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

Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 8.0

Reporting Period:

July 1, 2021 – December 31, 2021

DY5 Q3-Q4

Updated Template Release Date: September 8, 2021

Table of contents

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 July 1 – December 31, 2021

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

Table 2. Potential P4R AVs for Project Incentives, July 1 – December 31, 2021

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	5	4	-	-	5	-	-	4	18
Cascade Pacific Action Alliance	5	4	4	-	5	4	-	4	26
Elevate Health	5	4	-	-	5	-	-	4	18
Greater Columbia ACH	5	-	4	-	5	-	-	4	18
HealthierHere	5	-	4	-	5	-	-	4	18
North Central ACH	5	4	4	4	5	-	-	4	26
North Sound ACH	5	4	4	4	5	4	4	4	34
Olympic Community of Health	5	-	-	4	5	4	4	4	26
SWACH	5	4	-	-	5	-	-	4	18

Reporting requirements

The semi-annual report for this period (July 1 – December 31, 2021) includes three sections as outlined in the table below.

Semi-annual reporting requirements (July 1 – December 31, 2021)		
Section	**Item num**	**Sub-section components**
Section 1. ACH organizational updates	1-8	Attestations
	9-11	Documentation - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	12-13	Attachments - Implementation work plan - Partnering provider roster
	14	Documentation - Quality improvement strategy update
	15-17	Narrative responses - General implementation update - Regional integrated managed care implementation update - Scale and sustain update
	18	Attestations
Section 3. Value-based Payment	19-21	Narrative responses
Section 4. Pay-for-Reporting (P4R) metrics	22	Documentation
	23-24	Narrative responses

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.SAR8 Report.01.31.22
- *Implementation work plan:* ACH Name.SAR8 Implementation work plan. 01.31.22
- *Partnering provider roster:* ACH Name.SAR8 provider roster. 01.31.22
- *P4R metrics:* ACH Name.SAR8 P4R metrics.01.31.22

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

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2022 at 3:00p.m. PST.**

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

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

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "Semi-Annual Report 8."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 8.

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 July 1 – December 31, 2021.

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

ACH semi-annual report 8 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
a)	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2021 to ACHs	IA	August 2021
b)	Submit semi-annual report	ACHs	January 31, 2022
c)	Conduct assessment of reports	IA	February 1, 2022– February 24, 2022
d)	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	February 24 – March 1, 2022
e)	If needed, respond to information request within 15 calendar days of receipt	ACHs	February 25 – March 11, 2022
f)	If needed, review additional information within 15 calendar days of receipt	IA	February 25 – March 28, 2022
g)	Issue findings to HCA for approval	IA	April 2022

Contact information

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

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

Section 1. ACH organizational updates

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

Attestations

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

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

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

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

Documentation

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

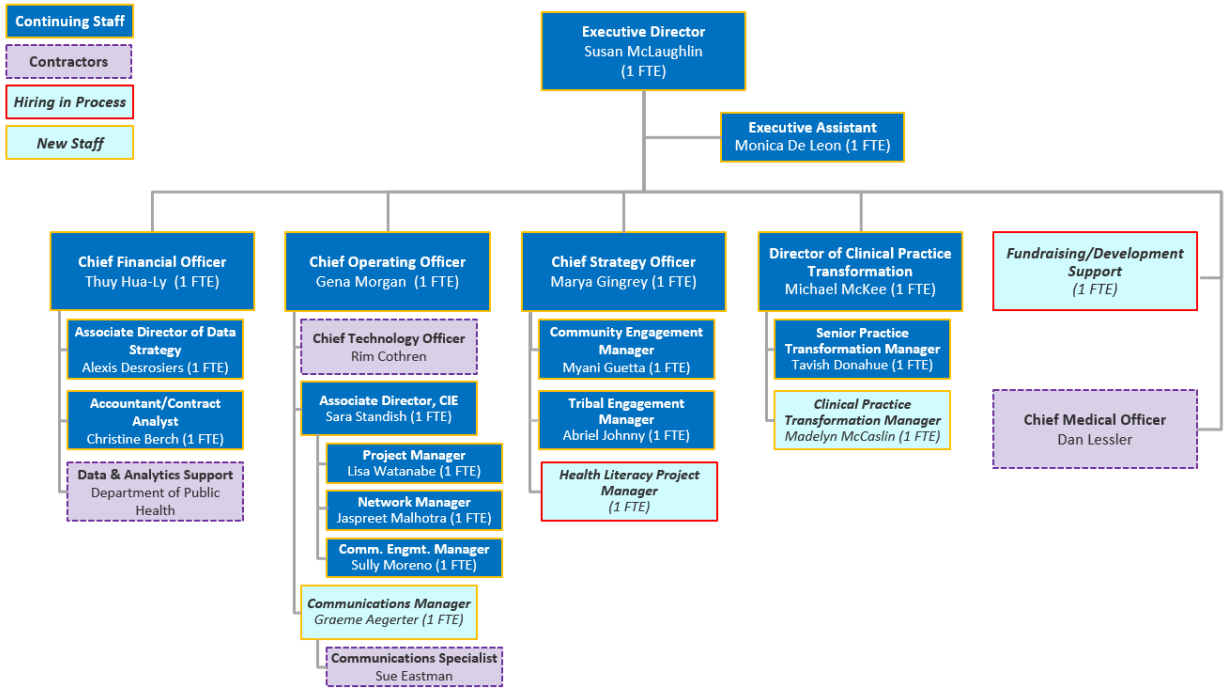
9. **Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

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

    If applicable, include current organizational chart.

HealthierHere Response

Figure 1. **HealthierHere Organizational Chart (as of December 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 payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.[3]

HealthierHere Response

The payment reconciliation spreadsheet is attached.

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**

Use of incentives to assist in the transition to integrated managed care			
Description	**Expenditures**		
	Actual	**Projected**	**Fund Source**
Funds directed to contracted Medicaid Behavioral Health Agencies (BHAs) to support infrastructure needs required for transition to integrated managed care (IMC).	$3,955,078	$3,955,078	DY1: IMC

[3] The HCA issued reconciliation workbook can be found at the following link: https://www.hca.wa.gov/assets/program/payment-reconciliation-form-sar-8.xlsx

HealthierHere is overseeing and maintaining training and technical assistance (TA). The ACH will purchase 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 Health and UW AIMS provider training and TA to support integrated care and VBP	$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 will purchase 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 Health and UW AIMS provider training and TA to support integrated care	$127,198	$127,198	DY2: Project
DY2 Subtotal	**$127,198**	**$127,198**	**DY2: Project**
HealthierHere is overseeing and maintaining training and TA. The ACH will purchase 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 Health provider training and TA to support integrated care	$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:	$1,925,080	$1,925,080	DY3: Project

h) 2020 Clinical Partner Resiliency Fund i) 2020 Multilingual Response Fund			
DY3 Subtotal	**$2,238,199**	**$2,238,199**	**DY3: Project**
2020/2021 approved IMC allocations: Testing models for whole person integrated care, training, and TA *(on hold during COVID-19 pandemic)*	$ 1,928,546	$ 2,448,184	DY4: IMC
HealthierHere is overseeing and maintaining training and TA. The ACH will purchase 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 Health and UW AIMS provider training and TA to support integrated care	$ 109,514	$ 109,514	DY4: IMC
DY4 Subtotal	**$ 2,038,060**	**$ 2,557,698**	**DY4: IMC**
HealthierHere allocated a portion of IMC funding to support Community and Clinical COVID Vaccination Funds (partner contract addendum templates available upon request)	$ 678,200	$ 840,000	DY5: IMC
2020/2021 approved IMC allocations: Testing models for whole person integrated care, training, and TA *(on hold during COVID-19 pandemic)*	$ 440,112	$ 2,551,816	DY5: IMC
HealthierHere is overseeing and maintaining training and TA. The ACH will purchase 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 Health and UW AIMS provider training and TA to support integrated care	$ 158,160	$ 789,867	DY5: IMC
Balance remaining	$0	$1,069,579	DY5: IMC
DY5 Subtotal	**$1,276,472**	**$5,251,263**	**DY5: IMC**
Cumulative Total	**$10,394,363**	**$14,888,972**	**All**

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

Implementation plans are "living documents" that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA information to monitor ACH activities and project implementation timelines. Updates to the ACH's implementation plan were made optional for SARs 5.0, 6.0, and 7.0.

