



Governing Board Meeting – April 6, 2023, 1:00pm – 4:00pm *(Virtual)*

MEETING GOALS

The objectives of today's meeting are to: (1) learn about HealthierHere's care coordination work and landscape analysis, (2) receive 2022 and YTD 2023 financial reports, and (3) get an update on HealthierHere's policy/legislative work.

AGENDA

1:00 pm	1) Land Acknowledgement	<i>Roi-Martin Brown, HealthierHere</i>
1:05 pm	2) Welcome & Introductions <ul style="list-style-type: none"> Meeting Goals/Agenda 	<i>Shelley Cooper-Ashford & Jeff Sakuma, Board Co-Chairs</i>
1:10 pm	3) Board Business <ul style="list-style-type: none"> Approval of March Meeting Minutes Interim CEO Report 	<i>Shelley Cooper-Ashford & Jeff Sakuma, Board Co-Chairs</i> <i>Thuy Hua-Ly, HealthierHere</i>
1:20 pm	4) Equity Moment	<i>Andrea Yip, Board Member</i>
1:30 pm	5) Care Coordination & Landscape Analysis <ul style="list-style-type: none"> Overview of Activities Small Group Discussions 	<i>Michael McKee, HealthierHere</i> <i>Madelyn McCaslin, HealthierHere</i>
3:00 pm	Public Comment	
3:05 pm	Break	
3:10pm	6) Finance <ul style="list-style-type: none"> 2022 Year-End Financials 2023 Q1 Reports for LLC & 501c3 	<i>Thuy Hua-Ly, HealthierHere</i>
3:30 pm	7) Policy/Legislative Session Update	<i>Thuy Hua-Ly, HealthierHere</i>
4:00 pm	8) Adjourn	

Next Meeting: May 4, 2023, 1-4pm <i>(virtual)</i>
--

Governing Board Meeting Summary

February 2, 2023, 1:32 p.m. – 3:06 p.m.

Video Conferencing

Members Present: Abdulahi Osman (delegate for Falis Community Services), Andrea Yip (delegate for Seattle/King County Aging & Disability Services), Betsy Lieberman (Betsy Lieberman Consulting), Christina Diego (delegate for Seattle Indian Health Board), Daniel Malone (Downtown Emergency Service Center), Elizabeth Tail (Cowlitz Indian Tribe), Giselle Zapata-Garcia (Latinos Promoting Good Health), Jay Fathi (Molina Healthcare), Jeff Foti (Seattle Children's Hospital), Jeff Sakuma (City of Seattle), Jesus Elizalde Lindgren (delegate for Swedish), Lisa Yohalem (HealthPoint), Michael Ninburg (Hepatitis Education Project), Kristin Conn (Kaiser Permanente of WA), Shelley Cooper-Ashford (Center for Multicultural Health), Steve Daschle (Southwest Youth and Family Services), and Tricia Madden (Harborview Medical Center).

Members Not Present: Roi-Martin Brown (Washington Community Action Network, Leo Flor (King County Department of Community and Human Services), Mario Paredes (Consejo Counseling and Referral Services) and Semra Riddle (Sound Cities Association).

Staff: Abriel Johnny, Catherine Seneviratne, Christine Berch, Graeme Aegerter, Jaspreet Malhotra, Lisa Watanabe, Maria Escalera, Marya Gingrey, Michael McKee, Monica De Leon, Thuy Hua-Ly, Tony Ke, and Christina Hulet (Consultant).

Guests: Amber Casey (Hepatitis Education Project), David Coffey (Recovery Cafe), Hali Willis (SCA), Ixtli White Hawk (Nakani Native Program), Laura Johnson (United Health Care), Laurel Lee (Molina Healthcare), Lois Bernstein (MultiCare), Sue Eastman (Eastman Strategies) and Travis Grady (Cowlitz Indian Tribe).

Governing Board Meeting

The Governing Board meeting, including board members, delegates, and the public, was called to order at 1:45 pm.

Welcome & Introductions

Thuy Hua-Ly welcomed everyone, and Jeff Sakuma reviewed the agenda.

Board Business

Approval of the Minutes from February 2, 2023

The board reviewed and approved the February 2nd meeting minutes unanimously.

Abstentions: None

Executive's Report

Thuy Hua-Ly reviewed the CEO report. See page 5 of the pre-read packet for details. Thuy's highlights included:

- Highlight Woman's History Month
- Bring attention to House Bill 1214, which would ban all gender-affirming care for minors.
- We had planned to meet in person for March but due to low registration we are meeting virtual.
- Our work with Care Connect providing care coordination services for people diagnosed with COVID-19 continues to be a heavy lift. This work is supported by a grant from the WA State Department of Health.
- HealthierHere staff will be volunteering at Sound Careers in Healthcare event on March 21st.

CEO Recruitment Update

Jeff Sakuma provided a brief update on the CEO Recruitment. Jeff's highlights included:

- We are continuing to work with Carlson & Beck firm
- The Hiring Committee has made a final recommendation and are moving forward with a CEO offer.

Equity Moment

Elizabeth Tail shared the meeting equity moment. Elizabeth spoke about data regarding equity and how it highlights the need for it. They shared some of the data they found in their research for funding for a client. The story about equity is not just about one thing and one narrative, it's a collective of principals and justice and correcting wrongs. Equity leverages resources across communities and co-horsts.

Governance

Policy/ Legislative Session Update

Thuy Hua-Ly provided an update on the Legislative Session. The items below are things HealthierHere is keeping an eye on.

- Sales Tax Exemption
- Statewide CIE
- MTP Waiver 2.0 Update
- Behavioral Health Workforce bills

Currently the legislative session is in full swing. We will have more information at our April meeting.

Public Comment

No comment

Overview of MTP Investment Impacts in Community & Tribal Partners

Marya Gingrey provided an overview of 2018-2022 investments and focuses on the areas below. Abriel Johnny provided an overview of specific investments. It was explained to the board that the data would be available via slides for board members to be able to share with their staff.

- HealthierHere Practice Partners
- Growth Areas of focus incentives
- Success stories in each Growth Area of Focus
- Resources provided: Convenings and trainings and tools
- Community and Tribal Engagement Timelines
- Key findings

David Coffey the Executive Director of Recovery Café provided a background of their organization and the work they do in our community. David provided a virtual tour of their health center located in the SODO neighborhood. It was through the investments they received from HealthierHere and Country Doctor that they were able to buy all the equipment in their exam room. These investments made their clinic a reality.

Ixtli White Hawk from the Nakani Native program spoke about traditional medicine investments. Ixtli spoke about how most of the time native communities are invisible but there's a mutual respect between HealthierHere and the tribes. The pandemic hit the native community hard. The investment that was received from HealthierHere was used for traditional native medicine to our people.

Time was given for board and community members to express their comments and Q & A.

The meeting adjourned at 3:22 pm.

April 2023 Chief Executive Officer Report

Date: April 6, 2023

To: HealthierHere Governing Board

From: Thuy Hua-Ly

Dear Governing Board Members,

The sun is coming out more each day, the flowers are blooming, and change is in the air!

HealthierHere recently [welcomed John Kim as our next CEO](#), who will join the organization on June 1st, 2023. We will be working closely to usher him into the CEO role, after which I will step into the Chief Financial and Operations Officer role. Thank you all for your support and guidance throughout the CEO search and hiring process. I look forward to starting an exciting new chapter for HealthierHere with John's leadership!

This month, we will also welcome Rogelio Mogollan to HealthierHere's staff as our new IT and Systems Administration Project Manager. Rogelio brings a fantastic combination of technical knowledge and stakeholder engagement experience and will be a critical addition to our team.

On April 1st, the Connect2 Community Network celebrated the soft launch of its technology infrastructure, which has been co-designed with network partners. In the coming months, we will be refining the system, testing initial integrations, and developing training and support plans as we continue our journey to create a connected system of whole-person care.

In April, we recognize Medicaid Awareness Month, a time to champion this federal program that provides health insurance to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. As King County's Accountable Community of Health, founded to transform care delivery and improve health outcomes for Medicaid recipients, HealthierHere remains committed to serving this population.

Notably, [thousands of Washingtonians](#) could lose Medicaid (known as Apple Health in WA State) coverage starting April 1, 2023 following the expiration of the federal pandemic-era [public health emergency](#). In King County, 100,000 clients will be up for plan renewal over the next year.

Please [spread the word](#) that the state will again require clients to renew their eligibility every year and clients will receive a renewal notice before the end of their renewal period over the next 12 months. Apple Health clients should ensure that their [contact information is up-to-date](#), look for renewal notifications, and act in a timely manner to maintain coverage. Partner organizations in our network may consider joining the newly launched [Apple Health Ambassador Program](#), which assists with community outreach.

Thank you, and I look forward to coming together to continue our collaboration this month!

Best,

Thuy Hua-Ly

Interim CEO, HealthierHere

MORE HEALTHIERHERE & NETWORK HAPPENINGS

[HealthierHere Recruiting for New Roles](#)

We are seeking applicants for the following new positions on HealthierHere's team:

- [Director, Community Information Exchange and Care CoordinationProduct Manager, Community Information Exchange](#)
-
- Product Manager, Community Information Exchange

Upcoming Training Opportunities for Community Health Workers

HealthierHere is excited to share various training opportunities for community health workers (CHW) as part of the CDC-funded [CHW CARE](#) initiative.

Giving Grace: A mental health conversation with CHWs

In-person (Tukwila Community Center), April 21st, 10am - 2:30pm

No registration is required. Contact kidawson@kingcounty.gov with any questions.

DOH Core competency Training – April 2023

The Washington Department of Health offers a free 8-week Core Competency Training course for Community Health Workers. Visit [their website](#) for more information. Email kidawson@kingcounty.gov to register for this upcoming training, beginning in April 2023.

To find and share additional resources, visit the new [Community Health Worker \(CHW\) Resource Center](#), developed by and for CHW's with leadership and support from Healthy King County Coalition.

Community & Consumer Voice Committee (CCV)*Meets the 4th Monday of each month at 1:30pm-3:30pm*

Roi-Martin Brown	Washington Consumer Action Network
Joe Chrasti	IAF Northwest/Health Equity
Gladis Clemente	Promotora Comunitaria South Park
Shelley Cooper-Ashford	Center for Multicultural Health
Shantel Davis	Peoples Harm Reduction Alliance
Michelle DiMiscio	Community Health Workers KC
Lisa Floyd	KC Department of Community and Human Services
Dorothy Gibson	Sound Alliance/AF
Riham Hashi	Living Well Kent
Shamso Issak	Living Well Kent
Elizabeth Kimball	Public Health Seattle/KC
Guo Liao	Asian Counseling & Referral Service
AJ McClure	Global to Local
Hani Mohamed	SKC Public Health
Sonia Morales	Molina Health Care
Cicily Nordness	Seattle Housing Authority
Janelle Okorogu	Center for Multicultural Health
Hallie Pritchett	Lake Washington Institute of Technology
Isabel Quijano	Promotora Comunitaria South Park
Jihan Rashid	Community Member
Marguerite Ro	AARP Washington
Julie Romero	Neighborhood House
Nadine Shiroma	Hepatitis B Foundation
Christine Stalie	DOH & Washington Immigrant Network
Michael Ninburg	Hepatitis Education Project
Laura Titzer	Northwest Harvest
Janet Zamzow Bliss	Community Member
Giselle Zapata-Garcia	Latinos Promoting Good Health

Staff: Marya Gingrey, Abriel Johnny

Executive Committee (EC)*Meets the 3rd Friday of every month at 8:30am-10:00am*

Shelley Cooper-Ashford (co-chair)	Center for MultiCultural Health
Steve Daschle	Southwest Youth and Family Services
Betsy Lieberman (chair Emeritus)	Affordable and Public Housing Group
Mario Paredes	Consejo
Jeff Sakuma (co-chair)	City of Seattle, Human Services Dept.
Elizabeth Tail	Cowlitz Tribal Health

