people to come together in a safe space to ask questions.

**SCAN Testing Barriers and Opportunities**

Information about SCAN testing was shared widely. Of the 32 partners organizations engaged through this project, 13 shared SCAN information and a priority code with over 5400 community members to access a SCAN test kit. Among them, 13 people used the code to request a test kit. When asked what may keep people from using SCAN, community partners described lack of awareness among some partners, difficulty with online registration, lack of confidence taking an at-home self-administered test, concerns about sharing personal data (name, address, status), and hesitancy about participating in SCAN as a research study. They recommended strategies such as increasing public awareness using widespread and simple messaging, helping people register, developing clear explanations about all steps in the testing process, and clarifying how personal data are protected and shared. They noted that explanations should de-emphasize participation in research as a benefit of getting a SCAN test and instead promote the importance of knowing one’s status. One partner recommended learning from home-based HIV testing programs, which distribute and collect kits using discrete packaging and clear, concise explanations about the testing process and data privacy.

*“The question we intentionally do not answer is ‘should I take the vaccine?’ Any challenges [with the vaccine] would irreparably harm the trust relationship we have with the community...”* - Community Partner
In Table 1, we summarize relevant results from the narrative section according to the RE-AIM framework, outcomes, and indicators. Please refer to the text for further description of these results.

| Table 1. RE-AIM Table of Primary Results, by Domain from the COVID-19 Information Sharing Project |
|---|---|
| Domain | Measures |
| **Reach** | # (% of CBOs who provided COVID-19 information and PPE) 32 (100%) partners provided COVID-19 information |
| | # (% of CBOs who distributed priority SCAN code) 13 (41%) partner agencies provided PPE (optional activity) |
| | # reached by media buys ~380,661 people reached through ethnic media |
| **Effectiveness** | Qualitative input from CBOs about successes and challenges of using outreach events to provide COVID-19 information and PPE (masks) |
| | Successful Strategies for Sharing COVID-19 Information |
| | Use clear and visual tools |
| | Culturally and linguistically aligned |
| | Through trusted messengers |
| | Incorporate personal experiences |
| | Combined with social events and services |
| | Non-judgmental |
| | Challenges Sharing COVID-19 Information |
| | - information that was too repetitive, not actionable, and not trusted |
| | Challenges using outreach events |
| | - focusing only on COVID-19 did not keep communities engaged |
| | - limited staff for outreach and engagement |
| **Adoption** | # of people who were provided information 58,117 people received COVID-19 information |
| | # who received PPE (masks) 23,308 people received masks |
| | # who received a priority SCAN code 5,408 people received priority SCAN code |
| | # who used a priority SCAN code 13 people used priority SCAN code |
| **Implementation** | (1) Qualitative input from CBOs about education messages that did and did not resonate |
| | Message content that resonated |
| | Include maps of testing sites |
| | How to talk to children about COVID-19, care for a household member, and practice safe activities |
| | How to cope with COVID-19, including stigma |
| | Message content that did not resonate |
| | Repeated messages about testing and safety |
| | Isolation & quarantine |
| | Information about vaccines (initially)* |
| | Barriers to testing access included lack of safe transportation, limited internet access, lack of cultural/linguistically appropriate services, privacy concerns |
| | Barriers to safety behaviors included high-exposure jobs, belief that vaccines reduced need for safety practices, inability to safely isolate and quarantine at home, need for connection |
| **Maintenance** | Not assessed for this short-term initiative |

*As the project evolved, CBO partners described a shift in information needs to focus on vaccines once they became authorized for use and community members proposed questions about safety and access. **Stratification of barriers was not conducted by CBO since common barriers were reported by multiple organizations.
Results | Aim 2: Evaluating this as a Model for Community Outreach and Dissemination

Several themes emerged about the partnership model in this project, described below, along with highlights from a survey of the 32 community partners.

Value of existing positive relationships, open and real-time communication, and meeting project goals

While respondents recognized the history of distrust between some communities and PHSKC in prior research projects, this partnership made progress in strengthening trust. Advisory Group members appreciated the diversity and representation of PHSKC project staff, describing it as an important aspect of creating safe and open communication during project meetings. The pre-existing relationships that CBO partners had with HH, as well as the facilitation skills that HH brought to meetings were described key factors that brought AG members to the table. Project meetings also provided a space for mutual learning and for “community members to say what they needed.” Partners valued the collaboration because they were able to achieve the project goals in a short time. Flexibility and real-time communication to address partners’ needs during meetings were mentioned as key contributors to the success of the project.