- The ACH must submit an **updated implementation plan** reflecting current status and *progress made since the last submitted update*.

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.[4] To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of partnering provider sites that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should use the template provided by the IA to indicate:
   i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.
   ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

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

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

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.[5]

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 response and recovery activities. Please describe ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., project management, communication and engagement, coordination of funding, etc.).

HealthierHere Response

In this reporting cycle, HealthierHere focused its COVID-19-related work on increasing vaccination rates in the region and supporting providers in transitioning from COVID-19 recovery to stabilization. A summary of this work is provided below.

Continuation of Regional Vaccination Efforts and Funding. In the first half of 2021, HealthierHere reallocated over $840,000 and partnered with 28 partners (four Federally Qualified Health Centers (FQHCs) and 24 community-based organizations (CBOs)) to increase vaccination rates in King County. The goal of this work was to amplify the capabilities of HealthierHere's various partners and to enhance the efforts of Public Health-Seattle & King County (PHSKC) in rolling out an equitable and accessible vaccination campaign in the region. Funded activities included vaccine capacity building, information sharing, outreach and engagement, and development and implementation of clinical and community partnerships.

[5] Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the "Narrative Responses" section

Throughout this reporting period, partners continued to implement the various initiatives made possible by the funds and met reporting requirements. (For a detailed description of the types of activities funded, see SAR 7.) While efforts are ongoing, see the response to question 15c for examples of successes to date.

Community and Clinical Vaccine Partnership Investment. In July 2021, HealthierHere launched the Community and Clinical Vaccine Partnership office hours strategy where community partners and clinical partners working on vaccination efforts gathered to discuss the changing COVID-19 vaccine landscape, methods for adapting to the needs of the communities, and best practices for information dissemination and access. Topics discussed at the July meeting included roadblocks and barriers in reaching vaccine-hesitant populations, community-driven solutions, and logistics and partnerships for pop-up vaccination events. The group met on an ad hoc basis during the current reporting period.

Improving Health Literacy Among Racial and Ethnic Communities and Vulnerable Communities. As reported in SAR 7**,** HealthierHere and PHSKC were 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.

HealthierHere is in the planning phase and in 2022 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. In this reporting period, HealthierHere established and convened an advisory group of 12 community partners to help guide the planning and implementation of project activities. HealthierHere developed the project work plan in partnership with PHSKC and provided subject matter expertise to PHSKC in initial planning activities and deliverables.

HealthierHere and PHSKC are preparing to identify and select community partners and FQHCs to implement project activities, using a procurement process developed by HealthierHere. Once partners are selected (expected in Q1 of 2022), they will begin to 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.

Supporting PHSKC COVID-19 Outreach and Engagement Activities. In August of 2021, HealthierHere began a process to identify King County communities with low vaccination rates and/or that have been disproportionally impacted by COVID-19 and community partners who could support PHSKC in disseminating accurate information, building a better understanding of COVID-19 vaccines, and ultimately, increasing vaccination rates in these communities.

Based on available data on vaccination and COVID-19 case rates, HealthierHere identified the following geographic areas and communities of focus:

- Auburn: youth, Hispanic/Latinx, Pacific Islander communities
- Federal Way: immigrants, youth
- Pacific/Algona: all residents
- Tukwila: Black/African American, Hispanic/Latinx

- Seattle/Central District: Black/African American
- Seattle/downtown, Belltown, SoDo: Black/African American; Hispanic/Latinx; teenage youth
- South Seattle: Hispanic/Latinx, Black/African American
- Renton: Black/African American
- Fall City: rural/white community
- Enumclaw: rural/white community

HealthierHere launched an application process where over 137 community partners submitted an application for funding for investments to support culturally relevant and responsive community-based COVID-19 vaccination in the communities of focus. HealthierHere's work enables PHSKC to quickly select community partners and begin project implementation. PHSKC is working directly with partners to implement project activities.

Expanding Access to and Engagement with the Health Care System for the King County Region. In Q2 2021, HealthierHere announced its plans to expand health care access and engagement in King County through a $2.35 million 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 ties to the culture and language of focus populations, community-based, non-licensed staff extend the reach of health care providers and can play an important role in improving access to care, health outcomes, and the patient experience while helping achieve cost savings.

HealthierHere received 28 applications from community, tribal, and clinical partners, and in August 2021 completed a review of the applications and funded 18 organizations, ensuring that populations disproportionately impacted by COVID-19 will be served by this investment. Funding per organization ranged from $44,850 to $144,850 ($2.35 million awarded in total), which reflects the scope of activities in the respective applications. Among the awardees are eight clinical partners, seven CBO partners, one tribal partner, and two Native-serving/Native-led CBO partners. The awardees are Arms Around You, Chinese Information and Service Center, Consejo Counseling and Referral Service, Country Doctor, Cowlitz Behavioral Health, Global to Local, HealthPoint, Living Well Kent, Lutheran Community Services Northwest, Mother Africa, Recovery Café, Sea Mar, Sisters in Common, Therapeutic Health Services, United Indians of All Tribes, UNKITAWA, Valley Cities, and Villa Comunitaria.

In total, the awardees estimate serving 26,341 unduplicated individuals and making 36,534 referrals to health care/social services over the course of the program period. Awardees have until November 2022 to complete their activities.

Distributed Mobile Phones to Connect Individuals to Telehealth and Community Resources. HealthierHere continues to partner with HCA and Foundational Community Supports (FCS) providers to provide cell phones to individuals enrolled in the FCS program in order to allow them to access telehealth and community resources to better navigate services during COVID-19. To date, HealthierHere has distributed 255 phones to 11 King County FCS providers for distribution directly to clients in need.

b) 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 previous SARs, HealthierHere reported that the pandemic had exacerbated many of the underlying risks to delivery system transformation — and many of these remain valid for this reporting period. In this reporting period, health care worker burnout and workforce shortages persist and remain at the top of the list for the region's most pressing challenges. Additionally, community partners report higher levels than ever of fatigue and stress from the long battle against COVID-19 where they've been providing constant, direct support to vulnerable communities. HealthierHere is working to mitigate these issues (see below) and recognizes that sustainable long-term solutions depend on multi-sector and/or statewide interventions.

Figure 3. **COVID-19 Issues and Mitigation Strategies for King County, Clinical Providers, and CBOs**

Issues	Mitigation Strategies	Impacted Subpopulations
Health Care Workforce Capacity and Burnout • Impact of staff reductions made during the peak of the pandemic and inability to recruit/rehire individuals. • Insufficient supply and an underdeveloped pipeline of both physical and behavioral health professionals (i.e., nurses, primary care providers, social workers, mental health specialists, etc.) to meet increased demand for services (now and in the future). • Regional backlog in providing supports to individuals in isolation and quarantine. • Increased rate of provider burnout due to increased demands from COVID-19. • Need to recruit and retain diverse health care staff and train existing staff on culturally relevant care. • Loss of navigators and referral partners due to workforce shortages.	• HealthierHere is helping partners augment current staff with community-based, non-licensed health care team members. (See response to question 15a.) • HealthierHere continues its partnership with the King County Integrated Care Network (KCICN), giving HealthierHere insight into behavioral health providers' 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 is in conversations with Service Employees International Union (SEIU) and the Harborview Medical Center (HMC) Behavioral Health Institute regarding the launch of a behavioral health apprentice program to train residents to become behavioral health technicians and peer support specialists. • HealthierHere, alongside HILT, sponsored a two-part training series (12/15/2021 and 1/12/2022) organized by the University of	• Clinical and community providers and the populations served by them, including individuals with substance use disorders (SUDs) and other behavioral health needs.