Staff: Christina Hulet, Thuy Hua-Ly

Finance Committee (FC)*Meets the 3rd Thursday of each month at 3:30 pm-5 pm*

Roi-Martin Brown	WA Consumer Action Network
Janine Childs	Neighborcare
Steve Daschle (co-chair)	Southwest Youth & Family Services
David DiGiuseppe	Community Health Plan of WA
Pam Gallagher	Swedish Hospital
Travis Grady	Cowlitz Tribal Health
Hiroshi Nakano (co-chair)	Valley Medical
Mario Paredes	Consejo Counseling & Referral Service
Karen Spoelman	King County DCHS - BHRD
Jenny Tripp	DESC

Staff: Thuy Hua-Ly & Christine Berch

Indigenous Nations Committee (INC)*Meets monthly*

Colleen Chalmers	Chief Seattle Club
Craig Dee	Fred Hutchinson
Matt EchoHawk - Hayashi	Headwater People
Travis Grady	Cowlitz Tribal Health
Camie Goldhammer	UIATF - Doula program
Sacena Gurule	Cowlitz Tribal Health
Christian Hogan	Unkitawa

Leslie Jimenz	KC Public Health - Environmental Health
Jessica Juarez-Wagner	United Indians of All Tribes Foundation
Ellany Kayce	Nakani Native Program
Esther Lucero	Seattle Indian Health Board
Sara Marie Ortiz	Highline Public Schools - Native Education
Jeff Smith	Nakani Native Program
Elizabeth Tail	Cowlitz Tribal Health
My-le Tang	Dept of Commerce - Tribal Homeless Youth
Raven Twofeathers	
Ixtli White Hawk	Unkitawa

Chair: Vacant / Staff: Abriel Johnny

Connect2 Community Network Advisory Group

Meets every other month

Tashau Asefaw	Community Health Plan of WA
Modester Chatta (co-chair)	Association of Zambians in Seattle, WA
Barbara de Michele (co-chair)	Issaquah City Council
Joanne Donahue	Sound Generations
Jon Ehrenfeld	Seattle Fire Department
Allie Franklin	Harborview
Michelle Glatt	HealthPoint
Donald Lachman	Westcare WA/WA Serves
Joceyln Lui	Asian Counseling & Referral Service
Sara Mathews	Premiera
AJ McClure	Global to Local
Thuy Hua-Ly	HealthierHere
Peter Muigai	Pamoja Christian Church
Michael Myint	MultiCare
Gary Renville	Project Access Northwest
Marcy Miller	King County
Michelle McDaniel	Crisis Connections
Marguerite Ro	AARP Washington
Lina Stinson-Ali	WA State Coalition for African Community Leaders
Sally Sundar	YMCA of Greater Seattle

Cody West	Peer Seattle
Kim Wicklund	Kaiser Permanente
Andrea Yip	Aging & Disability Services

Staff: Christina Hulet

Integration Assessment Workgroup

Meets the 1st Monday of each month at 2:30pm-4 pm

Liz Baxter	North Sound ACH
Dee Brown	United Health Care
Miranda Burger	Olympic Community Health
Tory Gildred	Molina
Jennie Harvell	HCA
Michael McKee	HealthierHere
Jessica Molberg	Coordinated Care
Colette Rush	HCA
Caitlin Safford	Amerigroup
John Schapman	North Sound ACH
Audrey Silliman	Coordinated Care
Lindsay Knaus	North Sound ACH
Celeste Schoenthaler	Better Health Together ACH
Tawnya Christiansen	Community Health Plan of Washington
Mattie Osborn	Amerigroup
Andrea Ray	United Health Care
Siobhan Brown	Community Health Plan of WA
Mary Franzen	HCA
Marc McManus	United Health Care
Sarah Bolling Dorn	Better Health Together ACH

Tri-Chairs: Tory Gildred, Michael McKee, Colette Rush

Staff: Diana Bianco & Cathy Kaufman, Artemis Consulting

Who	Purpose	Highlights	What's Next
Governing Board (GB, Board)	<ul style="list-style-type: none"> • Steward the organization's overall mission and strategic plan • Assume fiduciary responsibility/single point of accountability, including financial decision-making authority for demonstration projects and fund allocations • Hire, fire and evaluate the Executive Director (ED) • Maintain updated operating agreements and bylaws • Monitor organizational and project performance • Appoint Governing Board members • Represent and communicate HH's work to the public • Review and approve consumer/community engagement plan • Ensure alignment with regional health needs and priorities 	<p>March 2 Agenda</p> <ul style="list-style-type: none"> • CEO Hiring Update • Learn about our system transformation work with community and Tribal Partners 	<p>March 2 Agenda</p> <ul style="list-style-type: none"> • Learn about care coordination work and landscape analysis • Receive 2022 and YTD 2023 financial reports • Get update on HealthierHere's policy/ legislative work <p>Next Meeting: May 4</p>
Executive Committee (EC)	<ul style="list-style-type: none"> • Support the ED in achieving organizational goals • Oversee ED selection, compensation, and evaluation • Act on behalf of the Governing Board in cases of emergency or when urgent decisions are needed • Approve expenditures/contracts between \$100-\$500K not included in the board-approved budget as needed • Oversee board member recruitment and selection process 	<p>March Agenda</p> <ul style="list-style-type: none"> • Updated 501c3 bylaws & timeline for 501c3/LLC transition. • April GB appointments/ reappointments • Update on Board appointment process & timeline 	<p>April Agenda</p> <ul style="list-style-type: none"> • Updated 501c3 bylaws- pending INC recommendations • April GB appointments/ reappointments • Care Coordination Transformation Committee (charter) • Policy update/ leg session

Who	Purpose	Highlights	What's Next
	<ul style="list-style-type: none"> Oversee board governance (e.g., committee structure, bylaws) Support HH's future sustainability and the development of key initiatives such as the Equity & Wellness Fund Approve state-required reports 	<ul style="list-style-type: none"> Care Coordination Transformation Committee (charter) Review April's EC draft agenda 	<ul style="list-style-type: none"> CEO transition planning Review May's EC draft agenda <p>Next Meeting: April 14</p>
Finance Committee (FC)	<ul style="list-style-type: none"> Oversee HH's budgeting, financial monitoring, internal control processes and financial policies and procedures Ensure adequate protection of HH's assets Oversee distribution of funds to partnering organizations and for investment priorities Ensure HH is meeting requirements for state, provider, and other contracts Oversee/coordinate with Funds Flow Workgroup Facilitate value-based payment 	March meeting was cancelled.	<p>April Agenda</p> <ul style="list-style-type: none"> TBD <p>Next Meeting: April 20</p>
Community & Consumer Voice Committee (CCV)	<ul style="list-style-type: none"> Proactively engage communities and beneficiaries to co-design and embed equity in HH's work Engage and support community-based organization (CBO) partners and build CBO capacity Actively recruit and support community members serving on the Board/committees Provide input into and help design the community engagement plan Gather data/information on the experience of Medicaid members 	<p>March 27 Agenda:</p> <p>Jointly the INC & CCV</p> <p>INC and CCV anticipate having updates on:</p> <ul style="list-style-type: none"> The HealthierHere CEO search and The Tribal and Community Innovations projects <p>INC and CCV anticipate having discussion and feedback on the Equity Definition and Guidelines Implementation process.</p>	<p>April Agenda:</p> <ul style="list-style-type: none"> TBD <p>Next meeting: April 24</p>

Who	Purpose	Highlights	What's Next
	<ul style="list-style-type: none"> Monitor results and ensure accountability/transparency with communities 	<ul style="list-style-type: none"> INC and CCV will break out into individual committee caucuses: INC will review the proposed Bylaws language and have discussion on Traditional Medicines pertaining to canoe journey and a communications discussion on Missing and Murdered Indigenous Women and Girls and the upcoming MMIWG day on May 5th. CCV will hold Governing Board seat nominations and voting. CCV will then review proposed charter language changes and have a communications discussion around Juneteenth. 	
Indigenous Nations Committee (INC)	<ul style="list-style-type: none"> Proactively engage American Indian/Alaska Native/Indigenous (AI/AN/I) community and beneficiaries to co-design and embed equity in HH's work Engage and support AI/AN/I serving community-based organization (CBO) partners and build CBO capacity Actively recruit and support AI/AN/I community members serving on the Board/committees Provide input into and help design the tribal engagement plan 	<p>Jointly the INC & CCV</p> <ul style="list-style-type: none"> See CCV entry 	<p>Jointly the INC & CCV</p> <p>See CCV entry</p>

Who	Purpose	Highlights	What's Next
	<ul style="list-style-type: none"> Gather data/information on the experience of Medicaid members Monitor results and ensure accountability/transparency with community 		
Connect2 Community Network Workgroups	<p>Community Information Exchange (CIE) Collaborative:</p> <ul style="list-style-type: none"> Collaborative members will work together to establish a community-led governance structure and guide the development of a CIE <p>Network Partners Workgroup (NP):</p> <ul style="list-style-type: none"> Develop shared long-term CIE requirements and implementation plan in consultation with Legal Framework and Data & Technology Workgroups <p>Legal Framework and Data and Technology Workgroups (LDT):</p> <ul style="list-style-type: none"> Develop shared long-term CIE requirements and implementation plan in partnership with Network Partners Workgroup 	March meeting was cancelled	<p>C2C Network Partner Workgroup</p> <ul style="list-style-type: none"> TBD <p>Next meeting: May 10</p>
Integration Assessment Workgroup	<p>Supports statewide implementation of a standardized tool to assess level of integration for outpatient primary care and behavioral health agencies. Includes representatives from HCA, MCOs, & ACHs to:</p> <ul style="list-style-type: none"> Identify a tool to be implemented statewide Make recommendations to HCA on implementation and timeline 	<p>March 6 Agenda:</p> <ul style="list-style-type: none"> Continue to plan for and implement focus groups to gather feedback from Cohort 1 providers about their experience with the WA-ICA. These focus groups will inform future adaptations of the Integrated Care 	<p>WA-ICA Agenda:</p> <ul style="list-style-type: none"> WA-ICA workgroup will host two webinars for Cohort 1 providers to share out the high level statewide assessment results for primary care practices and for behavioral health practices.

Who	Purpose	Highlights	What's Next
	<ul style="list-style-type: none">• Make recommendations to HCA on data collection, analysis, reporting, and data sharing• Make recommendations to HCA on quality improvement structure and areas of focus including training, TA, practice coaching, etc. to help providers advance along the continuum of integrated care• Oversee launch of WA-ICA		<ul style="list-style-type: none">• Continue to prepare for key informant interviews of providers/practices in Cohort 1. <p>Next Meetings: April 3</p>



Landscape Analysis of Care Coordination King County, Washington

Executive Summary

Submitted to HealthierHere on Friday, March 25, 2022

Guiding questions and methods

- / **What is the current status of care coordination in Washington State?**
- / **What are the facilitators, challenges, and gaps in current processes?**
- / **What are promising practices for whole-person, community-based care coordination?**
- / **What will it take to make care coordination equitable for all residents?**

Note: The appendix contains additional information about the goals, methods, and findings from each data source in the landscape analysis.



