ADVANCING HEALTH EQUITY:

LEADING CARE, PAYMENT, AND SYSTEMS TRANSFORMATION

# Lessons from the Equity Learning Collaborative Program in Washington State


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AHE Advancing Health Equity

Leading care, payment, and systems transformation

Advancing Health Equity: Leading Care, Payment, and Systems Transformation
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## EXECUTIVE SUMMARY

# Community Health Plan of Washington (CHPW) has embarked on a multi-year journey to advance equity within its organization and communities.

As part of that effort, CHPW joined the national Advancing Health Equity (AHE) Learning Collaborative in 2019 in partnership with the Washington State Health Care Authority and the 21 community health centers (CHCs) that form the Community Health Network of Washington (CHNW). Initially, comprising 7 state teams, the collaborative has since expanded to include 12 state teams from across the nation. Through the program, CHPW has demonstrated its role as a leader in the national conversation about incorporating equity into value-based payment and managed care delivery.

The Washington state team, composed of a state Medicaid agency, Medicaid managed care organization (MCO), and Medicaid provider entity, received comprehensive technical assistance from national leaders in health care and health policy which include staff from The University of Chicago, the Center for Health Care Strategies, the Institute for Medicaid Innovation, and The Justice Collective. The Washington team aimed to design a health care delivery transformation to reduce and eliminate health disparities supported by a redesigned payment model. CHCs were tasked with analyzing their data through an equity lens to identify inequities, conduct root cause analyses, and help CHPW design a payment model to address the identified inequity. To create alignment and a shared definition, in this document, health inequities are defined as differences in health across populations that are systemic, avoidable, and generally unfair or unjust.

The Washington Learning Collaborative team recognized that focusing on a single inequity in care would limit the project's overall impact. Given that CHCs serve diverse communities across the state, each with unique populations, resources, and challenges, CHCs themselves are best positioned to design interventions that meaningfully address the inequities their patients and communities experience. Consequently, CHPW and the Washington Team developed the Equity Learning Collaborative (ELC), giving each CHC the opportunity to address inequities that were meaningful and specific to their community. CHCs we able to select a project focus and approach that aligned best with their community's needs. The flexibility in allowing CHCs to decide on the inequities or gaps they wanted to address, rather than taking a more prescriptive approach, proved instrumental to the program's success.

CHPW acknowledges that there is no one-size-fits-all solution for transforming care delivery, advancing equity, or incentivizing the reduction of inequities. CHPW shares insights with the aim of supporting others who are planning or actively working on innovative care delivery transformations.

**Community Health Network of Washington (CHNW) is made up of 21 CHCs. Most CHCs participated in the Equity Learning Collaborative program year over year.**

# CHC PARTICIPATION


# 46 projects across 3 years

**The following retrospective was written by Community Health Plan of Washington:**

## EXECUTIVE SUMMARY **KEY LESSONS**

Several key lessons emerged over the course of program development and implementation and were central to the program's success. They reinforce that health equity initiatives are most successful when operating within a broader organizational, community, or statewide long-term commitment to health equity.

In many ways, CHCs are an ideal setting to innovate and pilot new services or programs to reduce inequities. CHCs' role as a safety net provider, serving some of the most medically complex and vulnerable patients, requires them to test and utilize various team-based care models that include key wraparound supports like case management, behavioral health support, health education, and connections to social services to address social drivers of health. CHCs use these models to better manage their patients and reduce downstream health care costs. Managing costs is crucial for CHCs' survival and capacity to continue their missions. Current value-based payment arrangements add financial incentives for clinics to improve key quality metrics while keeping costs down. While these incentives are meant to improve health outcomes, what is so often missed is a recognition of "whose" health outcomes are improving. These incentives and financial drivers do not promote nor allow CHCs the time and resources to evaluate how different populations are being served and whether and why health disparities exist. That work, while ultimately essential to improving health outcomes and reducing cost, requires organizations to shift away from a traditional quality improvement mindset toward one that is grounded in health equity. This shift requires resources.

**LESSON 1: Creating a culture of equity across partner organizations is essential.**
The AHE Learning Collaborative grounded each state team in the concept that efforts to reduce health inequities are more effective and last longer when integrated into a broader culture of equity within an organization. It's not just staff recognizing the existence of health inequities. Rather, as noted in AHE's Roadmap to Advance Health Equity: "In a culture of equity, all employees, both individually and collectively, identify and reflect upon the organizational dynamics that reproduce health inequities and actively work to transform those dynamics." This concept was transformational for CHPW and its approach to health equity efforts.

CHPW recognized the importance of building a culture of equity at both the MCO and CHC level. Each year, CHPW hosted a webinar learning series which created an opportunity for CHCs to learn how to advance equity alongside each other and create a common language across the network. CHCs working on similar health equity projects were later grouped into learning cohorts which allowed for peer-to-peer sharing of best practices and general support. Staff members at each of the CHCs saw growth in their understanding of and commitment to equity and their ability to integrate it into everything they did. That knowledge came as a direct result of what they learned through their project, the learning series, and conversations with their cohort over the course of three years. Through the program, leadership and teams across the CHCs developed an understanding of what it meant to integrate equity into all programming and how to keep it at the forefront of their work. Creating a commitment to equity goes beyond external efforts to improve care, looking inward. CHPW and several of the CHCs identified opportunities to strengthen their internal diversity, equity, and inclusion efforts. This included improvements in policies and procedures, creating health equity councils and leadership engagement, and empowering their staff in their health equity journey.

### LESSON 2: Upfront and flexible funding is necessary to support foundational capacity building needed to advance equity.

Oftentimes, funding associated with Value Based Payment (VBP) is so specifically tied to metrics and outcomes that it's difficult to use it toward capacity building. Many organizations lack the funding and capacity to meet equity goals (i.e. specific tools, resources, and training). The ELC provided CHCs with an advance on their earned shared savings and encouraged them to use their funding to build a strong foundation of equity knowledge. Each CHC had the freedom to decide how to utilize the advance on their earned savings as long as there was a clear connection to their overall equity goals. Whether that was enhancing language assistance resources, training staff on unconscious and implicit bias, hosting community stakeholder events, creating equity committees, or hiring equity-focused staff, they identified opportunities that might not have been possible through other VBP payment models, grants, and funding streams. The flexible funding also allowed course corrections or pivots based on community, provider, and staff feedback.

### LESSON 3: Designing a single payment model for 21 independent CHCs is complex, requiring ample time for design and adoption.

CHPW knew the program had to respect the differences among CHCs, while also moving toward a common goal of disparities reduction. While traditional VBP models often prescribe measures or topics of focus, CHPW's model allowed providers and CHCs to prioritize what was most important and impactful to their communities. By validating and affirming the strengths that each CHC brings in understanding their community's needs and supporting them to act on those in whatever way seemed most equitable and effective, CHPW saw significant growth. The best equity work is locally tailored and community driven, which became clear through these efforts.

As an organization, CHPW is working towards engaging, involving, and prioritizing its communities better, and ensuring the funding and programming we use works for them instead of CHPW deciding what will or won't be successful. We chose being flexible over being prescriptive, and it paid off. While we still had requirements around reporting and participation, the details of CHC projects were fairly flexible to allow for communities and clinics to drive decision making. Had the program required disparities reduction in a calendar year, many CHCs likely would not have been ready to participate due to capacity constraints, conflicting priorities, and the fact that no CHC was at the same point in their equity journey. For example, they might have needed to build the ground work, knowledge, infrastructure and understanding to create programs aimed at reducing disparities. Instead, the program focused on a gradual introduction, giving the CHCs time to build their unique programming over the first three years. Over the next three years, each CHC will be asked to identify a measure of focus from a list of eight priority health measures and demonstrate improvement in the reduction of the inequity within that measure.

### LESSON 4: Collaboration is key.

CHCs emphasized the value of collaboration. Having the opportunity to learn from experts, CHPW teams, and their diverse set of peers and communities was invaluable. Creating spaces for interaction fostered community, shared learning, and problem-solving. CHPW's Equity Learning Collaborative Program highlighted that communities and partners are stronger together. CHCs accomplished organizational and structural changes together that wouldn't have been possible without the time and space dedicated to collaborating, listening, and learning from their peers and communities.

# CHPW Background & Health Equity Journey

## In 1992, a network of Community and Migrant Health Centers (CHCs) across Washington State formally established the Community Health Network of Washington (CHNW) and its subsidiary, Community Health Plan of Washington (CHPW) as the only local, community-governed, not-for-profit health plan.

CHPW was founded to provide access to quality care for Washingtonians–particularly those from marginalized communities–and currently serves more than 315,000 members through Medicaid, Medicare, and a public option on the Washington Health Benefit Exchange which allows Washingtonians who don't qualify for Medicaid or Medicare to receive quality, affordable health care. CHPW believes that health equity is core to our mission and requires a relentless pursuit of justice in how CHPW serves our members and communities.

Like many organizations, CHPW has been on a multi-year journey to advance equity within our organization and communities. CHPW has worked to thoroughly dissect and understand how structural racism influences its work. The organization made a commitment to learn how to become an anti-racist organization and promote health equity within the communities it serves. Structural racism is built into the fabric of the healthcare system, particularly the Medicaid program, which creates and exacerbates the health disparities seen across the country.[1,2] The COVID-19 pandemic exposed those inequities in the starkest terms, requiring organizations to approach health care transformation with a renewed sense of urgency.

To continue our equity journey, CHPW participated as one of seven original state teams, which later expanded to include twelve state teams, in the national Advancing Health Equity (AHE) Learning Collaborative in partnership with the Washington State Health Care Authority and the 21 community health centers (CHCs) that make up CHNW. Each state team (State Medicaid Agency, Medicaid Managed Care Organization, and Healthcare Delivery Organization) received in-depth technical assistance from national leaders to design a payment model to support and incentivize health care delivery transformation to reduce and eliminate health disparities. State teams were asked to analyze their data with an equity lens to identify disparities, conduct root cause analyses of identified inequities, and design an integrated care delivery and payment reform model to address the identified inequity. The AHE Learning Collaborative grounded each state team in the concept that efforts to reduce health inequities will be more successful if they are part of a broader culture of equity within an organization. It's not just staff having the ability to recognize that health inequities exist. "In a culture of equity, all employees, both individually and collectively, identify and reflect upon the organizational dynamics that reproduce health inequities and actively work to transform those dynamics."[3] That idea was transformational for CHPW and its approach to health equity efforts.