All 32 community partners completed a brief 26-item partnership survey. Areas rated highly about the partnership were: partners being open and responsive, transparent, culturally centered, having effective dialogue with listening and mutual learning, and addressing community needs.

- 84% (27) of community partners agreed that the partnership enabled PHSKC to include views and priorities of community members
- 84% (27) agreed that it enabled PHSKC to be responsive to community needs and problems
- 82% (26) agreed that resources within the partnership were adequate to share with communities
- 97% (28) reported an organizational commitment to maintaining the partnership

Partners support future collaborative work that builds on the current partnership model

HealthierHere, PHSKC, and community partners expressed interest in future opportunities to collaborate/partner because of the potential to impact inequities, though this would be dependent on funding. Community partners want to see findings applied to make policy and systemic change. Most (93%) partners responded that their organization was committed to maintaining this partnership with funding, and more than half would continue to collaborate even without funding. In the open-ended survey responses, one community partner commented: “I was surprised by how much growth opportunity there was for everyone at the table and having that trust and that openness be there, showed that there really was, really was opportunity for everyone to grow, for everyone to learn from the Public Health side to us to the community side and I was surprised by that...”

Community partner suggestions for sustaining this partnership model

While partners expressed desires to continue collaboration, they felt the main threat to future sustainability was funding. Community partners were asked, “What are some actionable things that would help the community you serve to overcome barriers to isolation among people with COVID-19 and quarantine for people who are exposed?” We also asked partners what supports were needed to
ensure equitable access to testing. Here we summarize what partners shared during those conversations.

Funding areas partners prioritized

- **Translation, interpretation, and navigation.** Community partners provide much needed translating and creating (transcreating) information in ways that community members can meaningfully receive including language, tone, and format. While PHSKC provides COVID-19 materials in over 30 languages, community partners have had to translate documents into languages that are less commonly spoken in King County. Because information sharing is more than language translation and includes a process of ongoing communication, investments are needed to support outreach staff with dedicated time for phone, online, and in-person discussion, interpretation, and navigation. This would expand capacity of outreach staff to connect community members with resources to support safety, testing, and vaccination.

- **Technology platforms and capacity building.** Additional discretionary funds to support partners’ online platforms (social media, websites, Zoom) and staff would have multiple benefits. It would expand reach of online information sharing, reduce barriers to online registration for COVID-19 testing and vaccination, and help community members stay connected. Partners highlighted the need to support more people with online registration for testing, a key access barrier identified in this project. Further, partners could expand their activities to promote safe social connections by hosting virtual social events and offering more trainings in how to use Zoom.

- **Direct assistance.** Despite the increase in dedicated resources for COVID-19 affected families in King County (e.g. gift cards, childcare, household products), partners emphasized the need for greater investments to increase the amount of assistance available and to coordinate services efficiently. This was especially important to support individuals and families to safety isolate and quarantine.

- **Mental health supports.** Community partners are uniquely positioned to work with families and connect community members with resources to handle stress, anxiety, and grief from COVID-19. One partner suggested investing in staff training in mental health ‘first aid’ to expand capacities of front-line workers and case managers to support community members to cope with stress.

Three next steps partners suggested

- **Establish an ongoing two-way communication and feedback channel between PHSKC and community partners.** Rapid, ongoing, and open communication between partner organizations supported the success of this project. PHSKC and community partners could expand this model by establishing a communication channel through designated contacts within the public health department. This would enable partners to access a single pathway for information about COVID-19 (or other public health emergencies) to share with community members, and to provide feedback to PHSKC on how to ensure that information is accessible and responsive to community needs.

- **Create and share a comprehensive, centralized information source of available resources** within the partner network for disproportionately impacted communities. Community partners described challenges with getting information about current resources available to support families, such as isolation and quarantine and cash assistance. Community partners mentioned the importance of developing and disseminating across their network a regularly updated comprehensive list of available services for families affected by COVID-19 and other emergencies.
• **Leverage existing partner network to launch a community-owned emergency preparedness plan.**

  Community partners identified an opportunity to expand on successes and challenges from COVID-19 and organization-specific preparedness plans to develop a network-wide, community-owned preparedness plan to prevent and mitigate future public health threats.