Issues	Mitigation Strategies	Impacted Subpopulations
	Washington on how to prevent nurse burnout for hospitals and primary care facilities. • HealthierHere welcomes opportunities to work with the county, state, and other stakeholders on developing strategies to build a robust, diverse, culturally relevant pipeline of health care talent. For example, HealthierHere is considering launching a learning action network to focus on these and other issues.	
Amplification of Ethnic/Racial Disparities • HealthierHere's Equity Dashboard shows known disparities in the King County Medicaid population prior to COVID-19. • King County's COVID-19 Dashboard 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.	• HealthierHere continues to support PHSKC and partners in rolling out an equitable, accessible vaccination campaign in King County. (See response to question 15a.) • HealthierHere continues 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.) • HealthierHere partnered 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 can leverage cross-sector alignment and collaboration to advance health equity and improve	• Black, Indigenous, People of Color (BIPOC). • Refugees and immigrants, and people who primarily speak a language other than English. • Communities experiencing health disparities.

Issues	Mitigation Strategies	Impacted Subpopulations
	outcomes. Findings are available at: https://drive.google.com/file/d/1uvJAh0cXdym5BLJrVMESdzHSv05ha7Ya/view	
Surge in Behavioral Health Needs Across the Region • 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 the 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 utilization across the state, such as suicidal ideation/attempts and emergency department (ED) visits for psychological distress.	• HealthierHere continues to support providers in their journey to integrate physical and behavioral health, including through the Innovation Fund and investments in community-based non-licensed staff. • In the last reporting period, HealthierHere reported that it received $40,000 from 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. This work continued in this reporting period in Enumclaw (in partnership with Valley Cities Behavioral Health Care) and Vashon Island (in partnership with Vashon Youth and Family Services).	• BHAs and FQHCs and the populations they serve, including individuals with behavioral health needs (depression, anxiety, isolation, acute stress, suicide, SUD). • Incarcerated individuals with mental health, SUD, medical, or other social needs (Enumclaw/Valley Cities work). • Latinx populations, including families who could benefit from assistance in navigating remote school participation for

Issues	Mitigation Strategies	Impacted Subpopulations
		their children and other health/wellness interventions (Vashon Island and Vashon Youth and Family Services work).

Lack of Access to Care
• Lack of access to accurate, relevant, culturally appropriate, and in-language information and care.
• Increased need for social determinants of health (SDOH) services and supports without increased capacity to deliver such services and supports.
• Lack of access to high quality masks and home test kits throughout the pandemic.
	• HealthierHere is supporting community-based, non-licensed health care team members who can extend the current reach of clinical, community, 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. (See response to question 15a.)
	• HealthierHere's COVID-19 vaccination efforts focused on ensuring community members had access to culturally relevant care.
	• HealthierHere has distributed over 19,500 KN95 masks to their partner CBOs and is continuing to support PHSKC in their home test kit distribution.
	• HealthierHere has partnered with HCA and FCS providers to distribute 255 cell phones to FCS participants to enable them to access telehealth and community
		• Individuals with:
		  ○ Limited English proficiency.
		  ○ Chronic disease diagnoses.
		  ○ COVID-19.
		• Low-income BIPOC families, particularly undocumented Latinx families

Issues	Mitigation Strategies	Impacted Subpopulations
	resources. (See response to question 15a for more information.)	
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.	• HealthierHere continues to discuss these issues with housing providers and other stakeholders, elevating issues and exploring opportunities to support housing providers and individuals. • On December 7, HealthierHere hosted an information session in partnership with Seattle Housing Authority, King County Housing Authority, and King County Regional Homelessness Authority (KCRHA), where community partners were invited to learn more about and join the Emergency Housing Voucher program, which offers limited financial assistance for move-in expenses and housing navigation for people who are experiencing or in imminent risk of homelessness. Participating CBOs identify potentially eligible individuals and submit referrals to the KCRHA to connect them with these essential services. • In an October 2021 Connect2 Community (C2C) Network meeting, HealthierHere facilitated peer learning related to housing eviction and prevention for network partners. HealthierHere invited Solid Ground and Crisis Connections to share eviction prevention resources available in King County, such as the Tenant Services Hotline and the King County Eviction	• Individuals experiencing unemployment and housing instability. • Housing providers.

Issues	Mitigation Strategies	Impacted Subpopulations
	Prevention and Rent Assistance Program. Network Partners were able to engage in discussion about the need to transform practices that contribute to racial inequity, such as the use of prioritization indexes for allocating housing resources. • 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 services during the pandemic. The program supports over 170 individuals with behavioral health conditions who have experienced long-term homelessness and have histories of justice involvement.	

c) 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

HealthierHere's investments in King County in the first half of 2021 equipped clinical providers and CBOs to increase vaccinations in communities with low vaccination rates, mitigating what would have been an even worse surge from the Delta variant and the more recently discovered Omicron variant. To identify target communities and inform funding decisions, HealthierHere used its Coverage Gap Analysis Tool (used in all procurements to support funding decisions), which pulls available local data on needs and disparities, including COVID-19-related data, and identifies the areas needing funding and support. As has been the case throughout the MTP, HealthierHere's years of authentic community, clinical, and tribal engagement gave the organization an ear to the ground regarding community needs and allowed the team to quickly bring these organizations together and respond to those needs.

Funded partners report feelings of pride and accomplishment in their efforts to consistently and quickly pivot work to meet the emerging needs, increase vaccination rates, and provide language-appropriate, culturally relevant, and accurate COVID-19-related information. Below are examples of specific activities that partners implemented in this reporting period:

- HealthPoint, a clinical partner, converted an emissions testing facility in Renton into a drive-through site for COVID-19 testing and vaccination and provided over thousands of vaccinations. The site offered individuals who were seeking testing/vaccinations the safety of not leaving their cars and the flexibility of alternate hours. HealthPoint also hosted various community outreach events to inform people of the site and hired patient engagement coordinators who assisted individuals in understanding their options for vaccination and addressed vaccine hesitancy. For many people seeking vaccinations, the convenience of this site played a critical role in their choice in getting vaccinated. Additionally, through a new COVID-19 testing- and vaccine-related partnership with the Marshallese Women's Association, HealthPoint strengthened connections with the Marshallese community, which has experienced significant disparities.
- Sea Mar used the funds to hire additional call center specialists, which increased its ability to reach more individuals, answer questions, and schedule vaccine appointments. Additionally, funding enabled Sea Mar to hire new staff to administer vaccines.
- Arms Around U focused efforts on addressing COVID-19- and vaccine-related misinformation, providing community members with fact-based information on the pandemic and preventive measures.
- Atlantic Street Center (ASC) organized various community events with partnering mobile pop-up vaccine units, where attendees could ask questions about the vaccines and get vaccinated. These events included ASC's Youth Health Fair and Summer Academy. ASC also collaborated with Seattle Public Schools to promote COVID-19 back-to-school readiness, which included details on what to expect in terms of COVID-19 precautions, general wellness, and prevention. Additionally, ASC assisted families facing housing-related challenges by keeping them informed about the eviction moratorium and providing financial assistance for rent and utilities.
- Global 2 Local conducted continuous outreach efforts to educate the community about

vaccines and COVID-19 guidelines and partnered with HealthPoint and PHSKC to host six community vaccine clinics in Tukwila from June through September, offering interpretative services at these events.

16. Scale and sustain update

a) In SAR 7.0, 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

The MTP has served as a catalyst for practice transformation that will enable partners to better address whole-person needs beyond the MTP. Below is a summary of HealthierHere MTP-related activities and investments that will continue to sustain the transformation of the health care system post-MTP.