1 Somers, S., & Perkins, J. (2022). The ongoing racial paradox of the Medicaid program. *Journal of Health and Life Sciences Law*, *16*(1), 96-112. AHLA - The Ongoing Racial Paradox of the Medicaid Program; Michener J. D. (2021). Politics, Pandemic, and Racial Justic Through the Lens of Medicaid. *American journal of public health*, *111*(4), 643–646. https://doi.org/10.2105/AJPH.2020.306126

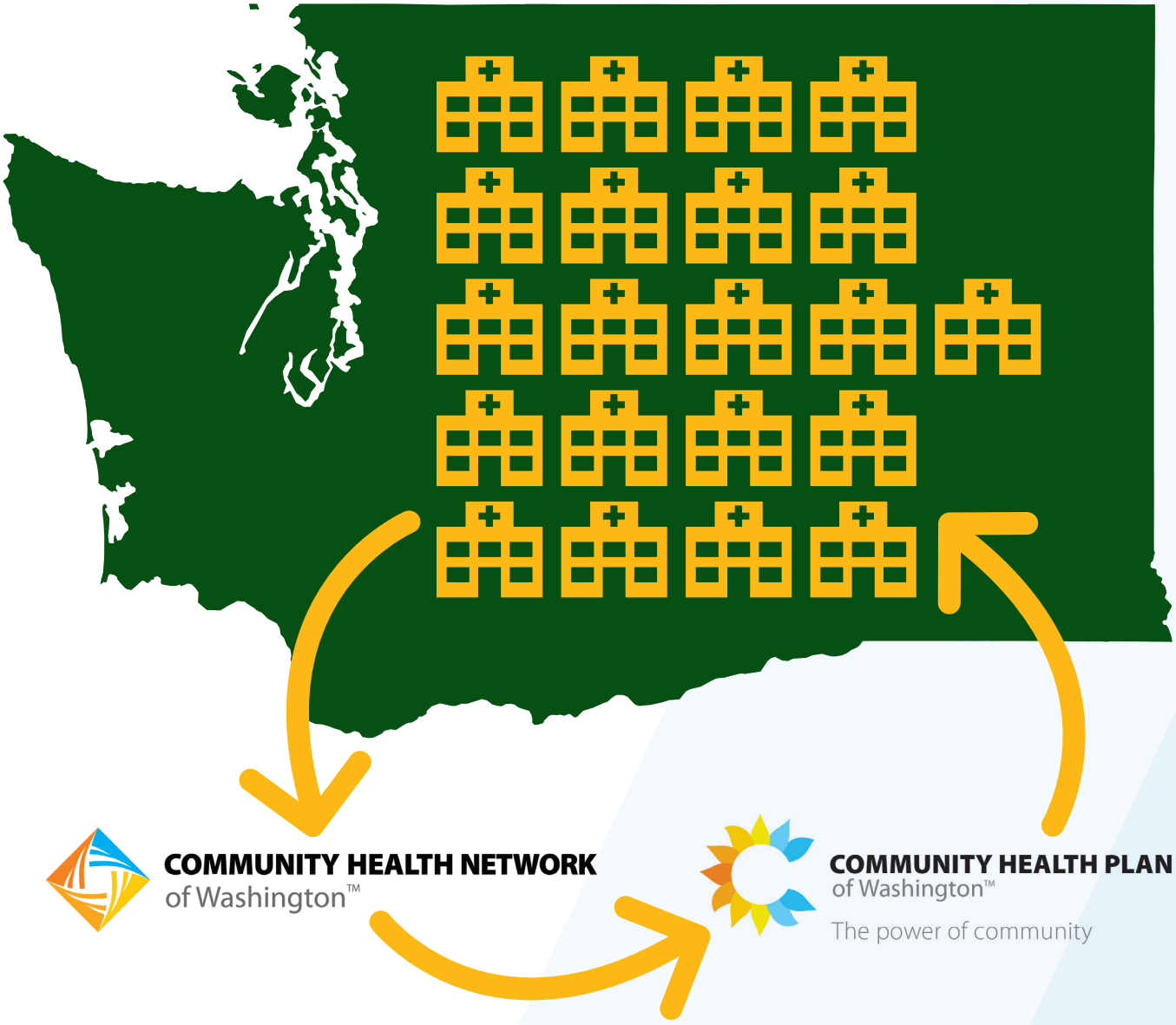
2 Furtado, K., Verdeflor, A., & Waidmann, T. A. (2023). *A conceptual map of structural racism in health care*. Urban Institute. Retrieved from https://www.urban.org/research/publication/conceptual-map-structural-racism-health-care

3 Furtado, K., Verdeflor, A., & Waidmann, T. A. (2023). *A conceptual map of structural racism in health care*. Urban Institute. Retrieved from https://www.urban.org/research/publication/conceptual-map-structural-racism-health-care

As CHPW continued the process of learning and identifying health disparities, it became clear to the Washington Learning Collaborative team that selecting a single health outcome or population would unnecessarily limit the scope of the project. The CHCs each serve communities across the state with unique populations, resources, and challenges. Embedded within the fabric of their communities, the CHCs are best equipped to design interventions to meaningfully address the inequities facing their patients. In addition, CHPW recognized the impact of internal efforts to foster a culture of equity and saw it as an opportunity to extend the results of those efforts to the CHCs. CHPW and the Washington Team thus designed the Equity Learning Collaborative (ELC) and set the foundation for future success in a VBP program.

# Who are we?

**In 1992, Washington State CHCs joined to create Community Health Network of Washington, and founded CHPW, the state's first and only not-for-profit health plan. Our integration with CHCs allows us to work hand-in-hand to break down barriers to care, focus on whole person health, and advance equitable healthcare for all.**



# CHPW/CHNW Equity Learning Collaborative

# CHPW/CHNW Equity Learning Collaborative Overview

## Flexible Capacity Building Funds

The three-year Equity Learning Collaborative (ELC) program funded projects to advance health equity and reduce health disparities at the community health centers (CHCs) that make up the Community Health Network of Washington (CHNW). The program was created in partnership with our state Medicaid agency, the Health Care Authority (HCA). Each CHC was eligible to receive up to $50,000 annually in 2021, 2022, and 2023. Funding was an advance payment of shared savings without risk of quality-based withholding or claw backs. CHCs used the funding to support a variety of activities from purchasing equipment, providing patient incentives, conducting focus groups, developing internal equity structures, and much more. Quarterly payments were made as CHCs participated in peer learning calls and provided progress updates on their work. Over the course of the program, CHPW invested roughly $2.3 million in participating CHCs to advance equity within their communities. Those capacity investments were designed to give CHCs substantial flexibility in identifying initiatives that met the needs of their community and addressed the disparities and inequities most relevant to them. Participating organizations have consistently reinforced the importance of flexibility and how rare it is for CHCs to have access to funds specifically to address inequities.

## Peer Learning and Collaboration

Organizations were free to continue a single initiative over multiple years or design new projects each year. CHPW hosted a pre-launch webinar series and provided a resource guide prior to the program launch to assist CHCs in designing projects in Year One, including a webinar series teaching the CHCs about what it means to create a culture of equity within an organization; how to stratify and analyze quality measures and other data by race, ethnicity, and language; approaches to root cause analysis; and recommendations on engaging patients to provide a good foundation and shared understanding before beginning the work. All sessions were recorded and made accessible to every CHC.

Organizations were encouraged to design projects with the potential to reduce inequities across their entire patient population, not just among CHPW Medicaid members. Each year, participating organizations were grouped into cohorts by topic of interest to discuss each organization's work as well as solve problems as a group. In cohorts co-led by CHPW staff, CHCs met bi-monthly to share progress, barriers, and support each other with relevant resources and best practices. Each cohort call reserved time for project updates, resource sharing, questions, support requests, and next steps but were flexible enough to account for unplanned conversations and topics we wanted to further explore. This structure allowed for integral peer-to-peer collaboration opportunities. Each CHC set and tracked individual goals for the year while collectively working across the program to enhance our understandings of equity and support each other in addressing barriers and meeting project goals.

## 2021 ELC Cohorts

| Equity Learning Collaborative Cohort Topics: Advance health equity within: | | | |
|---|---|---|---|
| **Member Experience** | **Pregnancy Care** | **Behavioral Health Condition Management** | **Chronic Condition Management** |
| 6 CHCs | 2 CHCs | 4 CHCs | 3 CHCs |
| ***15 CHC Organizations in Year One*** | | | |

## 2022 ELC Cohorts

| Equity Learning Collaborative Cohort Topics: Advance health equity within: | | | |
|---|---|---|---|
| **Member Experience** | **Clinical Care[4]** | **Social Drivers of Health** | **Foundational Equity[5]** |
| 5 CHCs | 4 CHCs | 3 CHCs | 4 CHCs |
| ***16 CHC Organizations in Year Two*** | | | |

## 2023 ELC Cohorts

| Equity Learning Collaborative Cohort Topics: Advance health equity within: | | | |
|---|---|---|---|
| **Engaging Patients and Reducing Disparities[6]** | **Internal Diversity, Equity, and Inclusion (DEI)[7]** | **Social Drivers of Health Data Collection** | **Maternal Health** |
| 5 CHCs | 3 CHCs | 4 CHCs | 3 CHCs |
| ***15 CHC Organizations in Year Three*** | | | |

CHCs also submitted quarterly progress reports to CHPW, which triggered quarterly payments to the CHCs. Quarterly reports provided an opportunity to share assistance requests, quantitative and qualitative updates, barriers experienced and overcome, and lessons learned. In addition to quarterly reports, CHCs participated in robust, yearly Learning Series. Those sessions expanded the scope of learning beyond individual project takeaways to true knowledge sharing, which helped build a true culture of equity across all twenty-one CHCs in CHNW, ultimately creating the infrastructure to undertake future equity work. Session topics incorporated a high amount of flexibility to be responsive to CHC needs and provide technical assistance, resources, and presentations to address gaps in knowledge. That approach proved instrumental to building trust and a shared knowledge and understanding of equity. Feedback from CHC participants throughout the course of the program drove discussion and determined future Learning Series topic areas.