**Limitations**

This project was not designed to measure long-term impact or behavior change due to the short project period (four months) and the need to prioritize partners’ time to conduct outreach activities. However, we did systematically collect short-term measures as well as rich qualitative information about barriers and successful strategies to overcome barriers to COVID-19 information and safety as well as ideas for sustaining this type of partnership as the pandemic evolves. A second limitation to note is that the 32 community partners who participated in this project are a subset of many community organizations working in and around King County. Findings from this project are not meant to represent experiences of all impacted community members. However, the 32 longstanding and trusted relationships that project partners have with communities allowed the project to successfully accomplish project aims within the four-month period.

**Dissemination**

Throughout the project, the HealthierHere and Public Health project teams have shared findings from this work with leadership and COVID-19 teams responsible for outreach and communications with both organizations to make sure that the voices and experiences of the community can help guide the COVID-19 response at the county level. Beyond the real-time dissemination work, HealthierHere and PHSKC continue to partner on projects to support COVID-19 community response. Leveraging this partnership model and longstanding professional relationships, HealthierHere and Public Health have submitted proposals to continue funding collaborative communication and engagement activities for COVID-19 response and recovery.

**Final Reflections**

This community partner-led rapid information sharing model was effective at expanding access to information about testing, safety, and vaccination to communities most impacted by COVID-19 during the 3rd wave and highest peak of the pandemic. The partnership between government and community partners was successful at responding rapidly to a changing pandemic context and information needs. Community partners held trusted relationships with community members and reached them using a combination of strategies (such as non-judgmental conversations, clear and visual messages, personal experiences, combining outreach with services, and being culturally and linguistically aligned) that continuously engaged community members. Project partners valued the partnership because the funding and structure allowed us to achieve project goals through open, ongoing communication, mutual learning, and flexibility needed for a dynamic situation. This led to feelings of a more trusting relationship between community partners and PHSKC.

This government and community partnership offers a promising model to resource and engage communities experiencing inequities during a public health emergency. To sustain this work and prepare for the post-pandemic recovery period, PHSKC and HH are pursuing several new funding opportunities.

“I think what we appreciate from the collaboration is for the community to be able to say what they need and not have institutions to come to us and say this is what we want you to do”

- Advisory Group member
through the Centers for Disease Control and Prevention and the Office of the Assistant Secretary for Health/Office of Minority Health (awards of $2 million to $17 million) that would leverage the partnership network and experiences from this project to advance toward health equity. Proposed projects would support community-led and owned initiatives, including culturally aligned health literacy strategies and community health worker training to support resource navigation and use.

Acknowledgements

We thank Gates Ventures for funding this work, HealthierHere and the 6 Advisory Group member organizations and community members for their leadership in this project, the 32 community partners for their on-the-ground work on the pandemic response, and Lulit Essayas for her contribution to the project evaluation.

Advisory Group Organizations

APICAT
Center for MultiCultural Health (CMCH)
Consejo
Headwater People
Sisters in Common
Unkitawa

Community Partners

APICAT
Arms Around You
AZISWA
Center for Human Services
CISC
Civil Survival
Center for MultiCultural Health (CMCH)
Congolesse Integration Network
Consejo
Eastside Baby Corner
Falis Community Services
Gay City
Headwater People
Interim-CDA
Latino Community Fund
Living Well Kent
Lutheran Community
Mother Africa
Nakani
New Traditions
Pamoja
Peer Seattle
Sisters In Common
Soar
South Sudanese Kuku Association of North America (SSKANA)
Teenagers Plus
Tlingit and Haida
United Indians of All Tribes Foundation
Unkitawa
Upower
Villa Communitaria
ZACUSA
**References**


COMMUNITY-LED COVID-19 INFORMATION SHARING PROJECT:
KEY FINDINGS AND LESSONS

A Partnership Between HealthierHere, Community Based Organizations, and Public Health-Seattle King County

December – April 2021

Funding for this project was provided by Gates Ventures

June 2021
Purpose of Project

King County’s COVID-19 pandemic has disproportionately affected Black, Indigenous, and People of Color. In response, this project was designed to take a community-led approach to improving access to information about COVID-19 testing and safety among the most impacted communities.

GOALS:
1) **Rapidly disseminate** existing information about COVID-19 testing and safe behaviors in a culturally responsive way, with a focus on reaching Black, Indigenous, and People of Color (including Black/African American/African-born, American Indian/Alaska Native, LatinX, and Native Hawaiian/Pacific Islander communities), as well as South King County residents, while identifying barriers to testing and COVID safe behaviors.