- **Primary Care and Behavioral Care Integration.** As partners are able, they continue to advance and evolve colocation of on-site primary care at behavioral health sites and on-site behavioral health at primary care sites. Analysis of partner responses to the Maine Health Access Foundation (MeHAF) site integration self-assessment survey, collected semi-annually since July 2019, indicates that the median level of integration has increased across hospitals, FQHCs, and BHAs. See Appendix A for results of analysis on data collected through partner semi-annual reporting data from 2019 to 2021. Additionally, enhanced screening and assessments for physical, behavioral, and social determinants of health have resulted in and supported increased referrals and improved care coordination.
- **Use of Registries, Risk Stratification, and SDOH Screenings.** These have generally increased across partnering hospitals, FQHCs, and BHAs. See Appendix A for results of analysis on data collected through partner semi-annual reporting data from 2019 to 2021.
- **Innovation Projects**. Partners continue to drive system transformation and advance evidence-based models in their implementation of the innovation projects: (1) connecting people who completed the induction of Medication-Assisted Treatment (MAT) in jails or an emergency department (ED) with community-based strategies; (2) reducing ED utilization through mobile, integrated health care; and (3) testing and advancing models for integrated whole-person care. In 2021, 10 projects (within the above three areas) were funded; six are funded to continue in 2022, two are considering a renewal, and two will not continue. In SAR 7, HealthierHere reported on the innovation projects' impact and successes for all but three out of the ten projects. (See Appendix B for an updated/complete list.)
- **Traditional Medicine Investment.** In previous SARs, HealthierHere reported on the

launch and success of the COVID-19 Traditional Medicine Fund, designed to support organizations serving American Indian, Alaska Native, and Indigenous (AI/AN/I) people in King County in their work providing traditional medicine, herbs, and culturally responsive care and supports during the pandemic. In response to community and partner feedback on the need for ongoing access to these services, HealthierHere is investing $1.1 million in five Native-led and Native-serving partners to increase capacity to provide traditional medicine, herbs, culturally responsive care, and support for AI/AN/I people in the region. HealthierHere is conducting an evaluation of the work as a means of identifying sustainability beyond the investment and has developed a professional learning community related to the provision of traditional medicine that will support sustainability and ongoing funding for this work.

- **Shared Care Plan Pilot.** In Q4 2021, HealthierHere launched a shared care plan pilot in partnership with HealthPoint and Valley Cities to test the enhanced use of Collective Medical Technologies in service of improved bidirectional communication and shared care planning. Using Collective Medical, HealthPoint and Valley Cities will test the sharing of patient information for a focus population of medically and behaviorally complex individuals enrolled in HealthPoint's care coordination pilot. The pilot, which will run through June 2022, may help expand how Collective Medical is currently used to coordinate care and will help inform whether this technology could support regional shared care plan objectives long term.
- **Connect2 Community (C2C) Network.** HealthierHere continues to partner with health and social services organizations to build the C2C Network, a unified community information exchange that enables care coordination among physical health, behavioral health, tribal, community, and social services organizations in King County. In August 2021, HealthierHere launched a technology request for proposal for a vendor or vendors to build and operate the C2C Unified Network infrastructure. Additionally, in December 2021, HealthierHere was awarded a grant of $400,000 from Regence Blue Shield's "Four Communities" project to expand and strengthen culturally and linguistically appropriate care coordination for people living in areas with known health disparities, including through use of the C2C Network's resource database and bidirectional, closed-loop referral technology. For additional details on these activities and other network activities, see Appendix C.
- **2022 Investment Strategy.** HealthierHere is in the process of developing its 2022 investment strategy, which will build off the investments made to date and the strengths of the systems. The strategy will be brought to the Governing Board for approval in Q1 2022.

b) As a result of MTP, please share your reflections on changes and improvements that have occurred and/or lessons learned over the past five years. Note, this is not expected to be a comprehensive inventory, but a summary of a page or less.

HealthierHere Response

The past five years have been a period of immense and rapid change for the King County health care delivery system. HealthierHere's commitment to its vision and approach to building trusted relationships with clinical, community, tribal, social service, and public health partners enabled

the organization to achieve improvements in the system during this challenging time. No decisions impacting partners were made without their representation and direct participation. Below are examples of improvements in the region made possible by this approach:

- **New innovative care models** that improved community-clinical linkages
- **Better coordinated care** through the C2C Network and Collective Medical
- **Increased delivery of integrated care** as evidenced in increased MeHAF scores
- **Improved provision of person-centered and culturally relevant care**
- **Centered health equity and anti-racist practices in care delivery**
- **Improved population health** as reflected in HealthierHere's achievement of performance targets for 11 MTP quality metrics across its selected MTP projects.[6,7]

See response to 16a and Appendices for additional details on the above.

Over the past five years, HealthierHere learned the following lessons:

- **Successful transformation starts with putting the person at the center** and depends on strategies that focus not only on providing the right care in the right setting and at the right time, but also in the manner and from the providers that people prefer.
- **Transformation is successful when led by a "backbone organization,"** like an ACH, that convenes and coordinates stakeholders, provides administrative and financial support, analyzes available data to develop actionable insights, and can activate a network to deploy a coordinated response to regional needs based on a shared vision.
- **Transformation requires investments in foundational tools and technologies, remaining flexible and nimble, and partnership.** HealthierHere took this approach for the MTP and partners remained engaged, implemented MTP activities, pivoted work to address COVID-19, and improved health in the region.
- **Traditional funding approaches are inadequate to support transformation.** The state should continue to seek creative financing mechanisms to invest in drivers of health (e.g., housing and food insecurity) and to support new models of care; traditional quality and performance measures do not adequately capture social needs and efforts to address them.
- **Opportunities to better support CBOs include** centering BIPOC CBOs in community health efforts; providing funding that enables CBOs to close gaps in the cost of existing services, build their resilience, and reimagine their work; and creating opportunities for CBOs to convene with peers and access targeted support/TA.
- **Transformation can happen quickly**, as evidenced by COVID-19, and requires regulatory flexibility, funding, and a shared sense of urgency and commitment.

17. Regional integrated managed care implementation and stabilization update

a) For **all regions**, briefly describe any challenges the region continues to experience due to the implementation or stabilization phase of integrated managed care. What steps has

[6] HealthierHere's MTP Projects: 2a, 2c, 3a, and 3d.

[7] COVID-19 had major impacts on the region's ability to meet various other population health objectives, but HealthierHere's COVID-19 response and recovery investments helped stabilize the social safety net to prevent even greater deterioration in community health. See HealthierHere Performance Measurement Dashboard, available at https://www.healthierhere.org/our-impact/

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 IMC implementation. As described in previous SARs, HealthierHere participates in the King County Integrated Care Network (KCICN) governance committees and works to ensure HealthierHere's projects and investments are aligned with IMC's 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. Specifically,

- BHAs, FQHCs, and hospitals are unable to fill vacant positions and retain staff.
- There is an underdeveloped pipeline of behavioral health practitioners to meet the surge of behavioral health needs.
- There is an increased need for behavioral health services.
- Existing behavioral and physical health staff are experiencing burnout due to the physical and emotional toll caused by the pandemic.

HealthierHere is working with the HILT and the Harborview Medical Center (HMC) Behavioral Health Institute 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 anti-racism in the health care workforce (e.g., via trainings and webinars) and identifying and implementing strategies to recruit and retain diverse staff. HealthierHere sponsored a two-part training series on how to prevent nurse burnout for hospitals and primary care facilities. Additionally, HealthierHere is in conversations with Service Employees International Union (SEIU) and the Harborview Medical Center (HMC) Behavioral Health Institute regarding the launch of a behavioral health apprentice program to train residents to become behavioral health technicians and peer support specialists. In developing its 2022 investment strategy, HealthierHere is exploring how else it can support addressing workforce shortages in the region.

Payment Models. As the region moves further toward integration, providers cite a need for payment models that support the delivery of integrated, whole-person care (e.g., a model that enables practices to offer care coordination that seeks to address a person's physical and behavioral health and social needs, behavioral health parity, and models that better support Certified Community Behavioral Health Clinics).

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 and/or the stabilization phase of integration post implementation?