**4** Clinical Care: Programs seeking to reduce inequities in specific clinical care outcomes (i.e., inequities in hypertension, diabetic eye exams, etc.)

**5** Foundational Equity: Building out an organization's equity foundation – cultural humility/implicit bias training for staff, creating a comprehensive patient engagement strategy, applying equity lens to all work, etc.

**6** Engaging Patients and Reducing Disparities: Projects focused on engaging communities to reduce specific disparities in their membership (i.e., partnering with spanish speaking members to improve diabetes access/care)

**7** Internal Diversity, Equity, and Inclusion: Improving internal DEI practices, specifically around improving clinical staff skills and training – implicit/unconscious bias, cultural humility training, etc.

Instead of focusing only on the necessary steps to design an equity-focused project, CHPW sought to help CHC staff "build the muscle" to think critically about how each of our organizations may reinforce inequities and learn how to take action. CHC staff made a conscious effort to foster a broader culture of equity within their own organization. Those learning opportunities focused on the organizational infrastructure necessary to take on equity work. Throughout each year of the program, CHPW hosted kickoff calls and Learning Series sessions to accompany the program and build knowledge around key concepts of health equity and spread the learnings from AHE's Learning Collaborative. Participants were encouraged to attend all webinars which included interactive breakout groups and opportunities to link the learning to their projects. Integrating learning opportunities into the ELC program was essential to ensure that funding was part of a larger shift in approaches to health care delivery, rather than one-time projects. CHCs were aware of the project's long-term goals and committed to the learning, funding, and equity journey CHPW and its network partners embarked on together. With the infrastructure in place, the level of equity knowledge and understanding as well as the commitment to the work grew dramatically as the program progressed.

## 2020 Pre-Program Learning Series

| SESSION 1<br>Identifying Health Disparities | SESSION 2<br>Diagnosing Disparities | SESSION 3<br>Selecting Your Intervention | SESSION 4<br>Patient Engagement |
|---|---|---|---|
| Identifying disparities (what the data does and doesn't show) and building an organizational culture that supports identifying and addressing disparities | Understanding root cause analysis with an equity lens | Designing an equity intervention/care transformation | Developing sustainable patient engagement and partnership strategies |

## 2021 ELC Learning Series

| SESSION 1<br>Program Kickoff | SESSION 2<br>Building Equity into Program Design | SESSION 3<br>Patient Partnership for Program Development and Implementation | SESSION 4<br>Year-End Program Review |
|---|---|---|---|
| Providing an overview of the ELC program | Reviewing development and implementation process for CHPW's Equity Assessment Tool | Discussing how to engage members and patients in the development and implementation of programs, including Journey Mapping | Highlighting CHCs' ELC work, including development and implementation of CHC projects and outcomes |

## 2022 ELC Learning Series

| SESSION 1<br>Program Kickoff | SESSION 2<br>Inequities within the Medicaid Program | SESSION 3<br>Equity Data | SESSION 4<br>Social Drivers of Health (SDOH) and Sexual Orientation and Gender Identity (SOGI) Data | SESSION 5<br>Year-End Program Review: Foundational Equity Capacities |
|---|---|---|---|---|
| Providing an overview of the 2022 ELC program | Reviewing the history of the Medicaid program and exploring how racism and inequity are part of the program's structure | Sharing best practices implemented by CHCs to overcome challenges related to gathering, analyzing, and distributing health equity data | Learning from CHCs with experience collecting SDOH and SOGI data, including their current process, journey to develop their process, existing challenges, and lessons | Highlighting CHCs' work, emphasizing foundational equity capacities: collection/use/analysis of equity data, member engagement, staff training, root cause analysis with an equity lens, community-based partnerships, and leadership buy-in |

## 2023 ELC Learning Series

| SESSION 1<br>Program Kickoff | SESSION 2<br>Creating a Culture of Equity | SESSION 3<br>Partnering with Members and Communities | SESSION 4<br>Role of Health Leaders in Advancing Health Equity | SESSION 5<br>Equity-Centered Approach to Trauma-Informed Care |
|---|---|---|---|---|
| Providing an overview of the 2023 ELC program | Reviewing CHPW's journey to foster an internal culture of equity and sharing equity journeys from CHCs | Building strong relationships with communities (individuals and organizations) to drive sustainable equity work | Sharing how leaders from a variety of health sectors prioritize and integrate health equity into their roles | Highlighting how individual and generational trauma can inform and drive equity work |

# Equity Learning Collaborative Program Overview

Over the three years of the Equity Learning Collaborative program, eighteen Community Health Centers participated in and implemented forty-six projects. The CHCs provide comprehensive and cost-effective care options for the most underserved communities, with staff providing primary care, preventive, and wrap-around services.

The chart below highlights several project outcomes from the program. See Appendix C for detailed information on each CHC and their project overviews and key outcomes.

| Name of Cohort | Project Outcome |
|---|---|
| **Behavioral Health Condition Management** | Implemented new depression screening workflow, informed by patient feedback. Increased Antidepressant Medication Management rate from 11% to 52% for continuing and 67% for acute. |
| **Chronic Condition Management** | Distributed blood pressure cuffs and other resources to patients with hypertension paired with instructions to help patients manage their high blood pressure. Saw more than 9% improvement in the organization's hypertension control measure. |
| **Clinical Care** | Ensured more patients experiencing homelessness received a follow up after positive Patient Health Questionnaire-9 (PHQ9) screening. While more patients received a follow up, this CHC only had a 16% follow up rate due to an increase in the number of patients experiencing homelessness who were being screened for depression, highlighting the need to hire more staff to follow up on positive PHQ9 screenings. |
| **Engaging Patients and Reducing Disparities** | Developed a Member Health Equity Advisory Council to support clinic-specific disparities reduction projects. Of their participating CHC clinics, 100% successfully implemented site-specific projects to reduce disparities identified in their communities. |
| **Foundational Equity** | Held an unconscious bias training for all staff, covering topics such as unconscious/conscious bias, identifying and challenging biases, cultivating connections through empathy and curiosity, and choosing courage. More than 82% of staff attended. |
| **Internal DEI** | Implemented the Institute for Healthcare Innovation (IHI) Joy at Work Framework, to ensure staff feel joyful, engaged, and that work is meaningful. The training was well received, with 100% of staff in attendance. Multiple staff members reported feeling more engaged and appreciated at work afterward. |
| **Maternal Health** | Distributed home screening equipment for pregnant people to reduce the need to come into the clinic. All members who requested a care package received a thermometer, nasal aspirator, and educational materials. 100% of providers received ultrasound equipment and training to provide ultrasound care so members do not need to travel much farther to a hospital to receive this service. |
| **Member Experience** | Hired community health workers and improved translation and interpretation services. Saw an increase in interpretation utilization by almost 20%. |
| **Pregnancy Care** | Increased the number of patients completing a postpartum visit from 43.6% to 66.02% for the general population, and from 22% to 70% for patients whose preferred language isn't English. |
| **Social Drivers of Health** | Began construction of a health and hygiene center to support the 15% of their population experiencing homelessness. |


BUILDING TRUST AND RELATIONSHIPS WITH COMMUNITY
ENGAGING WITH PATIENTS TO HEAR FROM THEIR EXPERIENCES AND INVOLVE THEM IN THE FUTURE
IMPROVING INTERPRE-TATION AND TRANSLATION SERVICES
OVERARCHING THEMES
TRAINING STAFF ON TRAUMA-INFORMED CARE
HIRING COMMUNITY HEALTH WORKERS
CULTURAL COMPETENCY AND IMPLICIT BIAS

# Lessons Learned

Throughout the three years of the Equity Learning Collaborative Program, several key themes and lessons emerged. CHPW recognizes that there is no single approach to transforming care delivery, advancing equity, or incentivizing reduction in inequities. By sharing our insights, CHPW hopes to assist others who are planning or currently working on innovative care delivery transformations.

# Lessons Learned from the Equity Learning Collaborative

## LESSON 1:
## Building a culture of equity across partner organizations is essential.

Efforts to reduce health care inequities will not succeed unless they are a part of a broader understanding of health equity and commitment to dismantling the systems and dynamics that reproduce inequities. It requires leaders to not only invest time and resources into a particular project, but also to actively pursue and promote a broader culture shift within their organizations. CHPW began that journey in earnest in 2016 with specific goals to advance health equity within the strategic plan and subsequent efforts to pursue equity-related distinctions and learning opportunities. CHPW's Chief Executive Officer has been a steadfast advocate for this work and has worked throughout the years to gain buy-in from CHPW leaders, staff, and the community health center leaders that comprise CHPW's Board of Directors. In 2020, CHPW created an Equity Council of internal staff leaders committed to a culture of equity and completed a DEI assessment that resulted in recommendations. Those recommendations informed a multi-year work plan that included hiring equity-focused staff, providing extensive DEI learning opportunities, and holding teams accountable for making progress on strategic equity goals. CHPW's Chief Equity Officer and Program Manager of DEI were both hired in 2022 and oversee that work today. Under the guidance of our Chief Equity Officer, CHPW's Board of Directors (CHC executives) have also received DEI training and expressed commitment to CHPW's anti-racist framework.

**KEY TAKEAWAY**

**A Culture of Equity goes beyond external efforts to improve care and looks inward. CHPW and several of the CHCs identified opportunities to strengthen their internal diversity, equity, and inclusion efforts. This included improvements in policies and procedures, creating health equity councils and leadership engagement, and empowering their staff in their health equity journey.**

Additionally, the cohort structure utilized each year provided a unique opportunity for peer-to-peer CHC collaboration. The cohort structure was greatly appreciated as an opportunity to converse with peers working on similar projects who may be at different stages of the work. Attendance and participation remained high after each year of the program. Participants wanted to maintain the peer-to-peer structure because it created a sense of community and increased opportunities to convene with other CHCs.