2) **Evaluate this as a model** for community outreach and education, including assessing partnering agencies’ interest and ability to sustain this work, and factors that contribute to sustainability.
Government and community partners collaborated to use community-grounded strategies that engage community members. These efforts can identify barriers and improve equitable access to information and resources.

HealthierHere and Public Health Seattle & King County partnered with 32 community-based organizations. 6 of these organizations were also represented on an Advisory Group.
Partnership

- Falis Community Services
- Living Well Kent
- Teenagers Plus
- United Indians of All Tribes Foundation
- Association of Zambians of Seattle Washington (AZISWA)
- New Traditions
- South Sudanese Kuku Association of North America (SSKANA)
- Center for Human Services
- Consejo Counseling & Referral Service
- Lutheran Community Services NW
- Center for MultiCultural Health
- Congolese Integration Network
- Chinese Information and Service Center (CISC)
- Latino Community Fund
- Civil Survival
- Sisters In Common
- Tlingit and Haida
- Unkitawa
- Headwater People
- Eastside Baby Corner
- Villa Communitaria
- Arms Around You
- Gay City
- Upower
- Peer Seattle
- Nakani
- Pamoja Church
- ZACUSA
- Soar
- Interim-CDA
- Mother Africa
- API Coalition Advocating Together for Health (APICAT)

HealthierHere and Public Health Seattle & King County partnered with 32 community-based organizations. 6 of these organizations were also represented on an Advisory Group.
Project Framework and Findings

Government and community partners collaborating

- HealthierHere
- Public Health Seattle King County
- Community Partners
- Community Advisory Group

Culturally & Linguistically Aligned
Clear & Visual
Personal Experiences
Non-judgmental approach

Trusted Messengers
Combining with Services

to use community grounded strategies

that continuously engage community members,

- Individuals
- Families, caregivers, partners & peers
- Leaders, faith community & service providers

in order to identify barriers and opportunities

Testing hours & location
Transportation
Traditional media outlets
Inequitable access to support
Myths
Stigma
Shared housing
Stress
Childcare needs
Economic disruption
High-exposure work
Digital access
Lack of language & cultural representation
Unanswered questions
Pandemic fatigue
Focus on vaccine over safe behavior
Fear & distrust
Need for personal connection

Systemic
Services & Providers
Social
Individual & Family

and improve equitable access to information and resources.

- Access to meaningful information, safe spaces for questions, & accessible support
- Improved ability to quarantine, isolate, get tested, and be safe
- Improved health & safety during COVID-19
Adaptive & Collaborative Evaluation

Advisory Group meets to review evaluation approach and findings

Community partners meet to discuss insights, confirm findings, and share challenges

Community partners share information throughout their communities

PHSKC & HH analyze and summarize data from discussion and Narrative Reports

Community partners share back about activities through Narrative Reports

Data collected through:
2 Narrative Reports
4 Community Partner Meetings
4 Advisory Group Meetings

Data analyzed for:
• Key themes on strategies and challenges
• Number of people reached, types of messages, PPE and SCAN distributed
Outreach Activities

Community partners conducted outreach and ongoing engagement in **33 different languages** other than English.

- 58,117+ people reached Dec 2020 – March 2021
- 23,308 people received PPE
- 5,408 people received SCAN priority code for test kit
- Partners worked across King County, mostly South
  - 91% in South King, 81% in South Seattle
- Common ways to deliver messages:
  - Social media
  - Printed materials
  - Electronic (newsletter / email)
- Main topics: Testing and safety, isolation & quarantine, vaccines
- Media buys with Native, Indigenous & Latinx media outlets

Languages are listed as provided by community partners.
Barriers to Safe Behaviors

Systemic
High-exposure jobs and lack of paid sick time to safely isolate and quarantine

Service Provider
Fragmented resources available for families in quarantine & isolation (rent assistance, food delivery, PPE)

Social
Pandemic fatigue making it difficult to continue social distancing; false sense of safety with close family and friends, vaccine overshadowing safety

Individual & Family
Managing exposure in multigenerational or shared housing; potential exposure of children in schools; challenges with meeting emotional needs to socially connect (grieve, gather, celebrate)

“Many clients including those required to remain home due to increased risk of COVID infection had to weigh the implication of lost incomes.”
- Community Partner
Community partners found these community-grounded strategies to be especially effective when sharing information with their community.