HealthierHere Response

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 by stabilizing challenges in behavioral health and workforce capacity. (More details can be found in response to question 17a.) HealthierHere invested $2.35 million in community-based, non-licensed health care team members such as CHWs, peer support specialists, cultural navigators, and recovery coaches to support providers in the delivery of integrated care. Additionally, partners continue to implement innovation projects focused on testing and advancing models for integrated whole-person care. (See response to question 16a and Appendix B.)
- Regionally, HealthierHere recently launched a regional care coordination landscape analysis that enables the region to identify gaps in the care coordination system and how it can be better organized and deployed to address whole-person, integrated care needs. The long-term vision is to achieve a model of "community-based care coordination" that is locally based, includes addressing social determinants of health needs, and ensures that all people receive the care coordination they need in order to make improvements in their health. This work will be completed in early 2022.
- At the statewide level, HealthierHere continues to support the statewide discussion among ACHs, MCOs, and HCA regarding standardized measurement and reporting on clinical integration. In summer 2020, HealthierHere helped launch a Clinical Integration Assessment Workgroup in partnership with HCA, all five Medicaid MCOs, and all nine ACHs. In SAR 7, HealthierHere reported on phase 1 of this work, which culminated in a final report and recommendation that HCA support statewide adoption of the Washington-Integrated Care Assessment (WA-ICA) to assess providers' levels of integration. From July through September 2021, HealthierHere led phase 2 of this work, under contract by HCA, and engaged with providers, their representative associations (i.e., the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the Washington Council for Behavioral Health), and other key stakeholder organizations (i.e., Bree Collaborative, UW AIMS Center, etc.) to:
    - Understand the unique needs and requirements for implementation of the selected standardized assessment tool (Continuum-Based Framework for Behavioral Health Integration into Primary Care and the Continuum-Based Framework for General Health Integration into Behavioral Health) by provider type.
    - Inform the development of an implementation road map that would provide recommendations for how to phase in the implementation of the tool, building off current strengths and infrastructure as well as information gathered in the phase 1 project.

- Determine milestones and timelines to move toward implementation at full scale.

HealthierHere submitted the phase 2 final report to the HCA on September 30, 2021, and the initiative was highlighted at HCA's Learning Symposium in October 2021. HealthierHere and the Integration Assessment Workgroup will continue to collaborate on implementation activities as HealthierHere has been selected to lead the launch of this effort under contract with the ACHs and MCOs in concert with the HCA. The WA- ICA will launch with an initial cohort in July 2022.

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 Comprehensive Measurement Across the Region.** ACHs are only collecting data from a sample of 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 noted above in 17b, HealthierHere is supporting the state in the launch and implementation of the WA-ICA, which will help mitigate and address the above issues. HealthierHere is eager to continue working with the state to develop a statewide standardized approach to measurement and assessment and capture as comprehensive a view as possible.

- **Variability in Provider Readiness for Clinical Integration.** One challenge to supporting and training providers is the wide variability of the level of readiness for clinical integration. HealthierHere and other ACHs are finding that providers have differences in their needs, advance at different paces, and implement in different ways; therefore, providers need tailored technical assistance that reflects where they are in their integration journey. HealthierHere has provided a multimodal TA strategy (e.g., on-site TA, webinars, asynchronous learning) to best support providers in the region and meet them where they are. This type of approach will be critical as the work moves forward, and there is also a need for additional conversations around integration looking different for different provider types.

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.

	Yes	No
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: • Identification of partnering provider candidates for key informant interviews.	X	

	Yes	No
• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.		

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. Value-based Payment

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 5, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2021).*

Narrative responses

19. Identification of barriers impeding the move toward value-based care

a) Providers reported the following top three barriers in the 2020 Paying for Value survey: "misaligned incentives and/or contract requirements," "lack of timely cost data to assist with financial management," and "Lack of interoperable data systems." Describe whether these align with your region's experience or if you are experiencing other more impactful barriers regarding implementation of value-based care. Also, describe methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

HealthierHere Response

The above-stated barriers reflect HealthierHere's understanding of the challenges providers face. HealthierHere identifies providers struggling via individual responses for the state VBP survey, semi-annual reporting, and site visits for clinical and tribal partners. Since July 2021, HealthierHere has asked clinical and tribal providers to assess their level of VBP readiness as part of their semi-annual reporting requirement; over the last 18 months clinical partners have reported progressing to higher levels of VBP readiness. (See figure 4 for the detailed question, self-assessment scale, and aggregate responses from the July – December 2021 reporting period.)

Figure 4. **Semi-annual Reporting VBP Readiness Assessment, July – December 2021**

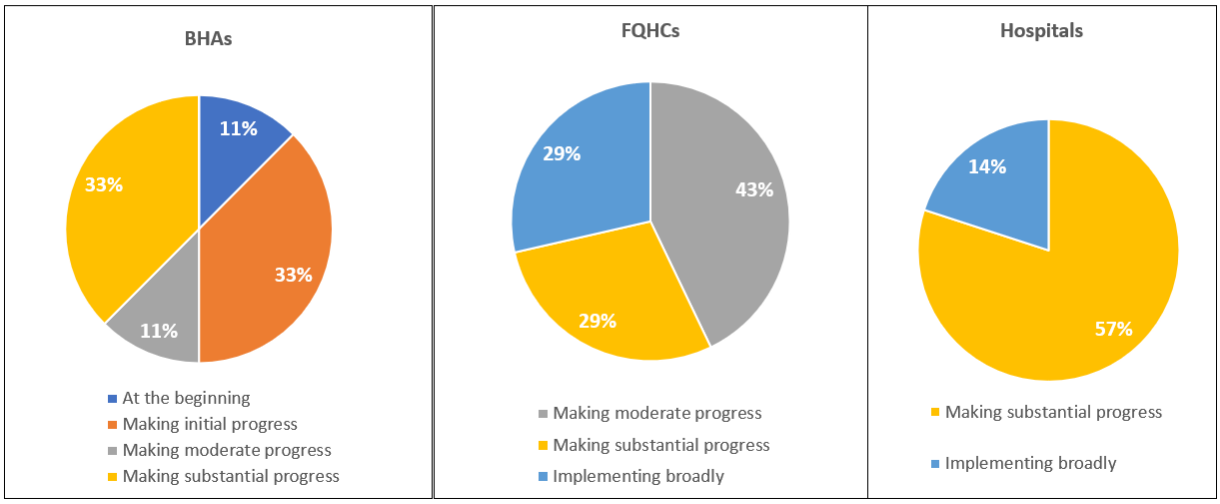
VBP Readiness - Clinical Semiannual Reporting Question

"As you consider your organization's attitudes, behaviors, or actions currently underway around payment, please select the description that best fits."

Description:	We are entirely fee for service and do not take on financial risk or incentives for the health outcomes of any defined populations.	We are having preliminary discussions with payers to take on financial risk or incentives for defined populations.	We have several risk or incentive-based contracts for defined populations	We are actively exploring adding new patient populations or additional payers over time. We embrace new financial models to improve the health of our patients and communities.	We are expanding to create mechanisms to share risk/incentives and savings across sectors in our communities.
Self-Reported Status	At the beginning	Making initial progress	Making moderate progress	Making substantial progress	Implementing broadly
July 2020 Responses	4%	17%	4%	42%	13%
December 2021 Responses	10%	15%	25%	35%	15%

*Over the last 18 months clinical partners have reported progressing to higher levels of VBP readiness.

VBP Readiness by Sector as of 12/2021



20. Support providers to implement strategies to move toward value-based care

a) Describe how the ACH has helped providers overcome barriers to VBP adoption; indicate if the scope or intensity of support has been different for small providers (25 FTEs or fewer), or behavioral health providers.

HealthierHere Response

HealthierHere employed the following strategies in 2021 to help partners overcome barriers to VBP adoption:

- **Maintained training and TA for BHAs.** Through Comagine Health and UW AIMS, HealthierHere continues to provide training and practice coaching/TA to support integrated care and VBP. Staff members are especially engaged in the online modules developed by UW AIMS. These trainings are available to all providers.

- **Exploration of VBP models.** HealthierHere has reinitiated conversations with providers and MCOs to design a bundled payment model for providing health and behavioral health care and supports to individuals with justice involvement (e.g., individuals recently released from jail or prison). Additionally, through work funded by the Innovation Fund, Downtown Emergency Service Center (DESC) and Community Health Plan of Washington (CHPW) have developed a bundled payment model for a set of services that are a part of DESC's model for delivering low-barrier MAT.