**"Our CHC would not be where we are in our equity journey had we not had the flexibility, funding, and equity capacity building that this program allowed for..."**

**CHC EXECUTIVE AND PROGRAM PARTICIPANT**

## LESSON 2:

# Upfront and flexible funding is necessary to support health equity foundational capacity building.

Much like a personal equity journey, organizations are also at various stages in their progress toward equity and some have more programming in place than others. That variation is further complicated by the reality that all CHCs have differing levels of resources and funding to support their health equity activities. Central to the program's success was the flexibility provided through the payment model. By advancing funds upfront from their total cost of care arrangement and not directly linking funding to quality outcomes, CHCs were able to utilize funds to support needed capacity building in areas like staff training, language assistance programs, data collection, and patient incentives. This is consistent with findings and recommendations from national leaders on alternative payment models like the Health Care Payment Learning & Action Network (HCPLAN) that note the importance of upfront capacity-building funds to advance equity within a payment model.[8]

**KEY TAKEAWAY**

**Flexibility in having the ability to change or evolve projects is important. One CHC initially aimed to implement a strategy that, after meeting with the community, no longer made sense. As often happens with healthcare organizations, the CHC looked at their quality data and identified a particular health outcome to work on with a community. The CHC took the time to build trust, gave community members the space to express what was most important to them, and had the humility to listen and ask CHPW to redirect their funding toward a project that the community found more meaningful. The flexibility in CHPW's model allowed them to course correct without an impact on their funding.**

Often, organizations struggle to identify funding sources to support internal capacity building, so flexibility in how and what to spend the funds on gave CHCs permission to reflect and invest in the areas of their organization that needed additional or different resources to foster a culture of equity.

One of the challenges of grants and grant-like funding is sustainability. To that end, we held conversations with CHCs from the program's genesis in early 2021 around building out the systems and structures needed to sustain their work after the program ended.

**"The flexibility in our grant to utilize funds to do this work was invaluable."**

**3-YEAR CHC PARTICIPANT**

8 Health Care Payment Learning & Action Network (2021). Advancing health equity through alternative payment models. Retrieved from https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf

## LESSON 3:

# Designing a single payment model for 21 independent CHCs is complex, requiring ample time for design and adoption.

One size does not fit all in health equity. Selecting a single health outcome measure and inequity of focus across the twenty-one culturally and geographically diverse CHCs was not possible nor was it likely to be successful. By allowing each CHC to focus on capacity building over the course of three years, CHPW set up a strong foundation to build on in future years that will more directly link funding to inequities reduction in health outcome measures. The work to create and sustain a culture of equity is a long-term investment that requires resources, staff buy-in, and continued championing from organizational leaders. Had inequities reduction been the goal of the program in the first year, some CHCs may have felt unprepared to participate and ultimately been left behind in the health equity journey CHPW was trying to support. Inequities were not created in a single year, and they cannot be solved in a single year. Creating a three-year program allowed for incremental and sustainable growth over time and provided CHCs with a roadmap to build their health equity infrastructure and create a culture of equity within their organizations. Those years of learning and "building the muscle" for a culture of equity prepared CHCs to take on more performance-driven equity work in the future.

**KEY TAKEAWAY**

**Health equity infrastructure–including data collection and use, well-trained staff prepared to implement health equity programs, and internal processes to ensure equitable access to care–will set an organization up for long-term success. While a single initiative may reduce an inequity in care for a period of time, a strong health equity infrastructure will have a lasting impact and trickle-down effect across an organization ensuring that the inequities reductions can be maintained.**

Driving performance and outcomes is a constant pressure for health systems and health plans. It can be very difficult to gain buy-in for a multi-year program that is aimed at capacity-building rather than immediate outcomes. CHPW was very fortunate to have its CEO engaged and championing the Advancing Health Equity work from the very beginning. Her leadership and advocacy helped propel the work forward and identify CHC and state champions along the way. Finding those champions early, providing education and training for leadership and seeking buy-in is essential. Each leader brings their own lens to this work, so it's important to meet them where they are, whether that's centering equity within the mission, identifying the long-term business case, or connecting it to other strategic work.

**"This 3-year program brought CHCs through the process gently, to ensure the investment, structure and buy-in was there to support this kind of work. I truly believe if we hadn't had the time to truly build a culture of equity, that we wouldn't be where we are and people might have felt intimidated about what was being asked of them."**

**3-YEAR CHC PARTICIPANT**

## LESSON 4:

# Collaboration is key

Each year of the program, CHCs emphasized to CHPW staff and peers the importance of collaboration to move their work forward. Having opportunities to learn from experts in the space, CHPW's teams and their peers who varied in size, population, location, and stage of their equity journey was integral. Creating spaces for organizations to meet, work with, and learn from others fostered a culture of community and shared learning, and provided an opportunity to ask questions, share resources, and address barriers as a group. It became evident as the program progressed, that participants were stronger and better together. One CHC participant was exploring how to increase the number of bilingual staff at their clinic. A peer in their cohort provided tangible resources on how to support existing staff as they completed bilingual competency tests. They also offered recommendations on providing increases in hourly pay for those who are certified bilingual as well as resources that aided in the recruitment and retention of bilingual staff. Collaboration, listening, and learning are inherent to truly advancing equity. Addressing inequities represent a key pillar of health equity work.

Additionally, CHPW relied on the feedback, experiences, and expertise of CHC participants to adapt and enhance the program year over year. For example, there were monthly program cohort calls in year one. However, CHCs didn't always feel they had enough of an update to provide every month and recommended meeting bi-monthly. We integrated their feedback into year two and three of the program, by transitioning meetings to a bi-monthly cadence, which provided CHCs more time to do the actual work, think through questions and needs, and feel prepared to provide a notable update on the work they'd done previously. This helped build trust and make the program more successful, showing that we truly listened and responded to the feedback our participants had to share.

**"The collaborative nature of this program was really enriching and provided a lot of insight and learning opportunities. I found hearing about successes and struggles from other organizations in our small cohort groups to be motivating, and really like the expert panel Q&A offered for the large group webinars. I hope that CHPW will be able to continue to offer similar collaborative learning opportunities in the future."**

**2-YEAR CHC PARTICIPANT**

# What's Next?

**FACT:** Apple Health, the Washington State Medicaid program, covers nearly 1 in 4 Washington residents, with approximately 1.9 million people enrolled in 2024.

In 2024, CHPW redesigned the Equity Learning Collaborative program to shift significantly from capacity building to action. The newly named Community Transformation Incentive (CTI) Program created an enhanced alternative payment model that incorporates accountability to reduce inequities by modifying the existing Pay for Performance (P4P) structure.

Specifically, CHPW aims to provide incentives to CHCs that demonstrate reduction in inequities in selected measures. CTI builds on the first three years of the Equity Learning Collaborative. It expands their internal health equity infrastructure, emphasizes learning and practicing the skills of root cause and data analysis with an equity lens, and fosters a culture of equity within their organizations. It also emphasizes various ways to engage with patients and communities, shifting the emphasis from primarily learning to do the work to having a measurable impact on reducing inequities. Peer learning methods, such as meetings with other cohorts and educational opportunities like the Learning Series, will continue to support CHCs each year.

As CHPW begins the next phase of its health equity work, staff members recognize that more can be done to emphasize the importance of partnering with and centering communities. Centering the voice of communities has been an area of growth for CHPW and many of the CHCs over the last few years; organizations are better positioned to do so more intentionally in the future. In 2023, CHPW began an effort to formalize its efforts by creating Member Advisory Councils to facilitate member engagement and embed member voice throughout the work of the organization. In 2025, CHPW expanded its engagement efforts to develop a Community Advisory Council. The council will focus on integrating the voices of community-based organizations that provide care and services to members to include their unique voices, experiences, and perspectives. It will create an opportunity for CHPW to engage with members and the broader community on the CTI program among other equity efforts and to support the CHCs in developing similar structures and capacities.

## **Year 1** (2024)

The program continued to provide upfront capacity funds while requiring CHCs to complete Cultural Responsiveness Assessments, which detailed the current state of equitable care provision in their organizations. The purpose of those assessments was to help CHCs identify strengths and opportunities in their organizational capacity to support diverse populations and inform CHPW about systemwide gaps that required state advocacy or additional training and support. By the end of 2024, each CHC analyzed their demographic data and selected one of eight priority health measures to address. CHCs were asked to select a single inequity to simplify the design of the payment model in Year 3. As our work matures into 2027 and beyond, CHPW may explore ways to expand the scope of measurement and incentives for reduction in inequities.

CHPW's 2024 Health Disparities Report, which tracked persistent inequities within our population, identified the eight specific priority measures on which to focus. It featured a focus on broad population measures that aligned with state and federal bodies including the Washington State Health Care Authority (state Medicaid agency) and the National Committee for Quality Assurance (NCQA). Those measures included:

- **Breast Cancer Screening**
- **Chlamydia Screening**
- **Colorectal Cancer Screening**
- **Controlling High Blood Pressure**
- **Diabetes A1c Control**
- **Follow Up after Hospitalization for Mental Illness**
- **Prenatal and Postpartum Care**
- **Well Child Visits**

## **Year 2** (2025)

CHCs used the funding to develop interventions targeting their chosen inequity. The bulk of the year was dedicated to intervention development, including patient and community voice in the design and implementation process. While community engagement was an important component of the work throughout the ELC, the emphasis and outcomes varied based on each organization's equity journey. The 2025 proposal asked CHCs to describe how they would engage patients in the design, implementation, and evaluation of their work. CHPW covered engaging patients and community as a key topic for Learning Series sessions as well as cohort calls.

## **Year 3** (2026)

CHPW will provide incentive payments to CHCs that demonstrate improvement in reducing inequities through the existing Pay for Performance quality incentive program. Rather than providing all of the funds as upfront capacity funds, some will be withheld and distributed to participants after improvements and reduction in disparities are shown.

# Conclusion

"The work we have done in collaboration with Community Health Centers has helped us create a culture that is more responsive to the specific needs of our communities. By engaging directly with those most impacted and creating a framework for better understanding, we have a shared approach to reducing the barriers faced by these communities. Together, we can make sustainable progress in ensuring everyone has the opportunity to achieve their best health and well-being."

**Leanne Berge,**
**CEO of Community Health Plan of Washington/**
**Community Health Network of Washington**

## Initiatives to reduce health care inequities are unlikely to succeed unless they are part of a broader commitment to and understanding of health equity. Upfront capacity building and flexibility provide the necessary time and space to undertake and sustain health equity work.

Designing alternative payment models that incentivize the reduction of inequities and transform our health care delivery system are complex and require time, commitment, resources, and a strong foundation from which to build. Significant thought, time, and intention went into developing the Equity Learning Collaborative program. CHPW hopes others can learn from and expand on this work as partners nationwide strive to create a system that meaningfully reduces inequities. Initiatives to reduce health care inequities are unlikely to succeed unless they are part of a broader commitment to and understanding of health equity. Upfront capacity building and flexibility provide the necessary time and space to undertake and sustain this work.