“[Sharing COVID-19 information] is a process, not an event.”
- COMMUNITY PARTNER

Information Sharing Strategies

Concise & visual

- Reaches large audience efficiently with the latest facts and easy to understand

Culturally & linguistically aligned

- Ensure ownership, accessibility, and relevance to community

Personal experiences

- Addresses concerns and shares personalized information

“Because our cultural navigators shared information and because messages were delivered in a culturally appropriate way and via venues relevant to community, we found that all messages were well received by the communities that we serve”

“Our community prefers infographics, short and clear communication and is more widely shared/consumed with the communication is delivered alongside Native art.”

“What was received well was real stories-people sharing their COVID experiences, particularly those that represent BIPOC communities. Using vaccination “interviews” that address questions & concerns of BIPOC communities & the historical context that influences trust in the health care system”
Engagement Strategies

Community partners found these community-grounded strategies to be especially effective when conducting outreach and engaging with their community.

“[Sharing COVID-19 information] is a process, not an event.”
- Community Partner

“Trust that we will provide information to all who need it.”

“Trusted messengers

Facilitates trust and connection

Listen with empathy & avoid judgement

Provides safe space to share concerns and keeps ongoing conversations open

Events that meet physical & social connection needs

More engagement, safe social connectivity, and encourages participation

“Our community has a lot of questions, fears, and need the reassurance of human contact by people they know and trust. Our mitigation strategies worked heavily with our circles of kinship and community to ripple out the information.."

"Our experience providing information without casting judgment at least makes people willing to listen without outrightly dismissing what is being shared."

“We distribute COVID care kits in person to clients that were meeting with staff for reason's other than COVID education. We utilized these interactions of service to be advocates of continued safety, testing and awareness. In doing so, we opened up many great discussions about the pandemic and concerns/questions people were having.”
Many strategies used overlap but were implemented in unique ways, tailored to the specific cultural community.

Community partners were asked: “What is an example of a strategy (for information sharing) that has worked well with the cultural community you primarily serve?”

As one partner said: "We serve individuals from the Asian Pacific Islander, African American, Kenyan, Tanzanian, Ethiopian, Eritrean, Haitian, Nigerian, Mali, Ghanaian, Tigray, Congolese, Somali, and Somali Bantu communities and...

Each of these communities receive and process information differently, so it's important to employ multiple strategies to reach individual communities, and equally important to have translated materials and use trusted advocates to deliver messages."
How partners engage cultural communities

“We serve the AANHPI community – best strategies are developing and providing culturally & linguistically appropriate educational materials (infographic) translated into Asian languages, Chinese, Korean, Samoan, Tongan, Vietnamese, Khmer.”

“We work with a large Chinese community and utilize the WeChat platform, do check-ins via the phone, and send information via grocery bag runs.”

“We serve primarily Chinese and information spreads fast through WeChat groups.”

“We serve the Alaska Natives in the Pacific Northwest and Facebook has been reaching the most people. We call on elders by phone.”

“We serve the Native American community in WA and we utilize storytelling as our primary strategy.”

“We share Indigenous communities and [information shared] through traditional practices and protocols are best received.”

“We serve the Latino community and what works best is in person, radio & social media”

“We serve the African American and African Heritage community. Strategies we use: Community Health Workers who are themselves members of the communities they serve, supported by our multi-media and linguistic and audio Community Alert Tool.”

“We work with a large Chinese community and utilize the WeChat platform, do check-ins via the phone, and send information via grocery bag runs.”

“We primarily serve refugees, immigrants, asylees and asylum-seekers - social media works best, linguistically appropriate information is useful, and providing verbal information to clients picking up in-kind or hygiene items are really useful.”

“We serve youth: flyers & small group discussions have been best.”

“We serve LGBTQ+ and social media works well for us. We have an active Facebook page.”

“We serve the Kenyan community and the Swahili speaking community. WhatsApp groups have been very effective.”

“We serve the Congolese community & used video recording & social media.”

“We serve the people of Zanzibar here in Seattle. We use social media and word of mouth.”

“We serve the African Refugee and immigrants as well as Middle Eastern and successfully used WhatsApp groups.”

“We serve African and refugee immigrants and use WhatsApp and encourage members to share personal stories about COVID, including vaccination.”

“We serve the AANHPI community – best strategies are developing and providing culturally & linguistically appropriate educational materials (infographic) translated into Asian languages, Chinese, Korean, Samoan, Tongan, Vietnamese, Khmer.”