  DESC and CHPW are now in contract to test the bundle using a sample of DESC's client population. DESC and CHPW will evaluate the effectiveness of the model annually, refine as needed, and share lessons learned with other providers, MCOs, and health care stakeholders as the work continues.

- **Clinical and Tribal Partner Semi-annual Reporting.** As described in the response to question 19, HealthierHere requires, on a semi-annual basis, that clinical and tribal partners report on their VBP readiness/progress. Partners earn incentive payments for completing these reports, which they may put toward strengthening VBP capabilities.

- **Continued Engagement with MCOs.** HealthierHere meets with MCOs bimonthly to discuss how MCOs and providers can work together to move toward value-based care.

21. Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey

a) Provide an example of the ACH's efforts to support completion of the state's 2021 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

HealthierHere Response

HealthierHere continued its support for the state-issued *Paying for Value Provider Survey* by encouraging partners to complete the survey in a timely manner. Specifically, HealthierHere:

- Sent direct emails to all HealthierHere clinical partners to ensure their organizations completed the survey.
- Posted the survey on HealthierHere's blog with a description of the survey and request for providers to complete it: https://www.healthierhere.org/health-care-providers-please-complete-hcas-2021-paying-for-value-survey/.

- Announced the survey at HealthierHere Governing Board and Committee meetings and encouraged Board members to ensure their organizations complete the survey.
- Included a reminder in the monthly Executive Director Report to the Board, which is highlighted at monthly Board meetings and posted publicly on the website.

These tactics were the same as the actions HealthierHere took in prior years. As in years past, HealthierHere did not offer any incentives for completion of the survey.

b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

HealthierHere Response

HealthierHere reviewed both the individual responses and aggregate data for King County upon receipt of the survey results. The HealthierHere Chief Financial Officer (CFO) distributed the information to the leadership team for their review and use in discussions and site visits with practice and innovation partners. HealthierHere used the information to inform and ultimately affirm its continued investments in and support for partners' core infrastructure, such as risk stratification and population health management tools. HealthierHere will continue to provide support for providers' core infrastructure and capabilities to succeed in VBP.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

22. 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 is considered optional for this reporting period but are encouraged. However, it is requested if an ACH continues P4R data collection, including the MeHAF assessments, that the ACH submit a completed P4R report. These reports are helpful in providing utilization numbers and provider engagement totals throughout the state.

MeHAF guidance:

- The state continues to develop future integration assessment surveys and processes to improve on the reporting of behavioral and physical health integration. Until a new assessment is officially implemented it is recommended ACHs avoid engaging new providers in MeHAF assessment.

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.[8] Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

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

Instructions:

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

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

Format:

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

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

Narrative responses:

23. 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. See attached P4R workbook.

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

HealthierHere Response

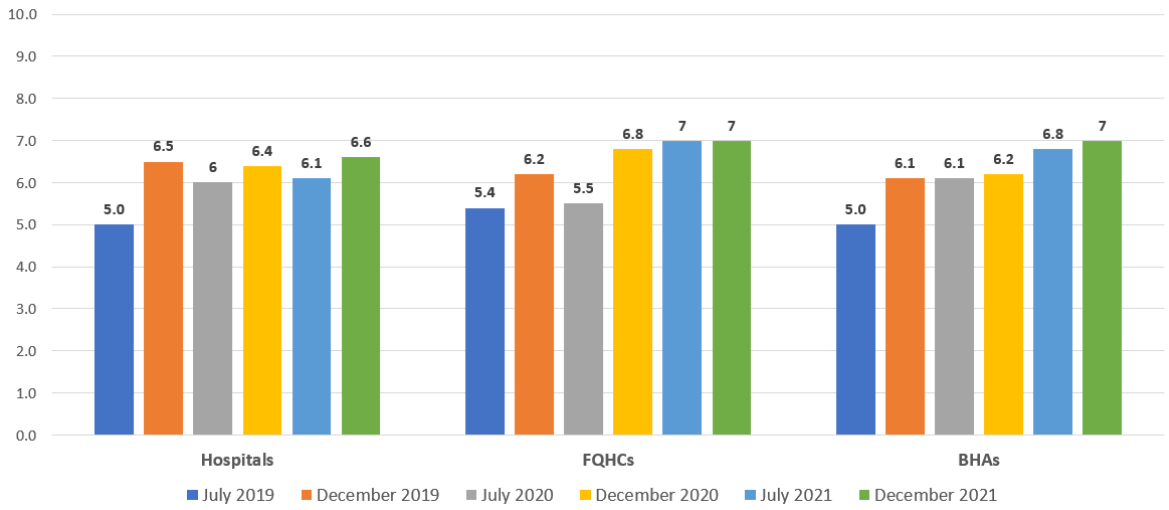
No additional context to report. See the attached P4R workbook for a summary of responses collected from partners.

Optional: The ACH may submit P4R metric information

Appendix A. Analysis of Semi-annual Reporting Data from July 2019 to December 2021

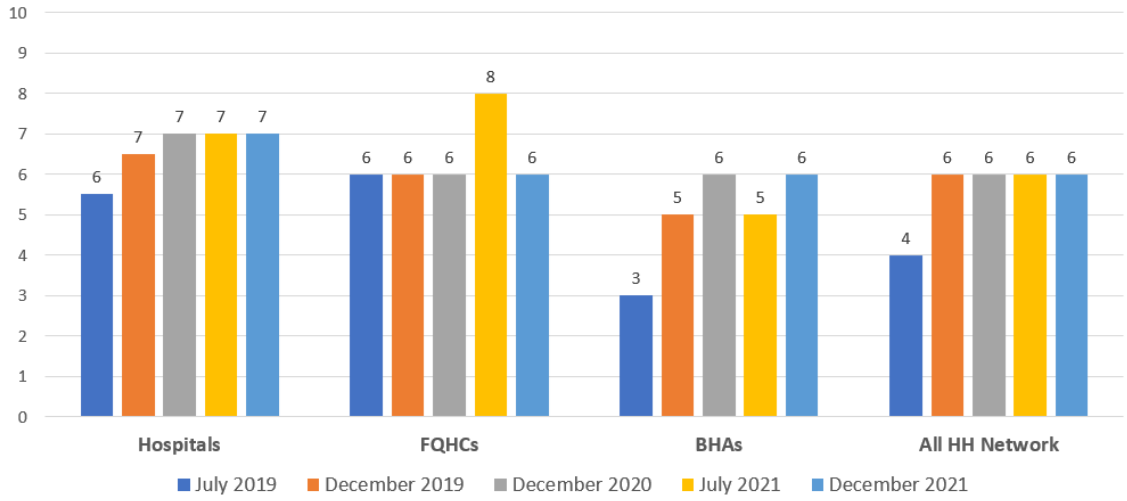
MeHAF Score Over Time, by Sector

Clinical and tribal partners are asked to assess their level of integration using the MeHAF survey.



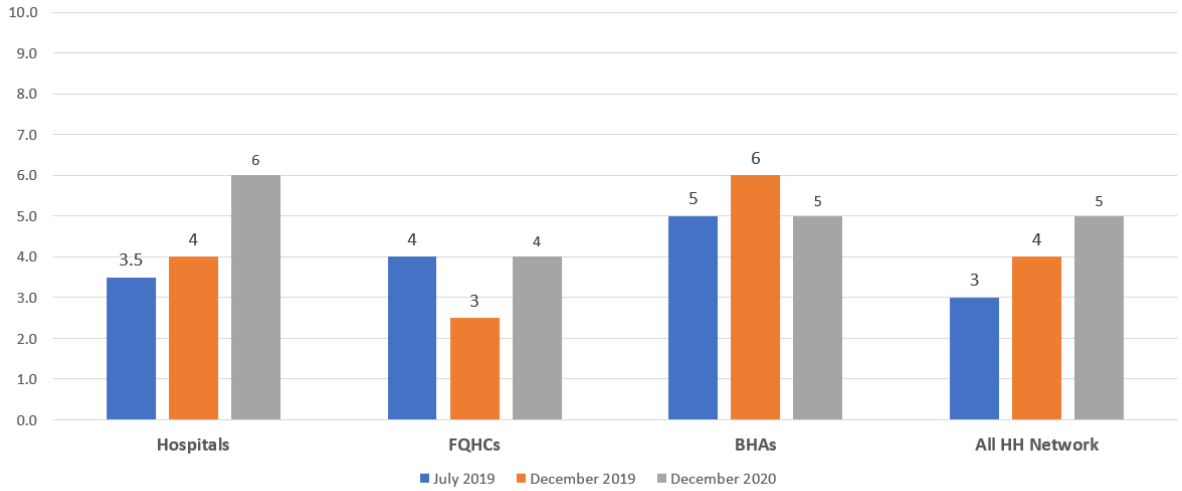
Population Health Registry Use Over Time

Clinical and tribal partners asked to report on use of registries and their functionality.