As we've seen in our work, single payment models and program structures that don't take into account diverse organizations and populations hinder creativity and genuine community engagement. Providing flexibility in programming should be intentional and is necessary to account for the challenges inherent to equity work such as data limitations, community learnings, and evolving needs. Flexibility allows CHCs to focus on addressing the unique needs of their particular organization and population. Centering the voices of participants and CHCs–and staying flexible–built trust and allowed the program to adapt, improve, and adjust course as needed. Having the runway to address health inequities and the flexibility to pivot when needed was integral. Taking these steps allows us to address structural racism embedded in the healthcare system by allowing the community to design meaningful solutions.

Advancing health equity is a never-ending commitment to centering communities' needs, challenging our assumptions and ingrained ways of thinking, and holding ourselves accountable to our highest aspirations. Collaboration is crucial to the success of health equity work. Not only does it foster a culture of shared responsibility and understanding, it inspires creativity and innovative problem solving. Participation in the Equity Learning Collaborative and the Community Transformation Incentive encouraged us to look beyond traditional quality measures and ensure that member and community voices guide our decisions. The more organizations listen to their staff and communities, adopt community-driven approaches, experiment with equitable care transformation, and share their results, the more health care systems and communities can collectively shift toward a more inclusive and equitable health care system. A commitment to keep going, keep learning, and keep trying in spite of setbacks and missteps puts progress within our reach.

# Appendix

# Appendix A: Proposal Template

**CHPW-CHNW 2023 Apple Health Pay for Performance (P4P) Program: Equity Learning Collaborative Grant Proposal for NEW PROJECTS**

| | |
|---|---|
| **1. Community Health Center:** Choose your CHC | |
| **2. Project Leader(s)/Executive Sponsor(s) and Title(s):** | |
| **3. Project Title**: | |
| **4. Project Goal** (specific and measurable): | |
| **5. How will this project advance health equity?** | |
| **6. What are your organization's greatest strengths and opportunities in terms of organizational capacity to advance equity?** | |
| **7. Which equity capacities would you like to focus on through this project** (feel free to check more than one)**?**<br>☐ **Root Cause Analysis**<br>☐ **Data Analysis with an Equity Lens**<br>☐ **Partnering with Patients**<br>☐ **DEI Staff Training**<br><br>**What are your goals for moving this work forward?** | |
| **8. Project Description**<br>Please briefly describe your project, referencing the questions to the right – we expect that your project design was informed by a root cause analysis. We also encourage seeking feedback from patients about the proposal. | **Questions to Consider:**<br><br>How did your root cause analysis influence your project?<br><br>How were patients involved in the project selection and design process?<br><br>How will you engage senior leaders in this work? |

| | |
|---|---|
| **9. Measurement Plan**<br>(Please briefly describe the metrics–process and outcome–that you will use to evaluate your project, referencing the questions to the right.): | **Questions to Consider:**<br><br>Are your metrics objective, specific, measurable, and relevant to the goals?<br><br>Can metrics be tracked according to race, ethnicity, or language if needed?<br><br>Do you have baseline measurements now or do you need to build a reporting mechanism? |
| **10. Patient Engagement Strategy**<br>(Please briefly describe how you engaged patients in the project design and how you will collect feedback throughout the project, referencing the questions to the right.): | **Questions to Consider:**<br><br>How will you engage new patients (beyond existing advisory boards)?<br><br>How will you ensure equitable access for patients to engage?<br><br>What will engagement look like? |
| **11. Proposed Budget**<br>(Please briefly describe your budget request up to $50,000, including how you plan to allocate funding, referencing the parameters to the right. You may attach a separate budget in Excel if preferred.): | **Parameters to Consider:**<br><br>Budgets should be broken into categories such as: patient engagement stipends, staff time, materials, training, travel, etc., with a short justification for each category. We are looking to have an understanding of how the funding will be spent but are not expecting a federal-style grant budget. |

# Appendix B: Quarterly Report Template

**CHPW-CHNW 2023 Apple Health Pay for Performance (P4P) Program: Equity Learning Collaborative Quarterly Report**

| | |
|---|---|
| **Community Health Center:** Choose your CHC | |
| **Quarter:** Choose a quarter | |
| **Project Title**: | |
| **Project Goal** (specific and measurable): | |
| **Data Collected** (Please provide updated data on your identified metrics, referencing the questions to the right.): | **Questions to Consider:**<br><br>What are you learning from this data so far?<br><br>Have you had to make any adjustments to the metrics or methods used to collect this data? |
| **Project Update** (Please give a brief update on your project, referencing the questions to the right.): | **Questions to Consider:**<br><br>What key implementation milestones have you met during this quarter?<br><br>What adjustments (if any) have you made in response to data or patient feedback?<br><br>What, if anything, has surprised you during this quarter? |

## APPENDIX B: QUARTERLY REPORT TEMPLATE

| | |
|---|---|
| **Barriers Experienced and Overcome**<br>(Please briefly describe any barriers you've experienced this quarter and how you've addressed them, referencing the questions to the right.): | **Questions to Consider:**<br><br>What challenges have you experienced?<br><br>How have you overcome/ minimized these challenges?<br><br>What support can CHPW provide?<br><br>What, if any, support is needed from HCA (other agencies)? |
| **Q4 Only: Lessons Learned**<br>(Please briefly describe the outcomes of your project and any lessons learned, referencing the questions to the right.): | **Questions to Consider:**<br><br>What were the central outcomes of your project?<br><br>Did you achieve your goal?<br><br>What have you learned through this process?<br><br>Is there anything you would do differently? |
| **Q4 Only: Organizational Capacity Update**<br>(Please give a brief update on how your organization is progressing on its equity journey, referencing the questions to the right.): | **Questions to Consider:**<br><br>Has your organization:<br><br>-made any changes to how REaL/SOGI data is collected and used?<br><br>-identified new ways to solicit feedback from patients?<br><br>-conducted equity training initiatives for staff?<br><br>-explored new community partnerships? |
| **Q4 Only: What feedback do you have for CHPW about this program? What would you like us to consider for 2024 and beyond? How can CHPW best support advancing equity within CHCs?** | |

# Appendix C: CHC Project Overview and Key Outcomes

## CHAS Health

With more than 30 years of experience, CHAS Health serves 120,589 patients in the Inland Northwest and is supported by 1,870 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Behavioral Health Condition Management** | CHAS recognized that while less than 20% of their patients were experiencing homelessness, these patients make up more than 40% of claims for inpatient psychiatric care, highlighting the need for enhanced behavioral health support for this population. The project's goal was to enhance care coordination services to ensure their patients have access to the care and resources needed to live a healthy life. | ▪ Reduced discrepancies in psychiatric care claims between patients who were housed vs. unhoused by 17%<br>▪ Hired and trained new post-care and behavioral health coordinators<br>▪ Engaged with patients to gain their perspectives, hear their experiences, and ensure they are involved in future programs and interventions<br>▪ Met with other behavioral health networks and local hospitals to enhance coordination |
| **Year 2 (2022)** | **Clinical Care** | CHAS' Year 2 project goal was to address health concerns related to controlling high blood pressure for all of its patients, especially patient groups with the starkest disparities such as Black and African American patients, by engaging those communities to co-develop, test, and evaluate solutions. | ▪ Completed three focus groups to better engage with the community and gain insights into what interventions and efforts would be most impactful<br>▪ Attended community events to speak about the hypertension project, gain insight into potential root causes and interventions, and provide awareness of the project<br>▪ Paired their work with staff training |
| **Year 3 (2023)** | **Engaging Patients and Reducing Disparities** | CHAS' Year 3 project goal sought to reduce health disparities that exist between CHAS' Marshallese patients and their general patient population in key maternal health, cancer screening, and pediatric measures. They worked with the Marshallese community at every stage of the project and leveraged Community Health Workers (CHWs) to ensure project design and implementation was community informed/driven. | ▪ Achieved goal of identifying and beginning to test patient-driven solutions identified by the Marshallese community to help close health inequities<br>▪ Increased engagement, relationship building and trust from both patients and providers<br>▪ Highlighted the importance of CHWs in patient care Facilitated cooking classes with culturally appropriate foods at a local food bank<br>▪ Increased organization-wide focus on the need to address inequities |

# Community Health Care

With 53 years of experience, Community Health Care serves 46,922 patients in and around Pierce County and is supported by 495 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Chronic Condition Management** | Hypertension-related inequities were exacerbated as a result of the COVID-19 pandemic, so Community Health Care's goal for Year 1 of their project was to improve access to at-home blood pressure monitors and ultimately improve the organization's overall performance in the hypertension measure. | ▪ Enhanced workflow to ensure patients have blood pressure readings completed and documented more regularly<br>▪ Distributed blood pressure cuffs to patients and taught patients how to use them<br>▪ Garnered staff support and buy-in to prioritize hypertension efforts<br>▪ More than 9% improvement in the organization's hypertension control measure |
| **Year 2 (2022)** | **Clinical Care** | Eye screening performance for individuals with diabetes declined, partially as a result of the COVID-19 pandemic. That decline, in addition to patient feedback on the importance of prioritizing diabetes, inspired Community Health Care to prioritize eye screenings as their project focus for Year 2. Their goal was to improve the organization's overall performance in the diabetic eye screening measure. | ▪ Ordered in-house eye screeners<br>▪ Improved clinic workflows to couple diabetic and other screenings/care together<br>▪ Hired a Patient Resource Coordinator to implement compassionate care training for all staff and solicit patient feedback<br>▪ Hired additional CHWs to better support community |
| **Year 3 (2023)** | **Internal DEI** | Due to an increase in behavioral incidents between staff and patients in 2022, Community Health Care staff and leaders determined that there was a need for a dedicated staff member committed to improving patient-staff relationships. Community Health Care's project goal was to reduce Behavioral Incident Reports by 20% in Year 3 across two interventions: compassionate care training and creating a patient feedback committee. | ▪ Achieved a significant decline in behavioral incident reports<br>▪ Created new, more user-friendly training materials for front desk staff<br>▪ Developed new resources to support clinic staff in connecting patients to local Community Based Organizations (CBOs) to help address identified needs<br>▪ Implemented the IHI's Joy at Work Framework[9], to ensure staff were joyful, engaged, and felt their work was meaningful |