“We primarily serve refugees, immigrants, asylees and asylum-seekers - social media works best, linguistically appropriate information is useful, and providing verbal information to clients picking up in-kind or hygiene items are really useful.”
How to Improve Access to SCAN Testing

5408 people received SCAN code

13 people used the SCAN code

“For SCAN, a lot of people doubt the accuracy if they take it themselves. They would rather get a test administered by a professional.”

“SCAN is a great opportunity, but they would have to be comfortable putting in their address. Some people don’t want the government to have that information.”

Barriers to Accessing SCAN testing

- Lack of awareness about SCAN
- Lack of access to and familiarity with technology
- Low confidence using a home-test
- Concerns about sharing personal information
- Stigma of testing positive for COVID-19
- Hesitancy around SCAN as research study

Suggested Strategies to Improve Access

- Raise public awareness about SCAN with partners
- Offer support with registering online
- Demonstrate how to test and understand results
- Emphasize personal benefits of knowing status
- Clarify what personal data are shared
- Use discrete packaging to drop off and pick up tests
Evaluation of the Partnership

✓ All partners (PHSKC, HH, CBOs) placed high value on the partnership and expressed desire to continue because of the potential to impact inequities, though this would be dependent on funding.

✓ CBOs highlighted positive experiences with the partnership, expressing appreciation for: the flexibility and rapid communication, the real-time adaptations, and the diversity and representation of the PHSKC staff.

✓ The existing relationships, trust-building, and facilitation skills brought by HealthierHere were a critical aspect of the partnership success and partners willingness to participate.

✓ CBOs want to see findings applied to make policy and systemic change and for future collaborations to maintain focus on improving equitable outcomes for their communities.

✓ Although CBOs expressed mistrust of the PHSKC institution as an initial barrier, the partnership made progress in strengthening trust.

“The experience shows PHSKC & HealthierHere’s dedication to uplifting our community. It was a joy to work with the team.”
- Community Partner

“I was surprised by how much growth opportunity there was for everyone at the table. Having trust & openness showed that there really was opportunity for everyone to grow & learn - from the Public Health side, to us, to the community side.”
- HealthierHere

“This project has created an opportunity because of the established HealthierHere relationship with Public Health and the leadership of HealthierHere during COVID.”
- Advisory Group member
What has been done with these findings

Preliminary findings have been shared with:

- HealthierHere Governing Board
- Community and Consumer Voice Committee
- Indigenous Nations Committee
- HealthierHere Clinical Partners
- HealthierHere System Transformation Partners
- Community Partners & Advisory Committee
- Gates Ventures
- CDC-PHSKC COVID Monitoring and Evaluation
- UW SCAN Study Team
- PHSKC internal teams working on COVID response
  - Epi & Response Team 3/16/2021
  - Care Coordination Team 3/23/2021
  - Public Information Officer 3/24/2021
  - Equity Director and Vaccine Response Teams 4/5/2021

As of May 1, 2021

PHSKC and HealthierHere will continue pursuing ways that these findings can be used to inform communication and engagement activities for vaccination rollout, as well as future public health efforts.
Funding Areas
Partners Prioritized

✓ Translation, Interpretation, and Navigation: Continued need to create and translate for less common languages; resource outreach staff who support community members with interpretation and navigation.

✓ Technology platforms: Funds to support community-created online platforms (social media, websites, Zoom) and staff time to help individuals register online for testing and services.

✓ Availability of direct assistance: More resources for basic needs; funds for staff navigators who connect families to assistance.

✓ Support for mental health of community: Community members have faced increased stress, anxiety, and grief throughout the pandemic, and partners are well-positioned to support this ongoing need. As one partner suggested, investments in staff training on mental health ‘first aid’ could expand their capacity.

Three Next Steps
Partners Suggested

✓ Establish two-way communication channel between Public Health systems and community partners: An accessible communication channel would allow for more rapid information sharing, improved public health messaging and strengthening of partnerships

✓ Create comprehensive, centralized source of resources: Community partners emphasized the need for a current, comprehensive list of all available services, especially for isolation and quarantine.

✓ Leverage existing partner network to launch community-owned emergency preparedness plan. A network-wide, community-owned preparedness plan for all community partners could prevent and mitigate impacts of future public health threats on impacted communities.
Partner Priorities In Their Own Words

"In our community, everything has been a crisis. Now that we have this coalition, it would be great to make a plan [to have] in place for future."