Risk Stratification Use Over Time

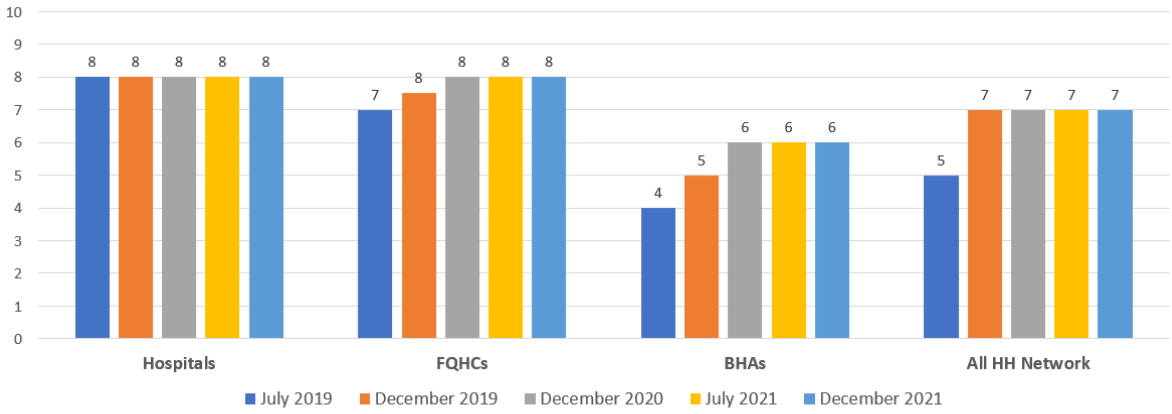
Partners asked to report on their use of risk stratification; question revised in 2021 to become a narrative question rather than a scale.



*To reduce the burden of data collection during the COVID response, data was not collected in July 2020.
**The risk stratification metric was revised in 2021 to become a narrative question rather than a scale.

Whole-Person Care Screenings Use, Average Score Change Over Time

Primary care sites are asked how well they are integrating behavioral health (BH) screenings; BH sites are asked how well they are integrating physical health screenings. 1 – 10 scale.



*To reduce the burden of data collection during the COVID response, data was not collected in July 2020

Appendix B. Innovation Projects: Success and Impact to Date

Project	Implementing Partner	Project Impact and Success to Date
MAT Care Transformation	County Doctor Community Health Centers (CDCHCs) **(ongoing)**	• Created the first Saturday clinic providing medication for opioid use disorder (MOUD) in King County. Visits at the Saturday clinic increased from 1–2 per Saturday in 2020 to 3–4 in 2021. • Expanded day-of-release/discharge access to MOUD intakes for vulnerable populations at high risk of overdose death. • Developed and optimized referral workflows with feedback from project and jail/ED referral partners. • Created "Healthcare for People with Opioid Use Disorder" posters and handouts with locations, hours, and a menu of services offered. • Established direct phone lines to nurse care managers and Health Insurance Portability and Accountability Act (HIPAA)-compliant cell phones for community health workers (CHWs). • Hired a Reentry CHW to do intakes, support patients, and make referrals to SDOH services. • Throughout 2021, there was a steady increase in referrals from jails and intakes through established partnerships. • Had a breakthrough in relationship with King County jail, with referrals happening in real time.
	Public Health-Seattle King County (PHSKC) **(ended)**	• Reduced barriers to link patients to behavioral health services. • Supported patients with finding employment, finding housing, and reengaging with families and friends. • Strengthened care coordination via increased data sharing/information flow. • Increased organizational capacity to address SDOH. • Changes due to COVID-19 response provided new ways to connect with

		the Department of Public Health Jail Health Services. • Strengthened linkages/collaboration between PHSKC and Navos mental health clinics. • Promoted whole-person care. • Innovation is complete as of October 30; MAT services will continue to be provided at the Burien PHSKC clinic.
Mobile Integrated Health (MIH)	Seattle Fire Department (SFD) and Aging and Disability Services (ADS) **(ongoing)**	• From December 2019 to December 2020, the program saw 1,355 non-duplicated individuals who received five or more responses in that 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 non-duplicated clients were contacted via HealthONE responses or the high-utilizer program. • Prior to the COVID-19 emergency, 87% of HealthONE encounters did not require transport to a hospital or an ED. This number dropped to 75%–80% during COVID-19 but is expected to rise again. • Formed an integrated care team within the MIH program that cuts across the three subprograms: high utilizers, vulnerable adults, and the HealthONE response unit. • Expanded and launched the HealthTWO response unit in April 2021. • Designed a nurse triage service that will assess incoming 911 calls to help route callers to appropriate interventions. A vendor has been identified, and they have developed protocols and are working on connections back to services. • Fostered excellent working relationships with external partners, leading to improved flow of information and an increased number of closed-loop referrals. • Improved patient experience: Firefighters and case managers are highly skilled at implicit assignment of on-scene tasks, from building rapport with the client to interviewing family members or other firefighters to

		beginning telephone referrals.
Testing Models for Integrated Care Innovations	Virginia Mason Franciscan Health and Valley Cities Behavioral Health Care **(ongoing)**	• Built a successful model by identifying a physician champion who maintained continuous process improvements for the program. • Hired and onboarded a behavioral health provider for the Des Moines test clinic quickly and on schedule. • Des Moines behavioral health provider continues to build his caseload, has 88 patients as of November 2021, surpassing the benchmark of 60–80. • 41% of active patients in treatment for at least 10 weeks have decreased their Patient Health Questionnaire (PHQ)-9 score by at least 50%. • 41% of active patients in treatment for at least 10 weeks have decreased their General Anxiety Disorder (GAD)-7 score by at least 5 points. • Testing billing of collaborative care codes as a potential sustainability strategy.

	HealthPoint and Valley Cities Behavioral Health Care **(ongoing)**	• 125+ patients served as of December 2021 (goal is 150 patients).
		• Established significant data-sharing capabilities (shared patient registry) and successful workflows, expanding access to the psychiatric advanced registered nurse practitioner (ARNP) and ultimately making significant progress in truly integrating care teams.
		• Discovered integration strategies and ways to connect teams that weren't previously apparent.
		• Developed a highly successful model for care conferences, now a regular practice among HealthPoint care coordinators and Valley Cities care managers, where they convene, reconcile various information, share updates, and coordinate care and follow-up.
		• Met or exceeded many clinical outcome goals in the first year of the program:
		  ○ Lowered PHQ-9 scores (62% toward goal of 30%).
		  ○ Exceeded goal for controlling hypertension (76% toward goal of 70%).

