SWACH Framework and Roadmap

Our Vision
SWACH believes all people should have equitable access to quality whole-person care and live in connected and thriving communities without barriers to wellness. SWACH is working with partners in our region to improve health, increase the quality of care and services, enhance employee satisfaction, increase employee retention and maintain a sustainable workforce. We will invest in prevention, support wellness for our neighbors at every stage of life and help build strong families.

Our Strategy
Our collective impact strategy is built on three gears that turn together to catalyze and drive long-term transformation: a strong and diverse set of cross-sector partnerships, authentic community engagement, and a strong data and shared learning infrastructure.

Our Focus Areas
1. Use improvement methods to work in and across settings to implement key change ideas and standards of care for:
   - Whole-Person Integrated Clinical Care
   - Community-Clinical Linkages
   - Sustainable Large Scale Impact

2. Use authentic community voices, provider inputs and data to identify priority populations and communities with the greatest needs and disparities.

3. Identify the settings of care and providers people rely most heavily upon for care, and infuse resources and supports to transform those settings.
   - Quality Improvement Technical Assistance
   - Value-Based Payment Support
   - Workforce Development
   - Assistance Incorporating Authentic Community Voice
   - Tools and Technology for Population Health Management
   - Address Inequities, Stigma, Trauma and Institutional racism
   - Community-Clinical Linkages/Partnership Development

4. Use data to optimize efforts and conduct robust evaluations on our priority initiatives. Spread effective approaches to other populations, settings, and providers throughout the region through a community-driven shared learning and action infrastructure.
   - Shared Learning: Robust Monitoring and Evaluation
   - Collective Systemic Change & Action: Scale, Spread, Innovate
   - Sustainability
Our Framework

<table>
<thead>
<tr>
<th>Care Settings</th>
<th>Medicaid Transformation Projects</th>
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<tbody>
<tr>
<td>Physical Health</td>
<td>Bi-Directional Clinical Integration</td>
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<tr>
<td>Behavioral Health</td>
<td>Community Care Coordination</td>
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<tr>
<td>Emergency Department</td>
<td>Opioid Response</td>
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<tr>
<td>Non-Clinical Providers</td>
<td>Chronic Care</td>
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**Vision**
A healthy Southwest Washington region where all people have equitable access to quality whole-person care and live in connected and thriving communities without barriers to wellness.

**Community Engagement**

<table>
<thead>
<tr>
<th>Health Information Exchange / Health Information Technology</th>
<th>Workforce Development</th>
<th>Value-Based Payment</th>
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<tbody>
<tr>
<td>Partners across the SWACH region have consistent communication and connectivity for improved whole-person, integrated care</td>
<td>Support the development of an empowered, compassionate and sustainable workforce that is responsive to community health needs in our region</td>
<td>Provide support to the region to transition from a volume-based payment structure to a value-based payment structure to promote whole-person care</td>
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Document Purpose
The following roadmap is intended to give a deeper look into the three primary goals SWACH intends to support. These strategies and tactics are a mix of work that has been completed, is currently in motion and will be done in the future.

GOAL 1. WHOLE-PERSON INTEGRATED CARE

Problem Statement: We currently do not have a comprehensive and integrated approach to delivering healthcare in our region. Our current system of siloed care and fragmented data and health information sharing does not adequately support individuals and families. Integrating behavioral and physical health across the care continuum helps create a system of care that offers individuals the services they need when they need them.

AIM Statement: SWACH supports regional partners through targeted investments and technical assistance for integrated, team-based models of care. SWACH will support regional workforce development and authentic community engagement to enhance equity policies and procedures to include reducing institutional racism, stigma and trauma-informed care. Alongside our partners, SWACH will support the development of community clinical linkages, advancement of population health management systems and will support providers to build capacity to be successful in value-based payment contracting.

STRATEGY #1: Understand the current state of clinical partners in the region through an assessment portfolio (Health Information Exchange (HIE), Health Information Technology (HIT), Clinical Assessments)
- Develop and deploy a two-part assessment. First, a HIT/HIE assessment for clinical providers. Second, a comprehensive clinical assessment for behavioral health or organizations and physical health practices.
- Analyze assessment results to inform potential regional investments.

STRATEGY #2: Co-design with partners, ensuring community voice, the framework for system changes and desired future state transformation.
- Establish Bi-Directional Clinical Integration Workgroup to develop system change framework, priorities, strategies and tactics to enhance clinical integration in the region.
- Develop bi-directional future state requirements in collaboration with providers.
- Ensure authentic community voice is embedded throughout the system.
- Develop opioid future state requirements in the areas of prevention, overdose, treatment and recovery.
- Develop chronic disease targeted populations and corresponding interventions across care settings.

STRATEGY #3: Cohorts of providers develop organizational strategies to integrate physical and behavioral health supports along the six levels of SAMHSA integration framework. (Substance Abuse and Mental Health Services Administration [https://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf] )
- Support the development of a transformation plan (TP) that includes system change improvements for physical and behavioral health integration models, inclusive of chronic disease prevention/management, substance use disorders and the social determinants of health.
- Complete guidance documents for TP and provide regional and organizational technical assistance for completing TP.
- Establish continuous quality improvement principles to be applied to all settings.
- Develop and implement a region-wide monitoring plan that incorporates available data from multiple sources and includes regular reporting from partnering providers.
- Develop and implement an evaluation plan for key initiatives.
**STRATEGY #4:** Design and implement a shared learning infrastructure for providers across the region.
- Develop clear purposes, objectives and outcomes for each shared learning cohort.
- Align cohorts based on commonalities.
- Link cohorts to Policy Committee for policy development.
- Add regional value by incorporating community voices throughout shared learning infrastructure.
- Publish and disseminate learnings, barriers and opportunities.
- Support shared learning across data sharing partners and broader SWACH partners where results can inform Medicaid Transformation Project activities and decision making.