Co-design workshop
(2 hours, 30 participants)



Document review
(22 programs and 27 HealthierHere resources)



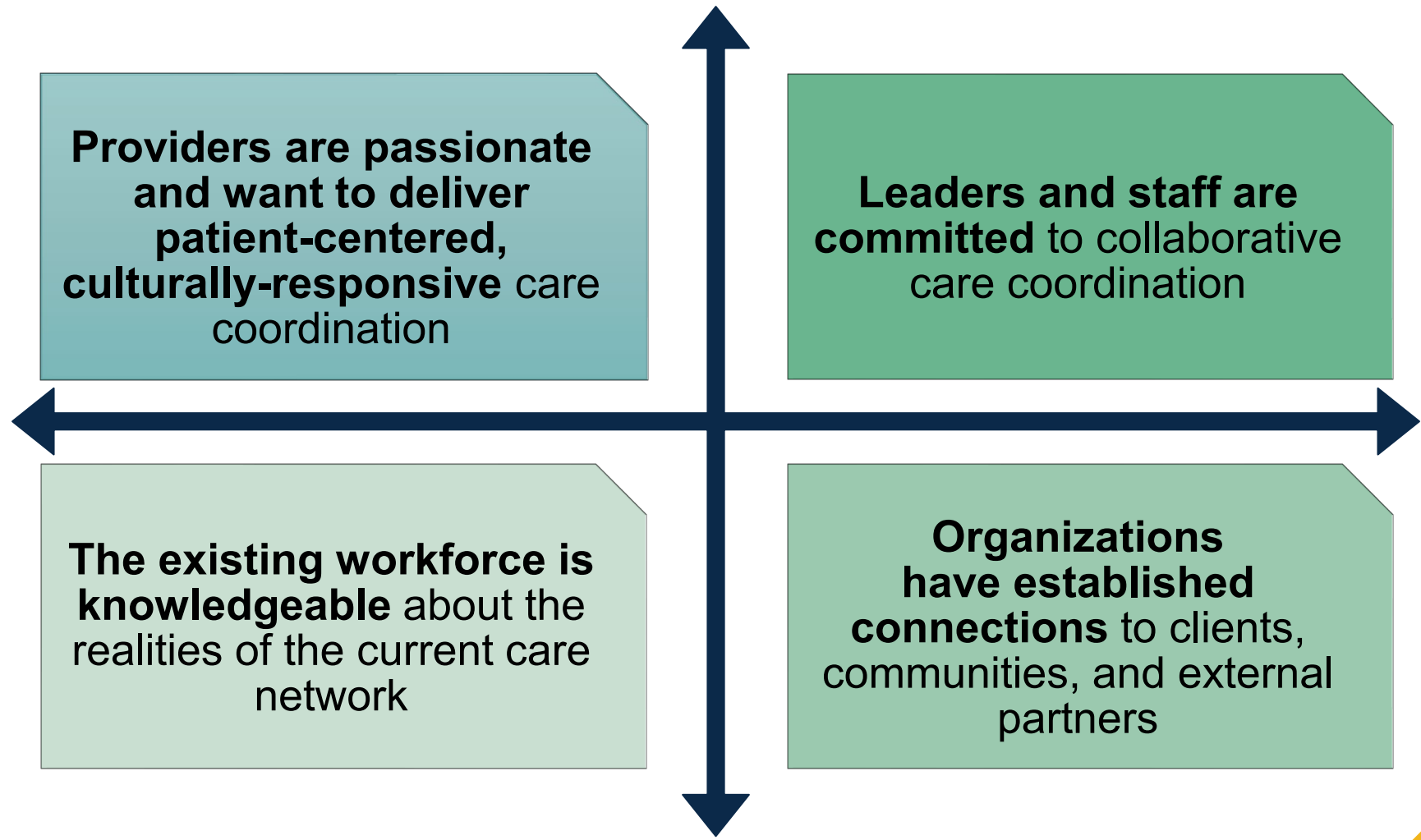
Interviews and focus groups
(13.75 hours with 30 participants)



Survey
(98 complete and partial responses)



Strengths of current care coordination system





Challenges

Financial capacity

Workforce

Data infrastructure

Lack of Trust

Cultural and linguistic competency

Affordable and accessible services

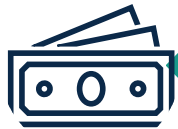
Referral processes and communication



Top four suggestions from survey respondents for improving care coordination



Data-sharing technology that all agencies involved in care coordination have access to and can use



Sustainable funding for care coordination activities



Culturally responsive approaches to reach people served by health and social services



Hiring, training, and retaining a sufficient workforce

Suggested goals for each recommendation area



CIE and data sharing

- Implement solutions that work with current workflows while promoting changes to realize the full potential of technology.



Funding

- Diversify fundings streams and secure equitable, sustainable financing to support everyone who contributes to care coordination.



Cultural competency

- Build a diverse care coordination workforce with the skills to provide culturally and linguistically-tailored care.



Workforce

- Support and foster connections between existing care coordinators and take steps to increase diversity, equity, and inclusiveness.



Community engagement



- Earn and strengthen community trust through intentional and ongoing engagement, investment, and power-sharing.



Policy

- Improve access to existing services and move upstream to address root causes of harm and inequity.

Snapshot of roadmap recommendations

	CIE and data	Funding	Cultural competency	Workforce	Community engagement	Policy
 Near-term	<div>Prioritize CIE features people will use (resource directory, connecting with partners)</div>	<div>Increase partner funding to build capacity for transformation</div>	<div>Work with the community to create a resource on community-based care coordination</div>	<div>Acknowledge and seek ways to address burnout</div>	<div>Amplify community voices</div>	<div>Loosen requirements for existing services</div>
 Longer term	<div>Make CIE usable for consumers and give them ownership of their data</div>	<div>Consider community-participatory budgeting processes</div>	<div>Host trainings (e.g., working with translators, trauma-informed care, and crisis management)</div>	<div>Match pay for non-profit staff to that of hospital service providers</div>	<div>Create paid positions, professional development opportunities for community members</div>	<div>Go further upstream to address root causes of care fragmentation</div>



To contact the Mathematica–Comagine Health Care Coordination Landscape Analysis team:

**Alyssa Crawford, Project Director,
Mathematica**

acrawford@mathematica-mpr.com

(202) 484-5720

**Lisa Packard, Co-Principal Investigator,
Comagine Health**

LPackard@comagine.org

(206) 660-3105

Other report authors (listed alphabetically):

Toni Abrams Weintraub

Jackie Brenner

Christina Dionisio-Martinez

Mindy Hu

Elena Jimenez

Ken Lim

Vanessa Quince



Board Meeting Evaluation Form (also available online at [HERE](#))

On a scale of 1 to 10, how would you rate the quality of today's meeting?

What would it take to make it a 10?

COMMENTS (optional)

Glossary of Terms

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of the Health Care Authority
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	Community-Based Organizations
CCM	Chronic Care Model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community Health Worker(s)
CLS	Community Learning Sessions
CMCH	Center for Multi-Cultural Health
CMS	Centers for Medicare & Medicaid Services
DAST	Drug Abuse Screening Test
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	Emergency Department
EHR	Electronic Health Record
FIMC	Fully Integrated Managed Care
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
GAD	Generalized Anxiety Disorder
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network
HHSTP	Health and Human Services Transformation Plan
HIE	Health Information Exchange
HIT	Health Information Technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider

ILC	Interim Leadership Council
IOM	Institute of Medicine
IPT	Investment Prioritization
IT	Information Technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	Letter of Intent
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	Memorandum of Understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid Value-Based Purchasing
ODU	Opioid Use Disorder
P4P	Pay-for-Performance
P4R	Pay-for-Reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	Primary Care Provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program
PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	Substance Use Disorder
TA	Technical Assistance
TSP	Transition Support Program
UIHI	Urban Indian Health Institute
US	United States
VBP	Value-Based Payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington State Chapter
WAC	Washington Administrative Code
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association



Landscape Analysis of Care Coordination King County, Washington

Report and Roadmap

Submitted to HealthierHere on Friday, March 25, 2022



Contents



Landscape analysis report

Slides 3-27



Roadmap recommendations

Slides 28-44



Appendices

- Team contact information
- Additional information about landscape analysis

Slides 45-67



Landscape analysis report



Approach

Guiding questions and methods

- / **What is the current status of care coordination in Washington State?**
- / **What are the facilitators, challenges, and gaps in current processes?**
- / **What are promising practices for whole-person, community-based care coordination?**
- / **What will it take to make care coordination equitable for all residents?**

Note: The appendix contains additional information about the goals, methods, and findings from each data source in the landscape analysis.



Co-design workshop
(2 hours, 30 participants)



Document review
(22 programs and 27 HealthierHere resources)



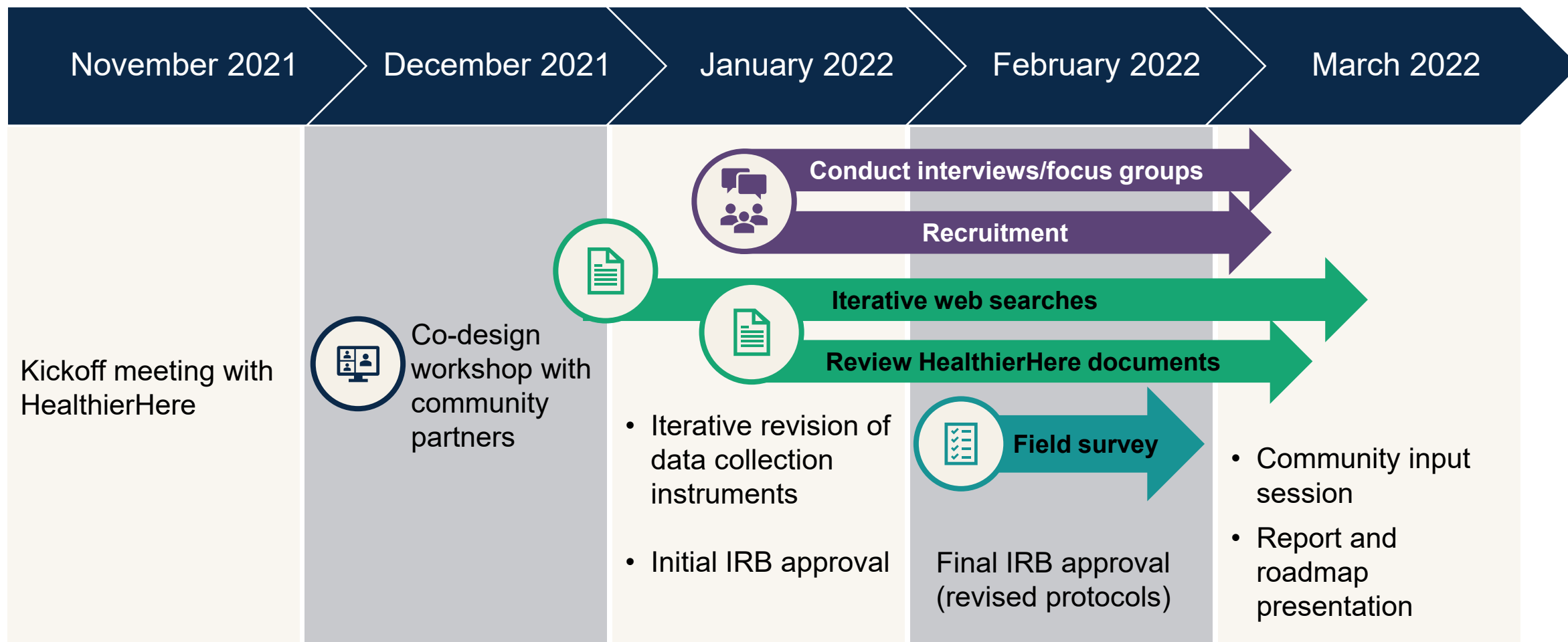
Interviews and focus groups
(13.75 hours with 30 participants)



Survey
(98 complete and partial responses)



Timeline



Not shown: COVID-19 Omicron surge (December on), spacing of data collection instrument feedback (throughout January), HealthierHere-requested pause in recruitment (mid-January).

Limitations

- / **Short timeline**
- / **COVID-19 Omicron variant surge**
- / **Focus on Western medicine**
- / **Incentive payments not vetted by and flexible to need of community**



Minimal data from

- 
- Patients and consumers
 - Tribal health
 - Community health workers
 - HealthierHere staff



Findings:

- Current state of care coordination
- Preferences for the future



Perceptions of current care coordination

- / **Siloes need to be broken.**
- / **Care coordination efforts vary.**
- / **Providers hold many constantly changing roles.**

“Everything is siloed...When someone walks through the door, that hallway should take them to the care that they need and not be dependent on the label on the door. We should be able to open the door, have the person walk down the hall, and access the care that is needed.”

—Representative from community organization

“No one has everything a person needs in one place. Because of that, people’s needs get siloed. [Care coordination] is really about providing whole-person care and giving clients access to that.”

—Representative from a clinical organization

“[Care coordination] covers all parts of the person. It takes in their Tribal affiliation and whole-person needs. Whole person [includes] personal health, physical health, their surroundings, environment, food...all aspects of their life. Taking care of all needs of the person—spiritual and environmental.”