		○ Exceeded goal for follow-up primary care visits after a hospital stay or ED visit (96% toward goal of 80%). ○ Exceeded goal for screening patients for SDOH needs (100% toward goal of 90%). • In the second year of the innovation, the follow-up visit rate continues to be as high as 93%. The patient activation measure (PAM) scores are also showing sustained improvement, indicating a continued increase of activation and engagement, which should translate into improved health outcomes.
	International Community Health Services (ICHS) and Asian Counseling and Referral Service (ACRS) **(ended)**	• Converted its 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 among the peer support specialists, their ACRS supervisors, and the ICHS care team. This has been very effective in coordinating care. • 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. • Program enrollment topped out at 33 and has been decreasing. Partners are working together to revise the program model to make it more applicable to patients in a COVID-19 environment with limits on home visits and face-to-face contact with patients.
	Seattle Children's Care Network (SCCN) and Seattle Children's Hospital Psychiatry and	• Seven practices participated in the first cohort of the learning collaborative. ○ All participating practices have either started seeing behavioral health patients for the first time or expanded/enhanced the behavioral health services they provide. ○ Cohort 1 completed a total of 73 trainings, webinars, and clinic

	Behavioral Medicine **(ongoing)**	implementation calls in the first year of the innovation. ○ SCCN continues to support Cohort 1 through monthly coaching meetings, primary care physician (PCP) case reviews, behavioral health specialist trainings, and family advocate affinity meetings. In addition, SCCN continues to work with Cohort 1 practices to collect process and outcome data. • Six practices have been recruited to participate in the second cohort of the learning collaborative. The first learning collaborative session for Cohort 2 was held in November 2021. • Every Cohort 1 practice has officially brought on a family advocate to be a part of their Core Integrated Behavioral Health (IBH) Team. Family advocates have lived experiences and support SDOH needs. • High partner engagement throughout 2021.
	Downtown Emergency Services Center (DESC) and Harborview Medical Center (HMC) **(ongoing)**	• In the first year of the innovation, partners developed a formal care coordination strategy between DESC and HMC. This included care coordination team members becoming familiar with HMC's Pioneer Square Clinic, building new relationships with a greater range of care team members, establishing a care coordination liaison between institutions, developing an informatics strategy, and creating and testing care coordination workflow best practices. • The partners developed a shared client registry in DESC's electronic health record (EHR). They navigate compliance and technical barriers to develop a process to match data and identify shared clients on a quarterly cadence. • They created a full-circle experience around coordination. The team is able to receive a referral, contact HMC, schedule appointments, take clients to appointments, and follow up with HMC and DESC case managers regarding the next steps. • In 2022, the partners will apply lessons learned from the first year of the innovation to build a care coordination model on a broader scale at a new colocated clinic set to open in 2022, also known as the Hobson Clinic.
	DESC, Community	• The partners worked together over the first year of the innovation to identify a bundle of services critical to the provision of extremely low-

	Health Plan of Washington (CHPW), PHSKC, King County Behavioral Health and Recovery Division **(pending)**	barrier MAT for DESC's patient population. Currently, the direct services are funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) grant, but that is not sustainable long term. • The partners met regularly throughout 2021 to better understand the current payment model, services provided, staffing model, population served, and member data to test the feasibility of a low-barrier MAT payment model. • Once the payment prototype was developed and tested, they discovered that inpatient hospital stays and ED visits were lower for the group receiving DESC services, and primary care and behavioral health outpatient utilization were higher. In summary, DESC engagement appears to have a greater impact on reducing high service expenses (inpatient) and increasing engagement in services that support penetration rates and member sustainability for our chronically homeless members (i.e., PCP visits and behavioral health outpatient services). • A major success, DESC and CHPW will enter into a contract in 2022 to test the bundled payment model for 26 CHPW members over 12 months with payment delivered through the bundled negotiated rate and achievement of quality measures, such as retention in MAT services and increased numbers of outpatient primary care, behavioral health, and SUD visits.
	MultiCare Health System and Sea Mar Community Health Centers **(pending)**	• Services began in Q3 2021. • The partners are meeting weekly on process improvement for data and registry systems. MultiCare has been working with its IT department team to build a shared registry in EPIC, creating episodes of care, and building out collaborative care management codes. The episode of care tracks minutes spent on the patient. The episode of care captures minutes of care team activities, which are helpful for billing collaborative care codes.

Appendix C. July – December Connect2 Community (C2C) Network Activities

HealthierHere C2C Network activities from the current reporting period include the following:

- Launched a technology request for proposal in August 2021 to identify and select a vendor or vendors to build and operate the C2C Unified Network Infrastructure (UNI). The UNI will serve as a "network of networks" connecting technology platforms used by organizations participating in the C2C Network. A vendor/vendors will be awarded in mid-2022.

- Received a grant of $400,000 from Regence Blue Shield's "Four Communities" project to strengthen culturally and linguistically appropriate care coordination across clinical and community organizations in partnership with Global to Local and the YMCA of Greater Seattle. The investment will provide critical support to community health workers (CHWs) in South King County and build a foundation for relationship-based and technology-enabled care coordination. Additional details are available here.

- Explored community-prioritized network use cases focused on using the network's resource directory and offering linguistically and culturally appropriate community-based care coordination.

- Conducted outreach to and hosted webinars for the King County Veterans, Seniors and Human Services Levy (VSHSL) partners so they can learn about and contribute to the C2C Network.

- Completed a language access assessment and developed an equity plan, in collaboration with network partners, to be implemented in 2022 and beyond.

- Appointed cochairs for the C2C Network Advisory Group (AG), which serves as the governing body for the Connect2 Community Network. To date, the AG has approved client-facing and provider-facing privacy agreements, reviewed the network's overall technology architecture, and laid the foundation for evaluation measures. The group is also engaged in discussions around best practices and lessons learned from other successful CIE efforts across the country (211 San Diego and Alliance for Better Health in upstate New York). Additionally, the AG is focused on efforts to design equity in the CIE and is contributing to the development of the network's equity plan and community engagement work.

- Continues to provide funding and programmatic support to 49 clinical and community organizations in King County through the C2C Network Catalyst Fund that are using the Unite Us technology to send and/or receive referrals on behalf of their clients. Conducted a survey of Catalyst Fund recipients on their experience with bidirectional referral technology.

- Gathered input from community members (e.g., individuals with SUD, older adults, veterans, immigrants/refugees, and indigenous individuals) on privacy, functionality, and engagement.

- Continues to coordinate efforts, share learnings with stakeholders, and ensure that actions are community-driven and informed by consumer needs and preferences.

HealthierHere coordinated efforts with other clinical and community stakeholders aligned around a shared goal of improving care coordination in the Puget Sound region, participated in a number of cross-agency meetings with state partners and other ACHs to share its planning and progress in community-driven design, and presented this past fall at the 2021 Community Information Exchange Summit, which focused on centering community voice, equity, and anti-racism principles in multi-sector data-sharing models.

Healthier Here

October 1-December 31, 2021

Cumulative snapshot		
Funds Earned	$	140,600,483.73
Funds Distributed	$	88,780,210.35
Funds available	$	51,820,273.38

Table 1: Incentive Funds earned

	Q3	Q4	Total
Project 2A	$ -	$ 850,219.00	$ 850,219.00
Project 2C	$ -	$ -	$ -
Project 3A	$ -	$ 345,401.00	$ 345,401.00
Project 3D	$ -	$ -	$ -
VBP	$ -	$ 106,277.00	$ 106,277.00
Bonus pool/High Performance Pool	$ -	$ 212,555.00	$ 212,555.00
Total	$ -	$ 1,514,452.00	$ 1,514,452.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	$ 1,391.57	$ 369.66	$ 1,761.23

Table 3: Incentive funds distributed, by use category

	Q3	Q4	Total
Administration	$ 5,000,000.00	$ -	$ 5,000,000.00
Community health fund	$ -	$ -	$ -
Health systems and community capacity building	$ 976,130.78	$ 1,997,760.95	$ 2,973,891.73
Integration incentives	$ 388,723.00	$ 518,749.11	$ 907,472.11
Project management	$ 57,487.63	$ 7,980.00	$ 65,467.63
Provider engagement, participation, and implementation	$ 662,500.00	$ 86,710.00	$ 749,210.00
Provider performance and quality incentives	$ 2,875,632.41	$ 95,000.00	$ 2,970,632.41
reserve/contigency fund	$ -	$ -	$ -
Total	$ 9,960,473.82	$ 2,706,200.06	$ 12,666,673.88

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 January 26, 2022 to accompany the seventh Semi-Annual Report submission for the reporting period October 1 to December 31, 2021.