9 Perlo, J., Balik, B., Swensen, S., Kabcenell, A., Landsman, J., & Feeley, D. (2017). IHI framework for improving joy in work. Institute for Healthcare Improvement. Retrieved from https://www.ihi.org/resources/white-papers/ihi-framework-improving-joy-work

# Community Health of Central Washington (CHCW)

With 31 years of experience, CHCW serves 27,671 patients in and around Kittitas and Yakima County and is supported by 359 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 2 (2022)** | **Member Experience** | CHCW wanted to ensure patients were receiving timely access to care in their preferred method of communication and were hoping to remove as many barriers to that care as possible. The primary Year 2 project goal was to improve utilization and access to video interpreter services. CHCW surveyed patients to gain feedback on their experience before and after use of video interpretation. | ▪ Deployed more interpretation technology and equipment to all sites and trained staff to ensure appropriate use of equipment to promote the utilization of interpretive services within all clinics<br>▪ Saw a significant increase in use of interpretive services, especially video remote interpretive services<br>▪ Included questions in patient survey to evaluate patient satisfaction and experience with video interpretation services. Overall, there was an 87.1% satisfaction rate and 94.3% of patients stated that they received services when needed. |

# HealthPoint

With 53 years of experience, HealthPoint serves 82,570 patients in and around King County and is supported by 1,288 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | HealthPoint's goal for Year 1 was to improve postpartum visits for Pacific Islander patients in south King County by building stronger, more equitable relationships. They focused on developing systems co-designed with the Pacific Islander community that would build trust and respect between HealthPoint and the Pacific Islander Community and create a sustained system and relationship to address other inequities experienced by the community. | ▪ Engaged in two listening sessions with the community<br>▪ Learned that there is a need to:<br>  ▪ build relationships with the community<br>  ▪ build internal systems that support health equity<br>  ▪ invest in understanding and measuring inequities data<br>▪ Supported the Pacific Islander Community during weekly food drives by providing two volunteers at each event to offer education, support and connections to other resources<br>▪ Created a Health Equity Advisory Council (HEAC) to provide recommendations to the organization on how to improve health equity data collection and address other equity issues in the communities they serve<br>▪ Trained five Marshallese community members as Community Health Workers and graduated three by the end of Year 1 |
| **Year 2 (2022)** | **Foundational Equity** | HealthPoint's goal for Year 2 was to have at least four HealthPoint health centers conduct their own root cause analysis and complete a Plan, Do, Study, Act cycle to understand or address a health equity issue specific to their clinic. The goal was to empower individual HealthPoint clinics to implement interventions that use an equity lens to improve health outcomes for the patients at their clinic who fall below average in one of HealthPoint's priority quality metrics. | ▪ Created specific projects across 10 HealthPoint sites to reduce inequities in their patient population<br>▪ Populations included: African American, Hindi, Hispanic, Native Hawaiian, Nepali, and Other Pacific Islanders (NHOPI), Punjabi, and Somali communities<br>▪ Inequities included: diabetes, hypertension, and vaccinations<br>▪ Enhanced collection of Race, Ethnicity, and Language (REaL) and Sexual Orientation and Gender Identity (SOGI) data<br>▪ Worked with the Health Equity Advisory Council to support these projects<br>▪ Learned the importance of integrating patient voice<br>▪ Improved use of focus groups as a mechanism to solicit patient feedback, provide enhanced support, and build trust<br>▪ Following feedback from focus groups and surveys that patients would appreciate more translated materials, HealthPoint invested in more translated signage throughout the building |

## HealthPoint *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Engaging Patients and Reducing Disparities** | HealthPoint's Year 3 goal was to increase and support health equity across all HealthPoint sites by incorporating patient voice into decision-making processes on health equity interventions and program development, and to be more authentic and intentional about engaging with the community so that it didn't feel performative.<br><br>Learned from Year 2 that health equity work takes time to do well and that unexpected barriers will inevitably arise. It is critical to involve patients in the process. | ▪ Made health equity a priority at all sites: Each site chose a unique health inequities reduction project with a different plan and outcome<br>▪ Expanded the Health Equity Advisory Council: The HEAC added two new members who would provide different perspectives to enhance representation and the diversity of council members with various roles and lived experiences<br>▪ Worked with a third-party recruitment firm to hire for a health equity leadership role starting in 2024 with a focus on guiding the team as it works towards health equity goals and creating new programming.<br>▪ Purchased Institute of Health Improvement (IHI) Open School subscription that provides staff access to health equity education topics and tools<br>▪ Offered trauma-informed care training for staff through HealthPoint's educational programs, integrating it into learning plans, provider meetings, and the internal HealthPoint University platform |

# International Community Health Services (ICHS)

With 50 years of experience, ICHS serves 30,612 patients in and around King county and is supported by 472 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Behavioral Health Condition Management** | ICHS focused on equitable depression and other chronic condition management. Their goal for Year 1 was to achieve a 20% increase in the success rate for the antidepressant medication management quality measure. ICHS Population Health Coordinators (PHCs) and/or Behavior Health Specialists (BHSs) planned to review the electronic health record (EHR) as well as the list from health plans to identify patients for outreach. During the outreach, PHCs planned to identify barriers to medication adherence. Pharmacists played a critical role in improving medication adherence by conducting patient outreach, providing consultations, and following up with patients after their initial prescription pickup. | ▪ Developed enhanced pathways and collaborations across departments (pharmacy, behavioral health, primary care, quality, etc.)<br>▪ Increased communications between behavioral health and pharmacy to increase referrals<br>▪ Improved workflows and hand-offs to ensure process was more efficient. Through this, learned that improving workflows takes time to do well.<br>▪ Increased Antidepressant Medication Management rate for continuing patients (11% to 52%) and acute (to 67%) |
| **Year 2 (2022)** | **Clinical Care** | The goal of ICHS' Year 2 project was to increase medication adherence for patients who receive an initial diagnosis of depression and were prescribed antidepressants by 10%.<br><br>They built upon Year 1's learnings and successes and worked to fill vacant behavioral health positions and add an additional clinical pharmacist to the team. | ▪ Increased Antidepressant Medication Management Continuous rate to 48%, exceeding their goal of 46%<br>▪ Solicited feedback from patients through the Patient Advisory council<br>▪ Enhanced equity training for all staff |

# Moses Lake Community Health Center (MLCHC)

With 47 years of experience, MLCHC serves 31,350 patients in and around Grant county and is supported by 297 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Pregnancy Care** | The goal of MLCHC's Year 1 project was to increase the timeliness of postpartum visits. After reviewing data they found that only 43.6% of women had a postpartum visit between days 7 and 84 after giving birth. That rate dropped to 22% for women whose language preferences were something other than English. | ▪ Increased the number of patients completing a postpartum visit from 43.6% to 66.02%<br>▪ Increased postpartum visit rate completion for women whose preferred language was something other than English from 22% to 70%<br>▪ Provided motivational interviewing training to all OB staff<br>▪ Developed a curriculum for the OB Care team about patient center communications<br>▪ Learned about the importance of enhancing workflows and creating seamless transitions within clinic |
| **Year 2 (2022)** | **Member Experience** | Building off Year 1 efforts, MLCHC set goals for Year 2 to better engage with the community to learn what they wanted/needed to enhance their experience, better utilize the OB Case Manager, and:<br>▪ Increase the number of pregnant patients choosing MLCHC providers from the current average caseload of 250 up to 300.<br>▪ Increase the percentage of patients with a postpartum visit from 67.97% to more than 75% | ▪ Conducted a patient journey map with staff and patients to better understand the workflow and handoffs between staff and providers once an OB patient enters the clinic to identify areas to improve<br>▪ Gathered patient feedback on the patient journey map<br>▪ Improved flow of transitions between appointments and handoffs among staff<br>▪ Saw an increase in deliveries for the first time in 27 months<br>▪ Worked with Cyrca Strategy, a third-party consulting agency, to conduct roughly 25 in-depth phone interviews with pregnant people to better understand their perspective and decision making, highlighting the need to slow down and listen to patients. This led to plans to conduct focus groups with the help of Cyrca Strategy in Year 3 |

# Moses Lake Community Health Center *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Maternal Health** | MLCHC's goal for Year 3 was to focus on maternal health. They planned to conduct focus group sessions to help co-design the MLCHC Obstetrics Service line and assist with branding and marketing materials and prioritized seeking out a diverse group of individuals, including holding focus groups in English and Spanish. | ▪ Created a rough draft of the patient care journey<br>▪ Developed a plan to co-locate services and move offices and working spaces to make it easier for patients to access necessary services in one location<br>▪ Made major progress in discussing new care team model with direct supervisors and impacted staff to prepare for rolling out new workflows in 2024 to enhance care coordination and better support staff and patients<br>▪ Wrote policies and procedures that will allow MLCHC to better connect their Maternity Support Program and OB clinic |

# Neighborcare Health

With 56 years of experience, Neighborcare serves 58,838 patients in and around King County, supported by 575 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Pregnancy Care** | Neighborcare's goal for their Year 1 project was to develop a survey to gather feedback from Black, Indigenous, and People of Color (BIPOC) and undocumented Hispanic and English-speaking postpartum patients to identify the top two barriers they faced in receiving postpartum care. | ▪ Recruited and surveyed patients from many different demographic groups through a combination of in-person and phone calls<br>▪ Explored options for engaging those who weren't currently in the system but may have been pregnant or postpartum<br>▪ Found through data analysis that 2.44% of patients surveyed were not able to get an interpreter and 27.27% of patients had trouble accessing transportation. Moving forward, they decided to prioritize closing those gaps in care. |
| **Year 2 (2022)** | **Member Experience** | Neighborcare's project for Year 2 aimed to combine newborn and postpartum visits in at least one clinic location. The goal was to have at least 20 postpartum/newborn couplets do a combined visit by the end of the year. | **Project outcomes:**<br>▪ Saw 24 postpartum/newborn couplets<br>▪ Increased postpartum visit rate by 10% (69% to 79%)<br>▪ Received feedback from patients asking to have midwives or CHWs from communities from the population served<br>**Other equity-centered actions that were taken:**<br>▪ Designed and launched SOGI-LGBTQIA+ Micro-Learning with 75% of Neighborcare Health staff<br>▪ Expanded data collection and reporting process for race, ethnicity, disability, and housing status<br>▪ Created DEI session for staff onboarding which launched 2023<br>▪ Program leaders completed a three-day Undoing Institutional Racism workshop<br>▪ Transitioned to centralized, dedicated patient outreach services using population health and panel management to ensure they are using one standardized, centralized approach to patient outreach |