—Representative from community organization



Care coordination involves many sectors

Health care providers
(including mental and behavioral health)

Government agencies

Social service providers

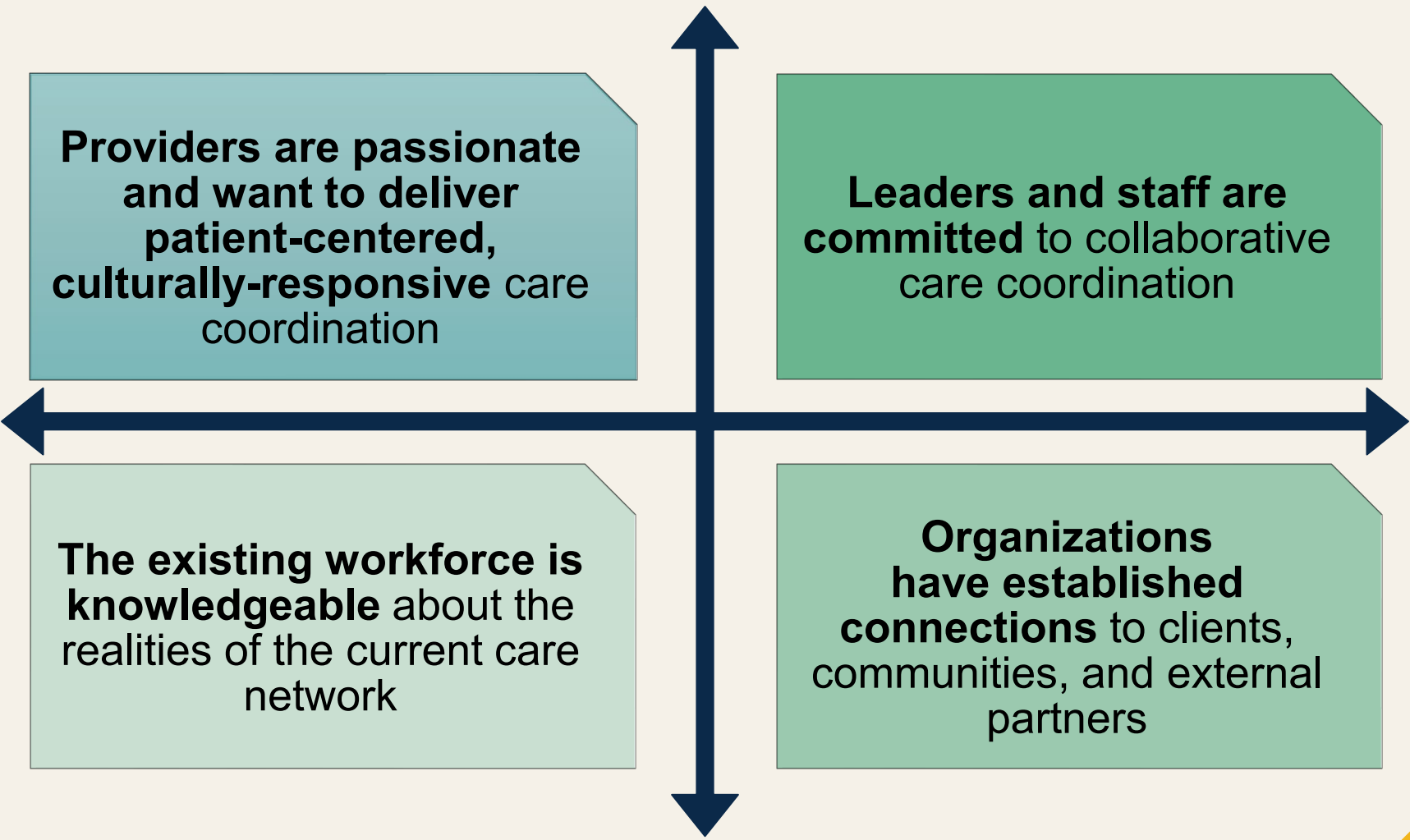
Managed care organizations

Non-governmental policy and advocacy organizations

Traditional and Tribal medicine practitioners



Strengths of current care coordination system





There is desire for improved patient-centered care coordination

What people say...

“King County is forward thinking about the need to coordinate care.”

“[Care coordination] is the foundation to providing good care, improving services, and obtaining better outcomes for clients.”

“Let's build programs to fit people, not expect people to fit programs.”

“Quality coordination can certainly save lives.”

What people do...

“Leverage my influence to improve the system and advocate for change.”

“Work hard to ensure systems continue to get improved to make access easier.”

“Actively build teams that represent the communities we serve.”

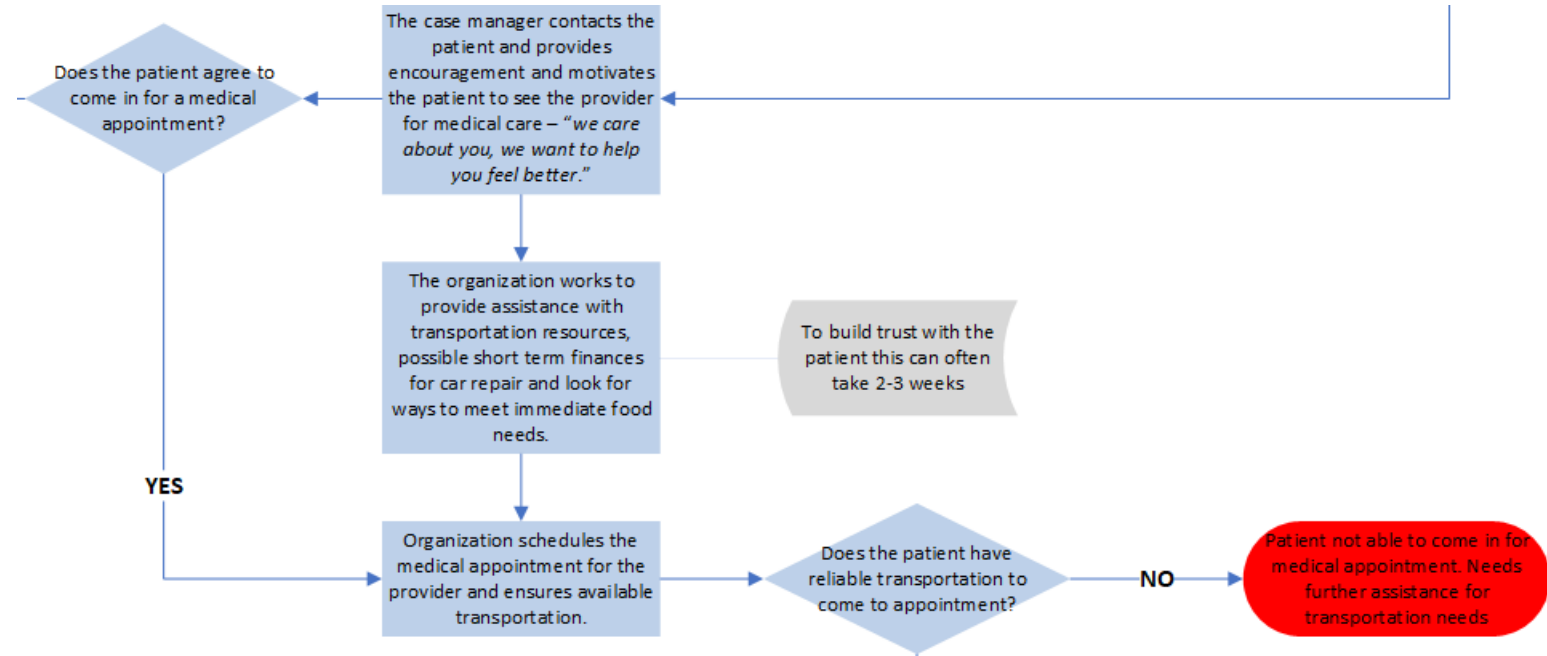
“Try to connect cross sector partners.”



Approach to whole-person, coordinated care

/ One example: team-based approach with a language-congruent social worker and nurse care manager

- Building trust: two to three weeks
- Overall process: five months (if all goes well)
- Challenges, gaps, and variations in practice still exist



Source: Extract of patient journey map created from small group interview with one clinical organization.



Leaders are committed to collaboration

- / **Nearly all survey respondents (94 percent) agreed that their leaders are committed to working across organizations.**
- / **Fewer agreed that their organization:**
 - Consistently communication and coordinates with a range of providers
 - Has committed sufficient resources for care coordination

Source: Responses from 88 to 92 survey respondents (90 to 94 percent of all respondents) on question A1, “Please indicate your level of agreement with each statement about your organization’s leadership and partnership for care coordination.”



Deep institutional knowledge

- / **Most survey respondents (79 percent) feel their organizations have the right partnerships to address whole-person care needs.**
- / **Two-thirds (66 percent) know to which external organizations to refer people.**



Challenges

Financial capacity

Workforce

Data infrastructure

Lack of Trust

Cultural and linguistic competency

Affordable and accessible services

Referral processes and communication



Organizations lack consistent, sustainable funding...

- / **Almost three-quarters of survey respondents (74 percent) report that their organizations often have inadequate funding.**
- / **Funding is often too low to offer competitive salaries and livable wages.**
- / **It is exacerbated by the changing needs of the community (e.g., aging population and increase in the cost of living).**

”

/ “We experience staff burnout. We will walk someone from outpatient to [the emergency room], and the [emergency room] staff will say, ‘Ughh.’ They are burnt out, but it doesn’t give the client what they need. We also need providers to be paid way more.”

/ —Representative from government sector

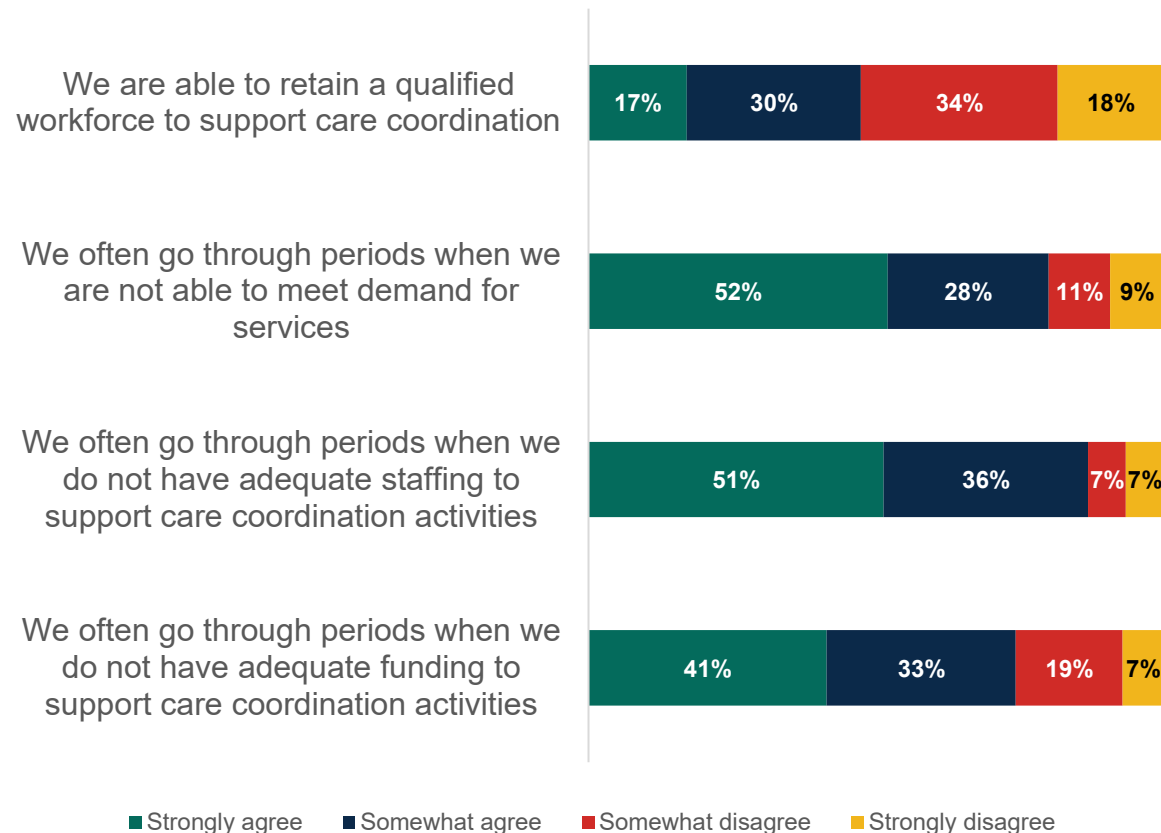


...and the limits of the current workforce further constrain capacity

/ **Nearly all survey respondents (80 percent) went through periods when they couldn't meet the demand for services.**

/ **Half (52 percent) were not able to retain a qualified workforce.**

- Limited availability of certain providers (e.g., mental health)
- Staff burnout and staff turnover





Care coordination most often occurs by phone, email, or on paper

A5. Which of the following does your organization use to share or communicate information with external providers for the purpose of care coordination? (select all that apply)



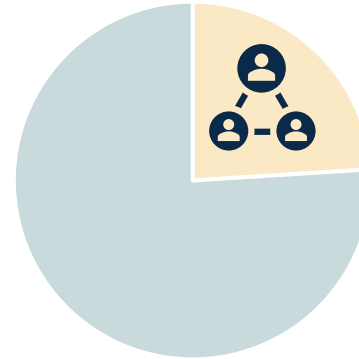
Source: Responses from 73 survey respondents (74 percent of all respondents), excluding those who reported “don’t know.”