"We mostly struggle with receiving resources and links that are culturally appropriate for the community we serve and our staff members. Most resources we receive are in English and have to be translated which takes several days to complete. This delays the information community needs to stay up-to-date. In addition, links to register individuals for the vaccines are not culturally accessible when they are only available in English."

“One area we need to focus on is creating more community-based, peer-to-peer COVID recovery action plan. What do we do to support people who have lost loved ones to COVID? A peer-to-peer model for emotional and behavioral health is critical.”
Conclusions

THE COMMUNITY-PARTNERED MODEL WAS:

1. Flexible and adaptive to meet changing needs
   The model allowed flexibility and adaptability to meet changing context and community information needs.

2. Effective in engaging most impacted communities
   This model complemented public health outreach work and intensively engaged communities experiencing inequities.

3. Effective for COVID-19 Information-sharing
   The model allowed information to be shared quickly and widely across multiple communities by...
   - leveraging existing network of partner CBOs
   - sharing SCAN information & identified barriers to use
   - incorporating Question & Answer sessions to address concerns and questions from community partners
   - shifting focus to include discussion of vaccines based on partner feedback

INFORMATION-SHARING STRATEGIES WERE:

4. Effective when community-designed & tailored
   Strategies were most effective when tailored to each community, fostering ongoing engagement and supporting informed decision-making.

THE COLLABORATIVE APPROACH FOSTERED:

5. Equitable evaluation
   A more equitable evaluation was possible through...
   - Long-standing partnerships
   - Ongoing discussions
   - Time and space for partners to share challenges, barriers, strategies, and to have questions answered
   - Ongoing input on evaluation process and findings
   - Regular discussion of findings to ensure accurate understanding of community perspectives

THE PARTNERSHIP WAS:

6. Highly valued & interest exists to continue
   All partners appreciated the collaboration and desired to continue. Despite historical mistrust of PHSKC, CBOs described a positive experience and HealthierHere brought critical relationships, trust-building, and facilitation.
Thank you!

For questions please contact:
Myani Guetta-Gilbert mguetta@healthierhere.org
## Cumulative snapshot

- **Funds Earned**: $139,084,270.50
- **Funds Distributed**: $76,113,536.47
- **Funds available**: $62,970,734.03

### Table 1: Incentive Funds earned

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>-</td>
<td>$6,273,818.00</td>
<td>$6,273,818.00</td>
<td>$12,547,636.00</td>
</tr>
<tr>
<td>Project 2C</td>
<td>$</td>
<td>-</td>
<td>$2,130,354.00</td>
<td>$2,130,354.00</td>
<td>$4,260,708.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>-</td>
<td>$936,368.00</td>
<td>$936,368.00</td>
<td>$1,872,736.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>-</td>
<td>$1,479,511.00</td>
<td>$1,479,511.00</td>
<td>$2,959,022.00</td>
</tr>
<tr>
<td>VBP</td>
<td>$</td>
<td>250,000.00</td>
<td>$150,000.00</td>
<td>$400,000.00</td>
<td>$650,000.00</td>
</tr>
<tr>
<td>Bonus pool/High</td>
<td></td>
<td></td>
<td>2,111,189.00</td>
<td></td>
<td>2,111,189.00</td>
</tr>
<tr>
<td>Performance Pool</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$</td>
<td>250,000.00</td>
<td>$13,081,240.00</td>
<td></td>
<td>$13,331,240.00</td>
</tr>
</tbody>
</table>

### Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$</td>
<td>226.55</td>
<td>$150,000.00</td>
<td></td>
<td>$226.55</td>
</tr>
</tbody>
</table>

### Table 3: Incentive funds distributed, by use category

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$447,186.03</td>
<td>$333,182.95</td>
<td></td>
<td>$780,368.98</td>
<td></td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$</td>
<td>393,716.92</td>
<td>$1,187,339.10</td>
<td></td>
<td>$1,581,056.02</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$34,411.38</td>
<td>$161,953.31</td>
<td></td>
<td>$196,364.69</td>
<td></td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$3,115,404.60</td>
<td>-</td>
<td></td>
<td>$3,115,404.60</td>
<td></td>
</tr>
<tr>
<td>Reserve/contingency fund</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$</td>
<td>3,990,718.91</td>
<td>$1,682,475.36</td>
<td></td>
<td>$5,673,194.29</td>
</tr>
</tbody>
</table>

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.