2020 STRATEGIC FRAMEWORK REPORT

March - April 2020

FOCUS AREA I: COLLABORATIVE IMPACT

Overall Aim: By 2021 we will build upon our collaborative infrastructure of over 80 diverse community partners to advance equity, whole person care, community health, and well-being. Utilizing community voice and data, we will identify optimal leverage points for collective intervention, capture the impact of our work, show alignment of partners’ interests and identify shared savings that may be reinvested in the community’s collective efforts.

Strategy 1: Create a regional collaborative learning and action system for whole person care.

- **Clark County Opioid Taskforce transitioned to virtual operations and meeting process with 25 individuals representing 21 agencies.**
- **Approved two Community Clinical Linkage Projects for funding in the amount of $1,600,000 over a two-year period. Contract negotiations underway. Partners include Council for the Homeless, Share, HHIP, SeaMar FQHC, CDM Services, Skyline Hospital, NorthShore Medical Group, White Salmon Valley School District, Comprehensive Health Care, Washington Gorge Action Programs and White Salmon Valley Education Foundation.**
- **Provided CHW/Peer Common Principles and Practices Training.**
- **Integrated Care Collaborative meetings are optional during COVID-19 situation. Discussions centered around telehealth, patient-centered care and new challenges.**
- **Equity Collaborative on pause since mid-March. Meetings are optional with COVID-19 situation.**

Strategy 2: Support regional stakeholder engagement and development of partner networks to identify and respond to community priorities.

- **In partnership with Washington State Department of Health, facilitated three training and listening sessions on Community-Based Workforce COVID-19 challenges with a reach of over 40 people.**
- **Partnered with service providers in 7 organizations (including HCA and DSHS) to coordinate the regional Trueblood response and service provision.**
- **Provided support in the development of procedures for the Homeless Quarantine & Isolation Motel.**
- **Ongoing COVID-19 communications between SWACH and behavioral health clinics has been established. Information provided by HCA and DOH is provided to clinics on a weekly basis.**
- **Participants of the regional collaborative quarterly meeting discussed opportunities related to Pathways HealthConnect, State Level Policy, and learned about the work of Youth and Family Link, who hosted the meeting.**
Strategy 3: Advance equity and amplify community voice to identify and change conditions that have resulted in inequities and infuse that spirit across our partners.

- Completed a one-year contract with CHAPS Network to advance community voice. SWACH staff, Dominique Horn, will serve as liaison between CHAPS Network and SWACH.
- Rose Village CHW project was suspended due to multiple issues. Next steps to support community engagement will be addressed post COVID-19.
- Influenced two State policies related to behavioral health and housing renter’s protection rights.
- An Amplifying Voices Initiative has been launched. The purpose of this Initiative is to amplify the voices of community members, stakeholders and organizational partners. Information that is gathered will be used to better understand regional needs, share learnings, identify regional training needs and prioritize potential policy changes.

FOCUS AREA II: HEALTHCONNECT HUB

Overall Aim: By 2021 develop and maintain HealthConnect infrastructure and partner networks that 1) provides community members with ready access to a continuum of supports and services 2) populates a longitudinal whole person care record of a person’s interactions with health, human, and social systems 3) supports care team coordination, collaboration and data sharing across a continuum of care models, supports and services 4) demonstrates outcomes and data illuminating strengths and gaps to support community planning, advocacy and resource allocation 5) demonstrates HealthConnect Hub value as driver for better care, better health and lower cost 6) supports braided funding and engages sustainability partners across public and private entities at national, state, regional and local levels.

Strategy 4: Build HealthConnect to reduce fragmentation across care systems, and improves access, coordination and support for individuals and their families across the care continuum.

- 2,699 pathways completed for HealthConnect Hub clients.

Strategy 5: Develop the HealthConnect infrastructure and operations that supports care model integration development and quality improvement. Support contracted agencies, community-based workforce and supervisors, continuous quality improvement, and security compliance.

- Implemented new policies and processes for telehealth and verbal consents for Pathways HealthConnect; trained all supervisors and CHW/peers in response to Stay Home, Stay Healthy Orders.
- Completed training of one CHW to work in partnership with HealthConnect system.


- Initiated pilot project with AAADSW to use HealthConnect as Client Master index for Health Homes program.
- Established data sharing partnership (tier 2) with Molina Managed Care.

**Strategy 7:** Increase access to meet the needs of vulnerable and marginalized populations through engagement with HealthConnect.
- Formed partnership with Clark County Public Health, Clark County Community Services and Council for the Homeless to refer Quarantine and Isolation Motel guests to HealthConnect CHW/Peers for care coordination and support.