There is limited ongoing communication after referrals



Half of survey respondents consistently follow up with individuals to confirm they connected with relevant services (an additional third sometimes do so)



Only 24% of respondents consistently receive feedback after referrals

Source: Responses from 75-79 survey respondents (77-81% of all respondents) on question A2, "Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations to coordinate care"



Lack of a shared, uniform data platform

Organizations already use multiple *different* platforms to help formalize and track referrals.

- Of survey respondents who use electronic referral systems, most used four or more systems.
- Organizations also relied on phones, WhatsApp, and email.

Most survey respondents used electronic files or systems, but only 30 percent used a single, dedicated platform.

- Adoption of new platforms is slow.
- Navigating multiple data systems affects capacity to deliver whole-person care.

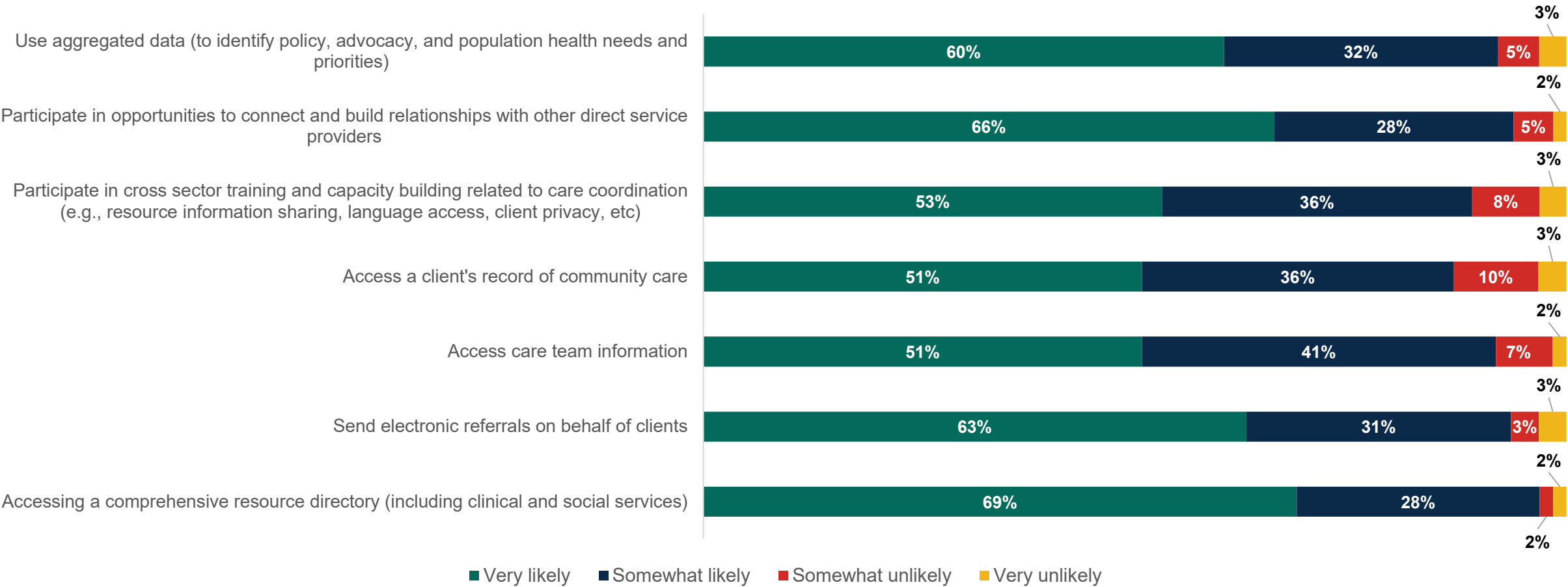
Source: (*top*) Responses from 36 survey respondents (82 percent of respondents who use an electronic system that enables data sharing, messaging, and/or closed loop referrals with external partners), excluding those who reported “Don’t know,” on question A7, “How many different care coordination systems does your organization regularly use?” (*bottom*) Responses from 71 survey respondents (72 percent of all respondents), excluding those who reported “Don’t know,” on question A8, “Which of the following does your organization use to file, monitor, or track information about individuals for the purpose of care coordination? (select all that apply)”.



Care coordination staff are most likely to use a community information exchange (CIE) to identify resources, connect with providers, and make referrals



47 of 124



■ Very likely ■ Somewhat likely ■ Somewhat unlikely ■ Very unlikely



Patient and consumer needs related to data sharing and CIE

Transparency

Impact of sharing data

Control

Agency over use of personal data

Trust

Comfort and confidence in health care provider

Confidentiality

Privacy protections

“What would be good is to access the information. Allow clients to see where they are at, and they can make corrections [in a CIE]. That is very empowering. I feel people would be more trusting. I have to tell people what is in the system. The client can’t see the information...Give them the power to be on the client.”

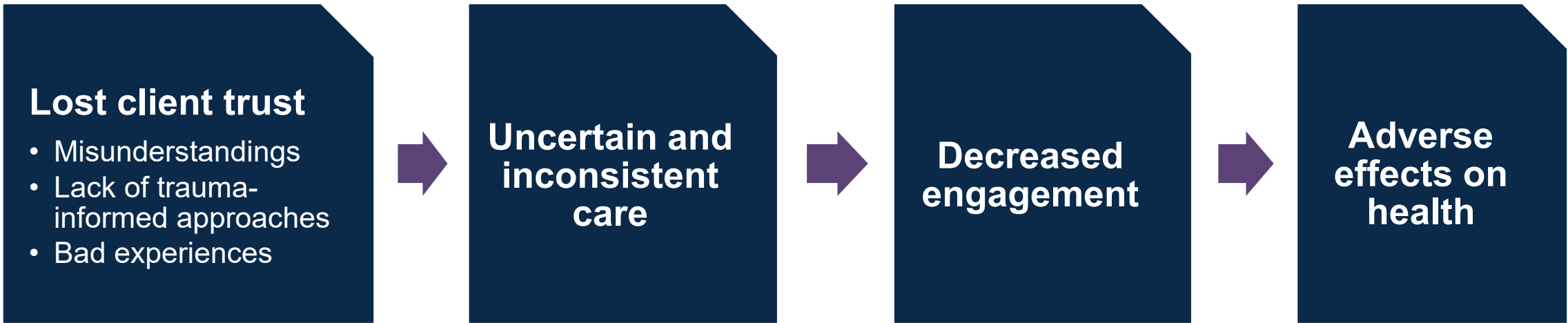
—Representative from community organization

Source: HealthierHere Connect2Care Community Engagement Results.



Need to build greater trust and cultural competency

- / **More than 75 percent of survey respondents highlighted a need for culturally responsive approaches.**
- / **Relationship are key.**



Source: (first bullet) Responses from 67 survey respondents (68 percent of all respondents), excluding those who reported “Don’t know.”



Breaking down distrust to rebuild a stronger foundation for engagement

- / **Build and strengthen relationships.**
- / **Reach out to those who otherwise may not engage with services.**
- / **Incorporate the right voices so everyone has a say.**
- / **Recognize and correct oppressive structures that affect how patients engage.**



Lack of affordable and accessible services

Existing benefit and service policies limit access

- Eligibility requirements
- Administrative processes

Insufficient service capacity

- Preventive care and chronic care management
- Mental health access and culturally appropriate care
- Oral health care
- Substance use disorder (SUD) prevention and treatment

“We have to make level of care in jail the same as in [the emergency room]. People don’t purposely set out to be in either of these institutions. In King County jails, your ability to work with clients (Medicaid, REACH) is more dependent on whether the justice system is going to allow you to have access.”

—Representative from community organization

“Income is the basis for additional services...if they want housing and Section 8, they have to have income.”

—Representative from clinical organization



Top four suggestions from survey respondents for improving care coordination



Data-sharing technology that all agencies involved in care coordination have access to and can use



Sustainable funding for care coordination activities



Culturally responsive approaches to reach people served by health and social services



Hiring, training, and retaining a sufficient workforce



Roadmap

Overarching strategy

/ Define size and scale of transformation.

- If CMS does not award the [anticipated](#) new five-year Section 1115 waiver, focus on fewer priority areas while exploring others potential sources of funding (e.g., other state- or county-funded initiatives, hospital community benefit programs, philanthropic organizations)

/ Prioritize recommendations with input from partners and community members.

/ Develop a detailed 5-year strategic plan.

- Define key goals for each area.
- Determine the specific strategies, actions, and funding sources for each priority.

/ Integrate monitoring metrics into the [HealthierHere dashboard](#) to transparently track and report on progress towards achieving community-based care coordination.





Recommendation areas

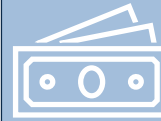


Suggested goals for each recommendation area



CIE and data sharing

- Implement solutions that work with current workflows while promoting changes to realize the full potential of technology.



Funding

- Diversify fundings streams and secure equitable, sustainable financing to support everyone who contributes to care coordination.



Cultural competency

- Build a diverse care coordination workforce with the skills to provide culturally and linguistically-tailored care.



Workforce

- Support and foster connections between existing care coordinators and take steps to increase diversity, equity, and inclusiveness.



Community engagement

- Earn and strengthen community trust through intentional and ongoing engagement, investment, and power-sharing.



Policy

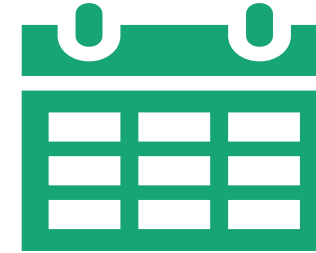
- Improve access to existing services and move upstream to address root causes of harm, inequity, and care disruption.

Assumptions for recommended actions



/ **Near-term strategies**

- Could start in 2022
- In HealthierHere's control
- Achievable with existing partners
- Fills existing gaps
- Foundational for transformation



/ **Longer-term strategies**

- Substantial lead time
- Deep engagement of new and existing partners
- Includes actions outside HealthierHere's control
- Larger systems changes



Recommended CIE and data sharing actions

- Prioritize CIE features that close the referral loop or are valued by the people least likely to engage.
- Build in automation.
- Align functionalities with preferred communication methods (e.g., email).
- Illustrate how CIE overcomes known challenges.
- Create resources (templates) to facilitate data-sharing agreements.



Near-term

- Provide on-demand training.
- Provide free access or tiered fee structures for organizations with fewer resources.
- Collect continuous feedback on user needs and challenges.
- Expand access to consumers.
- Give patients access to (and ownership of) their own data.