# Neighborcare Health *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Maternal Health** | The goal for Neighborcare's Year 3 project was to implement a quality improvement recommendation based on patient feedback and data analysis. They built systems and procedures to better support their patients' requests for congruent/consistent practice protocols, co-management, and consultation guidelines. Those new systems will expand and align their midwifery practice protocols, specific to providing care for BIPOC patients practice protocols, specific to providing care for BIPOC patients. | ▪ Learned that they needed to pivot their focus and funding towards internal DEI training before rolling our new protocols<br>▪ At least 10 providers completed the pilot DEI/Anti-racism workshops. They gathered feedback about partners' experiences and learnings from these trainings<br>▪ Completed five practice guideline/protocol revisions with a DEI lens (Gestational diabetes insulin management, Hyperemesis, 1-year postpartum, postpartum mood disorders, and Body Mass Index) |

# Sea Mar Community Health Centers

With more than 45 years of experience, Sea Mar serves 224,180 patients in and around Clallam, Clark, Cowlitz, Franklin, Grays Harbor, Island, King, Pierce, Skagit, Snohomish, Thurston and Whatcom counties and is supported by 1,950 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Chronic Condition Management** | Sea Mar's Year 1 project sought to reduce inequities in diabetes care. They planned to improve:<br>▪ Diabetes retinal eye exam rates for their American Indian and Alaska Native (AIAN) patients<br>▪ Foot exam rates for other Pacific Islander patients<br>▪ Diabetes blood pressure control for Black/African American patients<br>▪ Diabetes A1C poor control for Spanish-speaking and other Pacific Islander patients.<br>They also sought to improve access to care by increasing the number of patients creating a MyChart account. | ▪ Held focus group with patients who are Pacific Islander and have diabetes to learn more about the community and how to better support them<br>▪ Launched a text campaign to increase MyChart activation rates with a specific focus on their primary population of Spanish-speaking patients. Those patients also had the largest diabetes-related inequities of any demographic group<br>▪ Increased the number of patients activating on MyChart although targeted rates did not increase because of the influx of non-Sea Mar patients coming in for COVID vaccinations and boosters |
| **Year 2 (2022)** | **Social Drivers of Health (SDOH)** | Sea Mar's goal for Year 2 was to identify the root causes for lack of collection and documentation of SDOH data in Sea Mar's EHR. Additionally, they planned to do research and collect information to help them develop a process to standardize the collection and documentation of SDOH data. | ▪ Identified a significant need for more support related to food insecurity, which was the focus of their project in 2023<br>▪ Adjusted SDOH-question phrasing to be more culturally sensitive and person centered<br>▪ Collected patient feedback and took a thoughtful approach for how to collect sensitive SDOH data so that everyone feels comfortable<br>▪ Held monthly equity training initiatives with staff<br>▪ Trained staff on how to use/input SDOH ICD10 codes to improve EHR records and their ability to track needs and make referrals |

# Sea Mar Community Health Centers *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **SDOH Data Collection** | Sea Mar wanted to support their patients experiencing food insecurity. The goal for their Year 3 project was to focus on improving their current process of data analysis within Epic, their EHR system, and connecting the data to the SDOH wheel in Epic. The SDOH wheel is a tool which allows Sea Mar staff to collect SDOH data and then visually depict patient needs and available resources. It allows Sea Mar departments to see whether a patient is experiencing food insecurity and informs the department to reach out and support patients in getting the resources they need, such as connecting them to food pantries, etc. | ▪ They learned that the majority of patients being screened for food insecurity are screening positive, and that the need for food access is growing statewide. They also learned there is a need for increasing the consistency of data collection across more departments and staff at their clinics, as well as a reassessment of the status of a patient's food insecurity at least every six months to capture any significant life changes that may affect access to food.<br>▪ Expanded perishable food pantries and purchased fridges at several clinics to accompany non-perishable food pantries, placing pantries in clinic lobbies to make them more accessible for patients. Partnered with the community to ensure the inclusion of culturally relevant food<br>▪ Paired patient education with food access resources provided by health education and nutrition staff. They found that about 42% of the patients experiencing food insecurity had a diabetes diagnosis. Health Educators and/or Registered Dietitians met with patients to provide education and food access resources (such as grocery gift cards, participating in a produce prescription program, accessing onsite food pantry, etc.) to manage their health condition and prevent further complications<br>▪ Partnered with community, clinic administration, and staff to better integrate workflows to collect SDOH and food insecurity information, as well as improve referral workflows |

# Seattle Roots Community Health

***(formerly Country Doctor Community Health Center)***

With 54 years of experience, Seattle Roots Community Health (SRCH) serves 16,593 patients in and around King County and is supported by their 180 (FTE) dedicated staff. One of their clinics, the Carolyn Downs Family Medical Center, was founded in 1970 and is one of the 13 original Black Panther Party-founded health care clinics across the country. Carolyn Downs is the only one of those clinics still in operation.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Behavioral Health Condition Management** | SRCH's depression screening practices were inconsistent and not inclusive of all patients. The goal of their Year 1 project was to reduce the chance of inequitable care by removing the option of screening based on bias. Instead, they screen all patients. They recognized the need for improved depression screening as a result of a low screening rate (20.7%) and as a preventative measure for increased depression and risk of suicide, especially during the COVID-19 pandemic. | ▪ Implemented a new depression screening workflow<br>▪ Solicited feedback from patients who appreciated the revamp as well as the emphasis on universal screening. Several patients felt the new workflow made greater sense.<br>▪ Translated PHQ-9 depression screener into other languages spoken by patients<br>▪ Saw an increase in the team's depression follow-up rate to more than 60% |
| **Year 2 (2022)** | **Foundational Equity** | SRCH's Year 2 project focused on mandatory DEI training for all staff to foster an environment of learning, inclusion, and belonging. Specific goals for this year were on training staff on the collection of Social Drivers of Health (SDOH); Sexual Orientation & Gender Identity (SOGI); Screening, Brief Intervention, and Referral to Treatment (SBIRT) data; and other personal information that impacts health. Additional goals centered around ensuring all data collection and services were trauma-informed and destigmatizing. Another goal for the year was to develop a DEI council to help support and drive forward all of those efforts. | ▪ Communicated to all staff the importance of SOGI, REaL and income data collection to help them identify and understand where and for whom inequities exist<br>▪ Partnered with Utopia, a community-based organization focused on creating safe, welcoming and supportive spaces for LGBTQIA+ people of color, leading organization-wide meetings and developing training resources for their Gender Care program<br>▪ Built unity celebrating commonalities and differences with an all-staff meeting hosted by the DEI council. DEI facilitator helped create a safe space for dialogue and growth |

# Seattle Roots Community Health *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **SDOH Data Collection** | SRCH's Year 3 goal was to develop DEI ambassadors within clinics, continue to enhance DEI training for staff, and create an extensive training series for supervisors and managers. They wanted to ensure DEI work positively impacted encounters with patients and community. | ▪ Developed and implemented a DEI Council despite challenges with team participation and convening all-team conversations<br>▪ Enhanced SDOH data collection (e.g., transportation resources, virtual care, and incentives for visits) resulted in initial improvements to re-engage patients in care |

# Unity Care Northwest (UCNW)

With more than 41 years of experience, UCNW serves 24,748 patients in and around Whatcom county, and is supported by 313 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | UCNW's goal for Year 1 was to improve interpretation services for patients whose primary language was not English. Through a root cause analysis, they identified that visit duration was too short when using interpretation services and that telephone interpreter services hindered clinic staff's ability to implement their typical clinic processes. Their goals were: 1) to provide video translation services to 50% (100 per month) of UCNW's non-English speaking patients and 2) to reduce the third next available appointment for non-English speaking patients by 25%. The third next available appointment measure gauges how long it takes patients to access providers when they want to schedule an appointment. | ▪ Reduced restrictions regarding how many interpreter appointments providers could schedule, resulting in a reduction in concerns from patients and staff related to accessing interpreter services<br>▪ Conducted a staff and patient satisfaction survey<br>▪ Launched a pilot video program in Q4 before rolling out to all departments |
| **Year 2 (2022)** | **Social Drivers of Health (SDOH)** | For Year 2 , UCNW was focused on better supporting their patients experiencing homelessness. In 2022, they served approximately 21,000 people of all ages; more than 3,000 of those individuals (roughly 15%) were experiencing homelessness. Their patient population was primarily low-income, with 55% of patients living at less than 100% of the Federal Poverty Level (FPL) and 87% living at less than 200% of FPL. The goal for their project was to create The Way Station, a one-stop-shop to address the health and hygiene needs of individuals experiencing homelessness. They envisioned that The Way Station would be co-located with a variety of services providing recuperative respite care, case management, stable housing resources, and other public health services. The goal of the Way Station is to reduce rates of infection, increase hygiene and sanitation, connect individuals to necessary services and provide a safe space for patients to recuperate after traumatic experiences or medical procedures. | ▪ Provided virtual health equity trainings to staff to enhance DEI knowledge<br>▪ Outlined a plan and timeline for construction of The Way Station<br>▪ Worked to recruit a manager for The Way Station<br>▪ Held a panel with the community to introduce The Way Station and get feedback<br>▪ Provided support and training to neighbors of The Way Station<br>▪ Hired a diversity, equity, and inclusion (DEI) and anti-racism consultant to conduct surveys with staff to identify what additional training and tools were needed to achieve their DEI goals |

# Unity Care Northwest *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Engaging Patients and Reducing Disparities** | In Year 3, UCNW continued their work on The Way Station with the goal of starting the construction and community-building phase to prepare for opening the site. | ▪ Broke ground on The Way Station in August 2023<br>▪ Continued to build out the list of potential services, hours, and staffing needs<br>▪ Met with collaborative partners bi-weekly to plan and prepare for opening of The Way Station<br>▪ Held "Barriers & Opportunities for Housing Access," a community convening for providers to offer diverse perspectives regarding the barriers and limitations their clients face in accessing housing<br>▪ Staff attended the framing walk-through at The Way Station site and completed 10 hours of training on Way Station operations<br>▪ Received a 3-year, $1.5 million US Department of Housing and Urban Development grant to support the operation of the site's health & hygiene components |