**GOAL 2. COMMUNITY-CLINICAL LINKAGES**

**Problem Statement:** Whole-person health and wellbeing is impacted by many factors beyond clinical walls. Integration is not a cure for inadequate access to resources. More must be done to ensure our approach to whole health addresses the social determinants of health, which impact everyone's health outcomes, healthcare costs and our overall community wellness. To maximize whole-person health, we must include the community and social service sectors as essential partners in regional efforts to transform healthcare systems.

**AIM Statement:** SWACH will serve as a support for community-clinical linkages by incentivizing innovative cross-sector relationships and projects and providing opportunities for learning, action and care traffic control. SWACH will foster authentic community informed improvements to our healthcare system through investment in community-based partnerships with clinical settings. Investments will target workforce development, population health management systems and quality improvement support, as well as incorporation of equity policies and procedures to address institutional racism, stigma, and trauma. SWACH will also develop a Community-Based Pathways HUB to support a network of care coordination agencies, helping eliminate organizational silos and avoid duplication of services.

**STRATEGY #1:** SWACH believes that non-clinical partners are essential to achieving the goals of Medicaid Transformation. Co-design, with regional partners and community voice, the framework, approaches and strategies for system changes that realize a desired future state as a region with optimized community-clinical linkages.
- Understand the regional current state of community-clinical linkages through:
  - Review of the HIE/HIT and provider assessments
  - Reviewing data, including regional community health needs assessments
  - Identify current partnerships between physical health and behavioral health providers and non-clinical provider organizations
- Develop strategy and future state goals along a continuum of change for strengthening engagement between community and clinical settings.
- Implement three-pronged approach to elevate community voice, including creating a Community Voice Council, attending community meetings and holding regularly scheduled SWACH dialogues in different communities within our region.
- Ensure that community health workers, peers and people who use Medicaid services are represented in all parts of SWACH’s governance structure.

**STRATEGY #2:** Design and implement a regional shared learning infrastructure for community-clinical partnerships for exchange of best practices, barriers and solutions.
Transformation to include interdependent community-clinical partnerships is necessary and it will not be simple. The work ahead is new and SWACH will provide technical assistance and support for movement along the continuum of the partnership engagement framework to enhance community-clinical partnerships and projects.

Create learning cohorts of providers that are in similar stages of transformation and provide technical assistance.

Incorporate authentic community voice and other community input in the learning process.

Work with partners, community health workers, community health advocates, peers and community members to identify innovative ideas, system/program gaps and barriers.

Support development of Southwest Washington Community Health Advocate and Peer Support (CHAPS) shared learning network

STRATEGY #3: Enhance and support capacity development and outreach in existing care coordination efforts in the region.

Implement a community-based care traffic control system utilizing the Pathways HUB model.

Support expansion and integration of community health worker and peer providers as essential to whole-person care.

Support increased efficiency and access to information on real-time social services.

Support development of care coordination in rural areas as appropriate and informed by rural community voice.

Provide training and collaborative learning opportunities.

GOAL 3. SUSTAINABLE LARGE-SCALE IMPACT

Problem Statement: Complex issues in our community are causing increasing health inequities, rising healthcare costs and unaffordable housing. Multiple funding streams that often have conflicting requirements and regulations drive our healthcare system. Systemic barriers are preventing needed health improvements, but diverse communities have limited voice and opportunity to participate in decision-making.

AIM Statement: SWACH works to create healthy communities by bringing diverse organizational partners, funders and community members together to find ways to sustainably finance large-scale social impact innovations. We do this by convening, providing tools, technical assistance and investments that allow us to bring health, equity and community voice to decision making.

STRATEGY #1: Fund transformations that are scalable and significant system redesigns that address inequities, stigma, trauma and institutional racism.

- Utilize the transformation plan template and binding agreements between SWACH and partners to fund scalable, significant system redesigns
- Transformation plans that are system redesigns and inclusive of changes that address health inequities, stigma, trauma and institutional racism will be incentivized through funding and technical support.
- Develop equity framework with stakeholders, including community voice.
- Facilitate technical assistance to providers to help transition to value-based contracting.

STRATEGY #2: Develop a policy agenda that facilitates action for Southwest Washington at the local, regional, state and federal levels.

- Expand the reach of the HLC Policy Committee to cover all policy issues related to SWACH’s work.
• Hire a dedicated position to manage the policy portfolio.
• Create direct communication between all parts of the governance structure, workgroups, etc. and the policy staff and committee.

**STRATEGY #3:** Create braided funding for large-scale social impact by partnering with funders around the Community Resiliency Fund and other investments.
• Convene funders who are interested in this work to pool funding and create a shared governance model for decision-making.
• Deploy funding in a manner that encourages new partnerships, approaches and systemic changes, rather than one-off projects.
• Convene partners regarding shared savings and pay-for-performance models that promote large-scale social impact.

**STRATEGY #4:** Identify regional investments that will support the goal of whole-person integrated clinical care.
• Develop a transparent collective action process for decisions.
• Establish coordinating structure to align with, whenever possible, other ACHs’ regional investments.
• Coordinate with statewide health system capacity building partnerships.
• Continue to support regional efforts to integrate cross-sector data (health, education, housing), identify populations that are being served by multiple sectors and understand how experiences in one sector influence outcomes in another (“Community Connections” initiative).