Longer-term





Recommended funding actions

- Engage more non-traditional partners (e.g., houses of worship, schools, and mutual aid groups).
- Pay community members and caregivers for coordination services.
- Fund transportation.
- Compensate funded partners to protect staff time for collaboration.



Near-term

- Promote livable wages.
- Increase equitability and sustainability in contracts.
- Involve community in budgeting processes.
- Explore non-conventional funding streams (e.g., social impact bonds).
- Build partners' capacity to diversify financial support.



Longer-term





Recommended cultural competency actions

- In communications, acknowledge varied cultural approaches, such as caregivers and cultural navigators.
- Ensure directories of community resources include the languages staff speak.
- Increase access to translation services, which could include hiring family or community members as translators.



Near-term

- With the community, create messaging that raises awareness of strategies to transition to community-based care coordination.
- Host trainings for community service providers (trauma-informed care, best practices for communicating through translators, crisis management)
- Create and share simplified language on common medical conditions or care needs.



Longer-term



Recommended workforce actions

- Address burnout (e.g., delaying or reducing less-urgent activities).
- Create (and repeat) networking opportunities.
- Establish a mentorship or matching program to connect organizations.



Near-term

- Train and support staff working in and with communities.
- Increase pay for community-based service providers.
- Share care coordination and navigation positions across organizations.



Longer-term





Recommended community engagement actions

- Create written requirements and best practices for community involvement in HealthierHere's work.
- Amplify voices of people with experience navigating services.
- Have community members help develop the CIE, particularly regarding the CIE's consumer accessibility, functionality, and privacy.



Near-term

- Develop a publicly available guide to community-based participatory engagement.
- Train and support families and community members in navigating and advocating across systems.
- Create paid positions, professional development opportunities for community members.



Longer-term





Supports that make patient and consumer engagement equitable and sustainable

- / **Compensate participation.**
- / **Provide child care.**
- / **Be flexible when scheduling engagement activities.**
- / **Foster a sense of community and teamwork.**
- / **Intentionally facilitate and support staff coordinating activities.**
- / **Provide devices (e.g., phones) required to participate in engagement and training on how to use them.**
- / **Train participants on the topics being addressed (e.g., community-based care coordination, the current service systems) and the skills relevant to the engagement (e.g., sharing lived experiences, talking with cross-sector partners, systems thinking).**
- / **Provide translation and interpretation.**
- / **Facilitate transportation (e.g., transit passes or ride services).**

Source: HealthierHere documents (Connect2Care Community Engagement Results).

Recommended policy actions

- Reassess eligibility requirements for services that HealthierHere controls.
- Reconsider which services to conduct virtually or implement mitigation strategies (e.g., setting up support stations in public areas) to overcome barriers to virtual care.
- Pay for gas and provide devices to make it easier for patients and caregivers to access services.



Near-term

- Advocate to further align service eligibility requirements, applications, and determinations.
- Advocate to improve the availability of services that organizations offer.
- Advocate for expanding services for Medicaid-eligible people.
- Prioritize and advocate for policies and programs that address the root causes of care fragmentation.

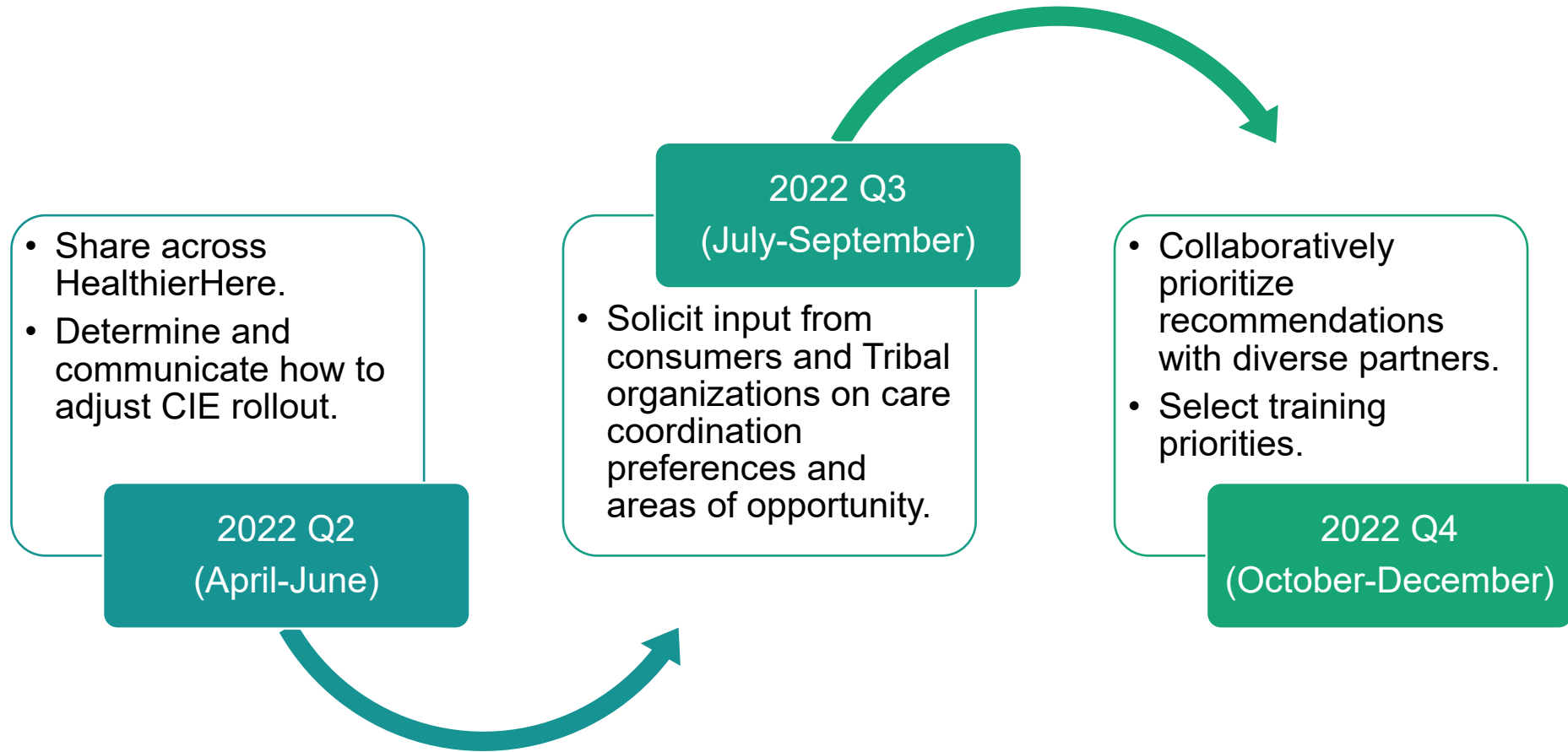


Longer-term





2022 milestones (*current waiver extension*)



2023 milestones

(anticipated first year of new waiver)



Suggested 2024-2027 milestones (rest of anticipated new waiver)

- / **Continue to identify and onboard new partners for ongoing and new activities.**
- / **Report (quarterly or twice a year) on the status of transformation**
- / **Regularly solicit feedback from consumers, community members, and partners to inform ongoing refinement of five-year strategy.**
- / **Conduct a follow-up analysis of the care coordination landscape around 2026 to assess how care coordination has changed, whether it has improved, and to identify emerging opportunities.**

Potential monitoring metrics for planning and partnership

Planning and prioritization

- Number and types of individuals and organizations that participate in prioritization activities
- Distribution of detailed strategic plan (timing, reach, number of updates)
- Proportion of partners that agree with selected priorities and strategies

Partnerships

- Number of partners (total, returning, new)
- Proportion of partners engaged in community-based care coordination transformation activities (any activity, specific activities like CIE, methods of engagement)
- Measures of trust (partners' trust in HealthierHere and in external organizations, patients trust in care systems) and collaboration (such as those based on the Himmelman model of collaboration or the patient activation measure)

Note: While some metrics are heavily tied to a single recommendation area or strategy, most are influenced by and have impacts on a variety of factors.

Potential monitoring metrics for funding and implementation

Funding

- Funding available (total and by source, describing trends in diversification and sustainability)
- Amounts earmarked, allocated, and spent on the transformation to community-based care coordination (total, by recommendation area, by source and type of recipient)
- Pay equity and fairness (lowest and average hourly rates, variation in pay within and across sectors)

Activities

- Involvement of community members/consumers and partners (number of co-design activities, number of participants, iterative feedback about engagement experience)
- Participation in CIE (number of users [organizations and individuals], frequency of use, user feedback)
- Trainings offered (number, topics, attendance, pre/post evaluations of learning)
- Culturally appropriate services (number and types of services offered, number and proportion of individuals reporting they received culturally-responsive care)



Appendix



To contact the Mathematica–Comagine Health Care Coordination Landscape Analysis team:

**Alyssa Crawford, Project Director,
Mathematica**

acrawford@mathematica-mpr.com

(202) 484-5720

**Lisa Packard, Co-Principal Investigator,
Comagine Health**

LPackard@comagine.org

(206) 660-3105

Other report authors (listed alphabetically):

Toni Abrams Weintraub
Jackie Brenner
Christina Dionisio-Martinez
Mindy Hu
Elena Jimenez
Ken Lim
Vanessa Quince



Additional information about landscape analysis approach and findings

Purpose of landscape analysis

/ **Describe the current state of care coordination in King County, Washington, including:**

- Current state of care coordination, including
 - Types of care coordination
 - Ways to promote whole-person, integrated care
 - Referral approaches
 - Multi-sector collaboration
- Perspectives from different service providers and patients about:
 - Current gaps
 - Barriers to care
 - Facilitators of successful care coordination
 - How to improve care coordination

Purpose of roadmap

/ **Recommend how to transform to a community-based model of care coordination, including the following:**

- Initial actions (to strengthen network and achieve early wins) and longer-term strategies to achieve community-based care coordination
- Milestones and timelines
- How to leverage HealthierHere's CIE



Co-design workshop

- / **Goal: Solicit broad perspectives related to the current and future state of care coordination in King County to identify critical topics for additional data collection activities in the landscape analysis.**
- / **Two interactive exercises conducted via MURAL board and facilitated discussion:**
 - *Empathy mapping:*
 - Captured what participants think, say, do, and feel about care coordination, based on personal and professional experiences.
 - Randomized breakout room assignments
 - *Goals grid:*
 - To understand what participants want to achieve, preserve, avoid, and eliminate in the future for care coordination.
 - For groups supported by MURAL boards, participants selected breakout rooms by topic: barriers to access, information sharing and interagency communication, referral pathways to services, workforce capacity
 - Additional breakout room (on topics) for participants who preferred verbal discussion



Engaged 30 community partners in the co-design workshop

- / 46 community partner organizations invited (selected together with HealthierHere)
- / 43 registered
- / 30 attended

Types of participating organizations
Area Agencies on Aging (AAA)
Black, Indigenous, and People of Color (BIPOC)
Hospital/Primary Care
Refugee/Immigrant Bilingual
Federally Qualified Health Centers (FQHCs)
Tribal Health System
Health Care Payor
Behavioral Health
Care Coordinators/Community Health Workers
Government Representatives



Co-design workshop limitations

- / Workshop participants drew from HealthierHere's existing partners.
- / There was no separate or explicit involvement of patients and consumers in co-design process.
- / The length of the workshop limited in-depth discussion.
- / It focused on general perspectives about care coordination using approaches informed by discussion with HealthierHere staff rather than input on data collection domains (limited co-design of landscape analysis approach with community partners).
- / Attendees had varied experience and comfort with MURAL, and we did not provide a detailed tutorial (affected participation for some participants).
- / One-time engagement that did not allow for ongoing feedback.
- / Ongoing challenges of COVID-19 pandemic likely impacted organizations' availability to participate.



Interview and focus group design

/ **Goals: Gather nuanced cross-sector perspectives on:**

- Understanding of whole-person care, current care coordination infrastructure, and care coordination challenges
- Opportunities to improve care coordination in King County
- Considerations for CIE

/ **Developed protocol with the following domains:**

- Perspectives on, and experiences with, care coordination in and around King County, including strengths and challenges
- Journey mapping to illustrate the care coordination process from initial intake through service delivery and to identify gaps in coordination and access
- Suggestions and priorities for improving community-based care coordination
- Considerations for CIE



Interview and focus group recruitment

/ **Selected and recruited organizations, together with HealthierHere, to represent a range of:**

- Organization types (e.g., community-based, clinical, behavioral health)
- Populations served (e.g., Black, Indigenous, and People of Color; immigrant; refugee; Medicaid and Medicare eligible)
- Participation in co-design workshop (to expand reach)

/ **Outreach by Comagine Health staff with some introductions from HealthierHere staff**

/ **Consumers offered \$50 Amazon gift card for participation**

Participant organization types	
Area Agencies on Aging (AAA)	Focus Groups
Black, Indigenous, and People of Color (BIPOC)	
Hospital/Primary Care	
Refugee/Immigrant Bilingual	
Federally Qualified Health Centers (FQHCs)	
Patient/Consumer	
Health Care Payor	
Long Term Care	
Behavioral Health	
Care Coordinators/Community Health Workers	
Tribal Health System	Small Group
Pharmacy	
Specialty Medical Services	
Durable Medical Equipment	
Government Representatives	Ind.
Patient Consumer Referral	



Interview and focus group data collection and analysis

81 of 124



/ **Scheduled interviews and focus groups to accommodate participants' schedules and preferences**

- Held during six-week period (1/20/22 to 3/3/22), with phased recruitment as priorities emerged
- Sessions included one facilitator and one notetaker
- Sessions were recorded after receiving participants' consent

/ **After each session, the team reviewed and validated notes against the recording**

- One team member coded all notes in Microsoft Excel with review and input from primary facilitators
 - Developed codebook of themes that aligned with guiding questions
 - Applied deductive reasoning to code the interview and focus group notes into broad categories
 - Used inductive approach to identify any additional themes that emerged
- Created visual journey maps illustrating care coordination steps, as articulated by participants



Conducted 13.75 hours of interviews and focus groups

- / **4 focus groups with representatives from multiple organizations**
- / **11 small group interviews (with representatives from a single organization) and individual interviews**
 - Led to 3 organizational journey maps describing processes, participants, and barriers to and facilitators of success in care coordination and referral processes

Partner type	Number of participants
Community (Includes community-based organizations, Tribal and native-led organizations, and consumers)	19
Clinical (Includes medical, behavioral health, and substance use organizations)	8
Government	3
Total	30



Interviews and focus groups limitations

- / The surge in the COVID-19 Omicron variant likely affected organizations' availability to participate; organizations with capacity to participate might not be representative of unavailable organizations.
- / Compressed timeline might not have provided enough notice for participants and limited opportunities for iterative recruitment.
- / There was limited engagement of consumers and Tribal organizations (one interview each), which require more time for building relationship and trust.
- / Did not interview HealthierHere staff, given time and resource constraints, and relied instead on information available in documents shared by HealthierHere.
- / Respondents in focus groups (multiple organizations) might have been reluctant to share in front of attendees from other organizations (e.g., if they compete for resources).
- / We did not interview HealthierHere staff because of time and resource constraints (missing perspectives of HealthierHere staff and relying on insights available from document review).



Survey design

/ **Goal: Collect a range of perspectives on organizational capacity and opportunities to improve care coordination in King County**

/ **Key domains:**

- Perspectives on organizational capacity
- Perspectives on care coordination systems and CIE
- Suggestions for improving care coordination
- Characteristics of respondents' organizations (sector, role, focus)



Survey recruitment

- / **Designed for and distributed to staff with any role in care coordination**
 - Included HealthierHere partners across sectors and members of the King County Mental Health Providers Association
 - Used a snowball sampling approach aligned with HealthierHere's usual survey distribution practice
 - Combination of Likert scale, multiple choice, and open-ended questions
- / **Fielded survey online in QuestionPro from 2/9/22 to 2/25/22 (in English and Spanish)**
- / **We offered participants a \$10 Amazon gift card for participation**



We received 98 survey responses

- / **This includes complete (49) and partial submissions (49)**
- / **Only half (42 to 54 percent) responded to the survey questions about sectors, roles, and populations served. Of those:**
 - Most worked in mental health, substance use, or social/human services.
 - Most often they were administrators and managers, with fewer care coordinators or navigators.
 - Most organizations served people with lower incomes, mental health diagnoses, substance use disorders, or experiencing homelessness; fewer focus on specific racial, ethnic, or Indigenous groups.



Data infrastructure

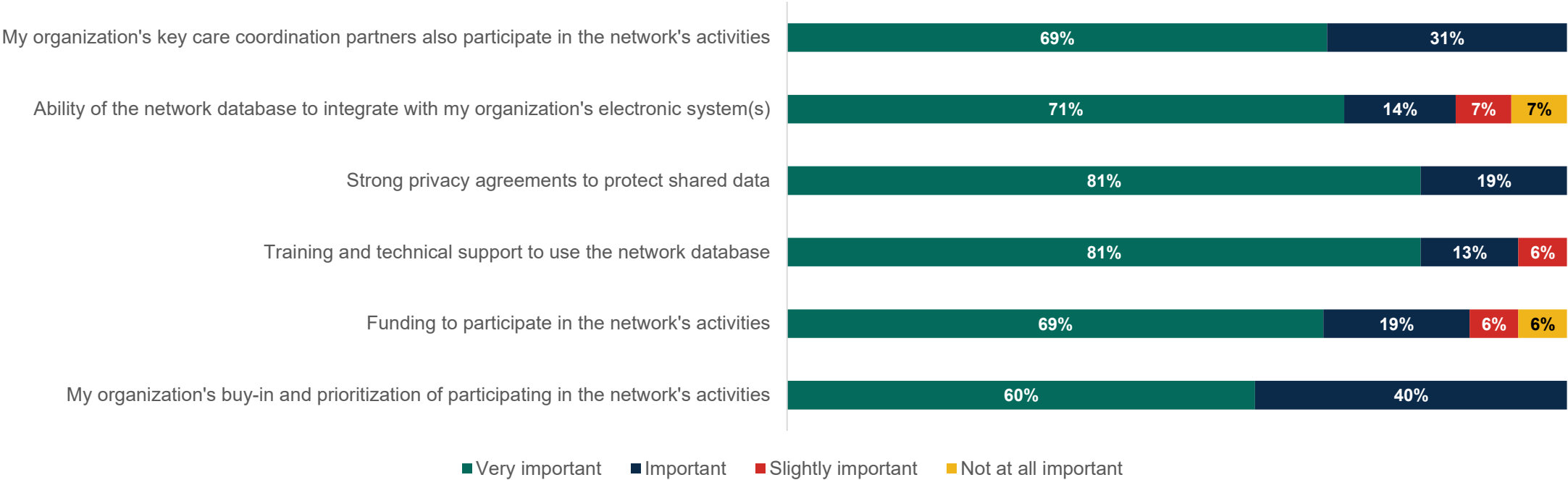
Data or referral sharing system	Number of survey respondents*	Number of interviewed organizations
Unite Us	17	4
Epic	5	2
Collective Medical	4	3
HMIS	4	0
Credible	4	0
Julota	3	1
Email and Spreadsheet	2	1
Apricot Systems	1	1
Other (Quartet, Community Connect, sftp, Trizetto, etc.)	23	2

Source: Responses from 45 survey respondents of the 49 respondents who indicated they use referral technology or care management platform. Respondents could indicate multiple systems.



Training, privacy agreements, and partner involvement might influence CIE participation

A11. The following factors might help or encourage you to participate in the Connect2Community network.
How important is each factor to you or others in your organization?



Source: Responses from 13 to 16 survey respondents (81 to 100 percent of respondents “somewhat unlikely” or “very unlikely” to participate in network activities; this question was only asked to respondents who selected those options in the previous question).



Survey limitations

- / The compressed timeline limited opportunities to vet draft protocols with community partners, make substantial revisions based on feedback received (e.g., that the survey was long and dense, that some people involved in care coordination are not affiliated with an institution, and that the survey wording might not be accessible to people with diverse backgrounds), or validate questions through pre-testing or other methods.
- / The surge in the COVID-19 Omicron variant likely impacted people's availability to respond.
- / Many respondents did not complete all the questions, which limited our ability to correlate responses with organization type and populations served.
- / The snowball approach to distribution doesn't allow us to determine circulation and reach.
- / The predominance of closed-ended questions did not allow for nuanced responses.
- / The delay in survey launch might have affected the response rate and precluded the ability of the survey findings to inform the approach for interview and focus groups.



Document review design and data collection

/ **Goals:**

- Assess the context for care coordination in King County, including previous transformations and existing whole-person, community-based care approaches
- Identify illustrative examples of current care coordination programs and practices
- Understand recent and current HealthierHere activities to inform roadmap recommendations

/ **Obtained and extracted insights from:**

- Targeted web searches
- 27 documents provided by HealthierHere

/ **Summarized care coordination program information in summary table**



Extracted descriptive information about 22 King County care coordination programs

/ **Identified (for most programs):**

- Service area
- Entities involved and their roles
 - Many led by government entities, partnering with health care, mental and behavioral health care, and social service providers (such as housing, nutrition, youth, and employment)
- Funding source (but sometimes limited detail)
- Eligibility criteria
- Care coordination activities



Example care coordination programs

Details	Health Homes	Referral and Navigation program	Crisis Solutions Center	King County Racial and Ethnic Approaches to Community Health
<i>Focus</i>	Managed care organizations or community-based organizations contract with care coordination organizations (clinics, community centers, service agencies, etc.) to provide and coordinate care at the local level.	Ten community-based organizations (referring partners) refer and provide care coordination support to help community members connect to resources available from eight human/social service organizations.	First responders refer people to short-term residential treatment facility for case management and psychiatric, mental health, and chemical dependency assessments and services. Clients who are homeless, or at risk for homelessness, are referred to step-down program.	Partnerships with community organizations and coalitions to upturn referral networks and access to culturally appropriate care (e.g., purchasing cooperative of small ethnic grocers and food banks, improving nutrition standards in food banks, increasing culturally appropriate breastfeeding services and supports).
<i>Main organization(s)</i>	Washington State Health Care Authority, six managed care organizations/community-based organizations	A Supportive Community for All	Downtown Emergency Service Center	Public Health - Seattle & King County
<i>Populations served</i>	Apple Health (Medicaid) clients (including those dually eligible for Medicare) with at least one chronic condition and Predictive Risk Intelligence System score of 1.5	Rural communities	People experiencing crisis who are in good behavioral control, have not committed a violent crime, and are willing to cooperate with services	Priority populations: African Americans, Asian Americans
<i>Funding source</i>	Medicaid (billed for services rendered)	King County Grant	Local taxes	Centers for Disease Control and Prevention grant



Document review limitations

- / **Reliance solely on publicly available resources limited information about characteristics of care coordination programs (e.g., care coordination model, referral processes and workflow, strategies for engaging clients, staffing, data sharing, health equity considerations).**
- / **Timeline for receiving documents from HealthierHere precluded the ability to use insights to inform interview/focus group and survey methods and instruments.**
- / **Compressed timeline and resource constraints limited ability to identify promising practices and innovations outside of Washington state.**



Care Coordination - Where we are and where we are going

HealthierHere Governing Board
April 6, 2023

Agenda

Care Coordination Background

Partner Reflections on Care Coordination

Next Steps

Thoughts & Questions

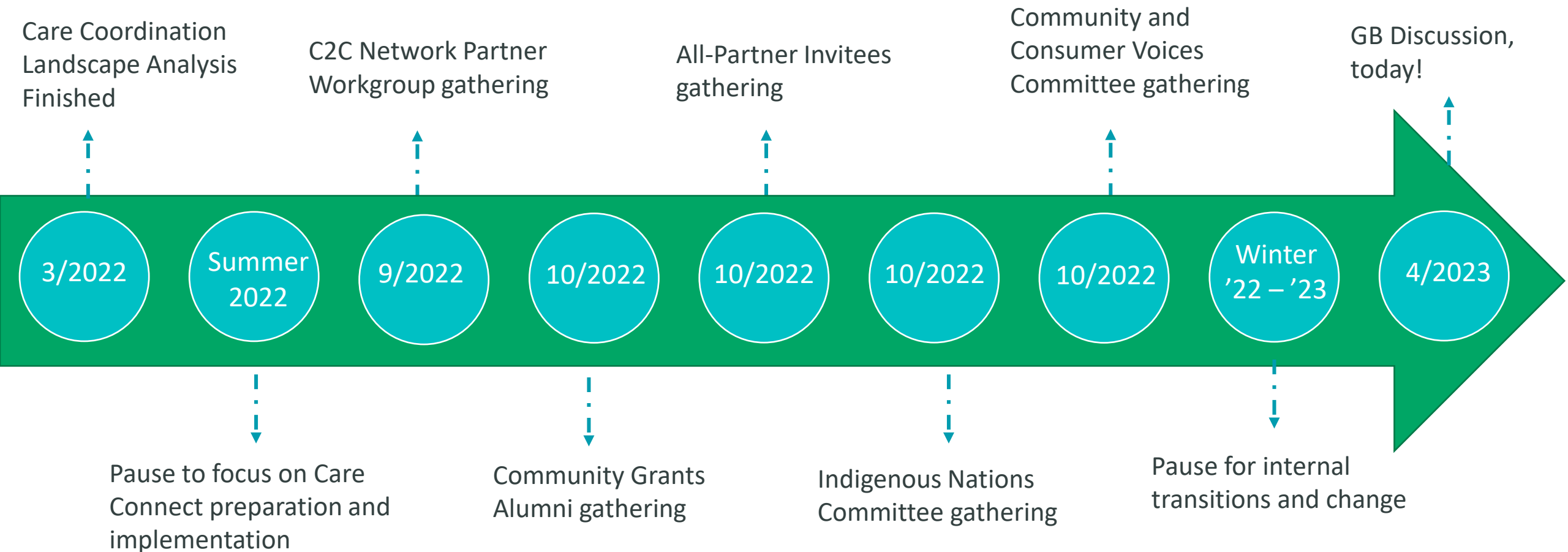
Discussion

Care Coordination Background

Background – why care coordination?

- Clinical and community partners have identified care coordination transformation work as a high area of need
- During the first 5 years of the MTP waiver, HCA identified community-based care coordination (CBCC) as a significant strategy for improving the health of Medicaid enrollees
- Throughout MTP, CBCC also emerged as an area of high potential for ACHs to have actionable impact, particularly with the positionality to:
 - *Be a neutral convener*
 - *Build trusted relationships with regional partners*
 - *Steward regional funding*
 - *Provide training, TA, and QI support*

Care Coordination Timeline



Care Coordination Landscape Analysis Recommendation Areas

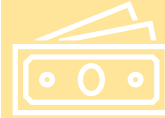
99 of 124

CIE and data sharing



- Implement solutions that work with current workflows while promoting changes to realize the full potential of technology.

Funding



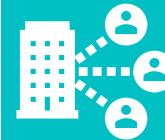
- Diversify fundings streams and secure equitable, sustainable financing to support everyone who contributes to care coordination.

Cultural competency



- Build a diverse care coordination workforce with the skills to provide culturally and linguistically-tailored care.

Workforce



- Support and foster connections between existing care coordinators and take steps to increase diversity, equity, and inclusiveness.

Community engagement



- Earn and strengthen community trust through intentional and ongoing engagement, investment, and power-sharing.

Policy



- Improve access to existing services and move upstream to address root causes of harm and inequity.

Fall 2022 – Care Coordination Partner Gatherings

100 of 124

- All partner groups received a high-level overview of the Care Coordination Landscape Analysis process, findings, and 6 recommendation areas
- Partners then had the opportunity to engage in either breakout room discussions and/or an independent sticky note activity to share their thoughts and reflections on the CCLA recommendations, their care coordination related work, and the future of care coordination efforts in King County

Small Group Breakout Discussion

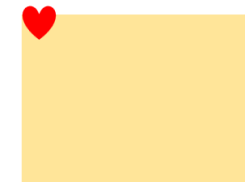


If you had a magic wand that could address any gap or area of need within care coordination, what would it do?

Where would you start?

What work are your organizations doing related to care coordination in King County?

What work *needs to be done and by whom* to improve care coordination in King County?



Partnership | Innovation |
Results

16

What did we learn from partners?

About the CCLA Recommendation Areas...

- The 6 CCLA recommendation areas are not off
 - *CIE & Data Sharing*
 - *Cultural Competency*
 - *Community Engagement*
 - *Funding*
 - *Workforce*
 - *Policy*
- Additional callouts/areas of focus include:
 - *Access (this is impacted by workforce as well as the availability of culturally responsive/appropriate care)*
 - *Advocacy*
 - *Collaboration (across entities as well as with community)*
 - *Quality Improvement (perhaps within the data category)*



About where we are...

103 of 124

“Care navigation by same-language speakers”

“Workforce diversity”

*Partners are deeply committed to doing CBCC
in a culturally responsive manner*

“Raising awareness about mental health and the ways to access culturally/linguistically appropriate services.”

“promoting cultural activities to build community trust”



About where we are...

104 of 124

“Participating in
Connect2
Community CIE”

“Supporting State CIE
planning”

“Using UniteUs (CIE)”

*Many partners are involved and invested in
the capability of data and technology to
improve the CBCC system*

“Using Collective Medical Technology”

About where we are...

“Creating multisector partnerships to address health/housing”

“Providing Transitions of Care services (CoS funded program) in partnership with Valley, UW, Harborview and other area hospitals”

Partners are leaning into and improvising relationships within and across sectors to do care coordination work

“Working in collaboration with other native organizations to offer traditional events for our native community members.”

“Working closely with MCO partners to consider how to expand and improve sustainability for Health Home services”

“Continuing partnerships with local schools to enhance referrals for youth with mental health needs.”

About where we are...

“Working to ensure patients have a primary care doctor for follow-up care”

“Weekly food hub and diaper giveaway program”

“Care Connect WA provider”

Partners are engaging in a variety of existing and reliable care coordination activities

“Providing health workshops: mental health, nutrition, heart disease. Activities: physical activities.”

“Implementing CCBHC model with a heavy emphasis on care coordination and health monitoring”

About where we are...

“Nakani Native Program will be integrating Traditional Medicines into a community health clinic, training medical staff and students on traditional uses for Traditional Medicines.”

“Coupling food distribution with health insurance enrollment”

Partners are implementing innovative approaches to care coordination

“Providing trauma-informed movement and play to King County youth through our partners”

“Participating in HealthierHere Shared Care planning”

What did we learn from partners about
where we need to go?

In order to improve care coordination in King County, partners emphasize a focus on...

109 of 124

“Clear and consistent funding streams for care coordination occurring in non-healthcare settings.”

“Funding that responds to the person, not the insurance provider”

Flexible funding

“An investment in the nonprofit sector to enable more competitive/liveable wages”

“More unrestricted funding. Allow CBO to be the expert.”

In order to improve care coordination in King County, partners emphasize a focus on...

“More effort to create cross-sector or multi-sector collaborations - e.g. HH facilitating new partnerships”

“Hospital buy-in”

systematic cross sector partnerships

“Lower barriers to cross-sector communication”

“Build bridges between organizations doing the same work but in different cities. Share resources with each other”

In order to improve care coordination in King County, partners emphasize a focus on...

111 of 124

“Improving access to SDOH based care services within the communities people live in”

“Understanding and utilizing resources”

“Broader approval and access to non-traditional medical services in the SDOH domains”

Access

“Access to health insurance and knowledge/education on how to best utilize it”

“Removing structural barriers to health access such as immigration status”

In order to improve care coordination in King County, partners emphasize a focus on...

112 of 124

“Staff retention and making sure that funding is available to keep them employed”

workforce support

“Sustain the CBOs who are working in the field by building their capacity”

“Leadership opportunities for community members/ greater involvement”

“Training diverse community members on system navigation, and peer support/cultural navigation: CBOs+Colleges + Health providers”

In order to improve care coordination in King County, partners emphasize a focus on...

113 of 124

“Change in legislation over ‘x license’”

“Unified, broad insurance system designed to meet SDOH needs (more accessible Apple Care network)”

“Advocacy and education at the policy level with elected officials and heads of depts.”

Advocacy

“Funding that responds to the person, not the insurance provider”

“Ability to advocate for LOC changes that meet the needs of the client/patient.”

In order to improve care coordination in King County, partners emphasize a focus on...

114 of 124

Better information/data sharing through technology

Simplification of resource finding/securing (one central site or hub)

CIE/Data sharing infrastructure

“The ability to share patient information between providers”

CIE needs to be a primary means of cross-sector referral (and it really isn't right now)

King County partners are highly invested in CBCC work. They have developed critical partnerships and innovative solutions to providing care coordination services and programs and they are committed to doing so in a culturally responsive manner.

Partners emphasize the following priorities for improving CBCC in King County:

- Flexible funding
- Systematic cross sector partnerships
- Access
- Workforce support
- Advocacy
- CIE/Data sharing infrastructure



Whether due to capacity, ability/expertise, or sphere of influence, these are also areas where their agency as service providers is limited

Summary

Providing those closest to the work flexible funding to do it in a culturally responsive way while investing in a sustainable workforce, elevating community voice through advocacy, facilitating cross sector partnerships, and improving data sharing capability has the potential to drastically improve the CBCC landscape.

Next Steps

Care Coordination Strategy

Releasing an RFP later in 2023 with the intention of contracting with an experienced consultant to develop a Care Coordination Transformation Strategic Plan

A Care Coordination System Transformation Strategic Plan

- Will be mindful of the recommendations from the 2021/2022 CCLA, partner reflections, and the MTP Renewal Waiver
- Will create alignment across workstreams at HealthierHere and with our partners
- Will illustrate HealthierHere's sphere of influence and optimal positionality for effecting change as it relates to care coordination and supporting partners in doing the same
- Will include the following:
 - *Updated shared vision*
 - *Goals*
 - *Objectives*
 - *Theory of change and theory of action*
 - *Evaluation (measures of success) criteria*
 - *SWOT analysis*

Care Coordination Transformation Committee

- Working on establishing a new Care Coordination Transformation Committee as part of the GB structure
- Focusing on:
 - *Providing knowledge and perspective across sectors about the current state of care coordination as well as priority areas of focus for system transformation*
 - *Informing how we engage partners and how entities across the county can contribute to system transformation collectively*
 - *Informing the Care Coordination Transformation Strategic Plan for King County*
- The work of the Care Coordination Transformation Committee will be guided by a charter defining purpose, principles of engagement, responsibilities, membership, and decision making

Care Coordination Transformation Committee

- The committee will begin meeting later in 2023
- Committee representation has been identified through a desire to have wide ranging representation across HealthierHere partner sectors and those involved in care coordination work in varying capacities
- Representation may include
 - *Governing Board Member*
 - *Federally Qualified Health Center*
 - *Community Based Organization*
 - *Government*
 - *Hospital*
 - *Behavioral Health Agency*
 - *Tribal led/tribal serving organization*
 - *Managed care organization*

What are we hoping to achieve?

Short-term (12 months): develop a strategic plan to achieve care coordination transformation in King County as a collaborative effort within HealthierHere and across King County partners

Mid-term (2-5 years): sustain and build upon current care coordination activities in King County by forming a Community Hub infrastructure with a robust network of providers and implementing Connect2 Community Network and Exchange infrastructure and integration capabilities

Long-term (5-10 years years): transform the care coordination system in King County to reduce fragmentation and improve access, coordination, and support for individuals and families across the continuum of care

Thoughts & Questions

Breakout Discussion

Discussion

Collectively, we want to move care coordination work in King County from an improvised network of relationships, activities, and programs to a systematic and coordinated network and process of improvement.

Partners shared that they have less agency to effect change in the following areas emphasized as priorities for improving care coordination:

- *Flexible funding*
- *Systematic cross sector partnerships*
- *Access*
- *Workforce support*
- *Advocacy*
- *CIE/data sharing infrastructure*

What would it look like for us (HealthierHere and GB members) to collectively effect change in each of these areas?