# Yakima Neighborhood Health Services (YNHS)

With more than 49 years of experience, YNHS serves 20,963 patients in and around Yakima county, supported by their 303 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Behavioral Health Condition Management** | In reviewing the data on utilization by CHPW homeless patients, YNHS found that 224 were screened for depression using the PHQ-9 tool in 2020. Of these, 121 (54%) screened positive and 69 of the 121 (57%) were returning for follow-up care within 30 days of a positive depression screen finding ≥5. This means 43% were failing to receive follow-up within 30 days. The goal for their Year 1 project was to improve the follow-up rate among this population to 72%. | ▪ Enhanced and improved use of Community Health Workers (CHWs) to build trust with community and patients<br>▪ CHWs completed digital literacy questionnaires with patients to determine their skill and comfort level with technology and provided individualized education and support<br>▪ YNHS staff connected patients with phones when needed to ensure staff were able to reach patients and that technology/access to a cell phone wasn't a barrier to their health<br>▪ CHWs facilitated telehealth appointments between patients and providers to follow up on depression screenings |
| **Year 2 (2022)** | **Clinical Care** | YNHS continued their work from Year 1 engaging with their patients experiencing homelessness. The goal for their Year 2 project was to have CHWs plan to continue providing instructions in English and Spanish on how to access the patient portal (to schedule appointments, request refills, view test results, etc.), and participate in telehealth visits to reduce barriers. Worked to build trust and refine the method for identifying patients with a positive PHQ-9 screening needing follow up. | ▪ Reduced the number of patients not receiving follow-up after positive PHQ-9 screening<br>▪ Adjusted schedules and workflows to follow up with patients in a timely manner<br>▪ YNHS quality staff transitioned to weekly reports (rather than monthly) to capture adolescents and adults with a positive depression screening and ensure they follow up promptly |
| **Year 3 (2023)** | **Engaging Patients and Reducing Disparities** | YNHS began a new project for Year 3. The goal was to increase the number of women screened for cervical cancer by addressing non-health related barriers to screening. | ▪ Data demonstrated that phone contacts with patients to schedule cervical cancer screening (CCS) and assist with removing barriers leads to higher rates of screening<br>▪ Improved workflows to ensure processes were efficient and effective and that more women were screened for cervical cancers and barriers to care were reduced<br>▪ Quality and Population Health Specialists contacted eligible patients to schedule CCSs and help reduce transportation and childcare barriers |

# Yakima Valley Farm Workers Clinic (YVFWC)

With more than 49 years of experience, YVFWC serves 194,947 patients in and around Benton, Franklin, Spokane, Walla Walla, Whitman, and Yakima counties, and is supported by their 1,676 (FTE) dedicated staff. They specialize in care for migrant and seasonal farmworkers and their families.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | YVFWC's goal for their Year 1 project was to increase patient engagement and access to school-based telehealth services. They coordinated with elementary and secondary schools to implement team-based care coordination. | ▪ Hired a full-time coordinator to coordinate between clinic and schools<br>▪ Hosted school vaccination days to improve access and build engagement, trust, and connections among students, families, schools, and doctors<br>▪ Developed new workflows for in-person and telehealth visits that improved staff coordination and access to visits and referrals. They also enhanced pharmacy workflows and use of new technology and equipment. YVFWC's changes received extremely positive feedback from patients.<br>▪ Identified a growing need for behavioral health services and worked to enhance the community's access to those services |

**The following CHCs have chosen to be de-identified and will be referred to as "CHC A, B, C, D, E and F."**

# CHC A

With 38 years of experience, CHC A serves 14,690 patients and is supported by 233 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | CHC A leveraged their business intelligence capabilities to identify health inequities and incorporate health equity awareness across all of its core programs and functions, including organization, leadership, and decision-making. The goal for their Year 1 project was to fund additional community health workers (CHWs) to increase meaningful community engagement and improve data disaggregation to be better equipped to identify inequities. Their underlying goal was to create awareness and understanding of health equity by intentionally infusing equity into all language and communication across the organization. | ▪ Hired more than 10 CHWs<br>▪ Built columns into their data analysis dashboards with disaggregated demographic data reporting to improve inequities tracking<br>▪ Prioritized patient engagement to inform all current and future efforts<br>▪ Invested in culturally relevant services, such as naturopathic primary care<br>▪ Leveraged outreach efforts beyond traditional marketing and promotion activities to ensure they were truly engaging with the communities they serve |

## CHC A *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 2 (2022)** | **Member Experience** | CHC A's goal for Year 2 was to improve access to quality obstetric (OB) services for those living far from pregnancy care resources such as increasing Spanish speaking education and OB coordination. CHC A used funds to build out a system for scheduling, referring, and consistently educating pregnant people to achieve a high-quality pregnancy experience. Specific goals included:<br>**Goal 1:** Increase the number of pregnant people receiving their prenatal visit (before 13 weeks gestation) at CHC A by more than 2%.<br>**Goal 2:** Increase the number of pregnant people seeking postpartum care after 6 weeks<br>**Goal 3:** Establish processes and begin tracking the number of internal and external referrals for pregnancy-related care with clear guidelines to follow up for any referrals<br>**Goal 4:** Explore feasibility of in-clinic support and education for pregnant people to be available at CHC A and their surrounding county. | ▪ Hired a Women's Health Coordinator who completed more than 200 referrals for pregnancy-related care<br>▪ Developed and prepared to launch an OB ultrasound program<br>▪ Standardized OB workflow across all six clinics<br>▪ Built a relationship with the Women, Infants, and Children (WIC) Nutrition program via the Women's Health Coordinator<br>▪ Provided childbirth education classes in English and Spanish<br>▪ Reviewed the prenatal and postpartum care gap list<br>▪ Trained clinic staff on use of Azara platform to enhance data collection and reporting |
| **Year 3 (2023)** | **Maternal Health** | CHC A built on the previous year's successes, setting the following goals for their Year 3 project:<br>**Goal 1:** Offer patient OB services nearer to where patients live via staff training and equipment purchases<br>**Goal 2:** Decrease financial and logistical barriers related to obtaining home screening equipment (e.g., thermometers, nasal aspirators, etc.) for infant health and wellness<br>**Goal 3:** Continue to fund a clinical director focused on perinatal and women's health<br>**Goal 4:** Offer patients an appropriate level of diabetes education from trained RNs during provider co-visits | ▪ Provided non-stress test (NST) machines in clinics and trained clinicians and staff on their use<br>▪ Ordered home screening equipment and prepared to disburse equipment to patients by end of year<br>▪ Completed ultrasound training for all providers<br>▪ Funded women's health clinical director<br>▪ Completed the Association of Diabetes Care and Education Specialists (ADCES) course for diabetes for all RNs and CHWs, using standardized handouts available on CHC A's shared drive for all clinicians and patients |

# CHC B

With 46 years of experience, CHC B serves 15,366 patients and is supported by their 170 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 2 (2022)** | **Social Drivers of Health (SDOH)** | CHC B's goals for Year 1 were to: improve patient data collection for SDOH from 21.06% to 40%; increase the patient full registration rate from 32% to 40%; and increase the patient portal adoption rate from 40% to 48%. | ▪ Held two focus groups with diverse sets of patients to ask questions related to their health, experiences with CHC B, timeliness and quality of service, access, communication, portal utilization, etc.<br>▪ Patient full registration rate increased to 41%, meaning that a higher percentage of patients were fully registered in the EHR, allowing them to add more demographic and SDOH-related information<br>▪ Increased patient portal adoption rate to 41%, reflected in more patients using the online portal to access their care team and health information<br>▪ Patients answering the question regarding "Concerns about meeting basic needs: food, housing, heat, etc.", increased from 21.06% to 27.3% with 1% stating concerns as of November 30, 2022<br>▪ Patients answering the question regarding "Transportation Difficulties" increased to 63%, a 13% increase from Q3 reporting, with 4% of patients stating they encountered transportation difficulties |
| **Year 3 (2023)** | **SDOH Data Collection** | CHC B's project goal for Year 3 was to hire a full-time Patient Navigator who could assist at least 20 patients per week and decrease the percentage of patients stopping at the SDOH questions in pre-appointment forms from 40% to 35%. | ▪ Hired a full-time Patient Navigator<br>▪ Between August 31, 2023, and December 10, 2023, the Patient Navigator assisted 204 patients<br>▪ Reduced the number of questions asked in the SDOH section of the pre-appointment form and changed the order of questions, resulting in a steady decrease in patients stopping at the SDOH questions – from 40% to 1.7% |

# CHC C

With 44 years of experience, CHC C serves 12,031 patients and is supported by their 126 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 2 (2022)** | **Foundational Equity** | CHC C's goal for their Year 1 project was to provide patient-centered solutions and equitable access to healthcare in a patient's preferred language. They focused on:<br>▪ Increasing their interpretation and translation services<br>▪ Providing unconscious bias training for staff and updating training on interpretation and translation services at CHC C | ▪ Held an all-staff training on unconscious bias<br>▪ A consultant provided a presentation on "Understanding Bias to Unleash Potential," covering topics such as: unconscious/conscious bias, identifying and challenging biases, cultivating connections through empathy and curiosity, and choosing courage<br>▪ Key leadership worked on developing competencies and trainings for staff on new interpretation technology<br>▪ Translated the clinic's most commonly used patient forms |
| **Year 3 (2023)** | **Internal DEI** | The goal for CHC C's Year 2 project was to build on unconscious bias training for staff from the prior year and provide additional training to enhance DEI understanding and practices. A cohort of senior leadership, directors, managers, and supervisors participated in a 12-month academy focused on DEI and integrating learning into practice. Leaders and their teams participated in monthly staff enrichment sessions, small group discussions, and bi-annual, all-staff meetings. | ▪ During Q4, managers successfully completed the "6 Critical Practices for Leading a Team" training by Franklin Covey<br>▪ Established an employee-driven workgroup meant to elevate staff voices and equity through employee-defined areas of need<br>▪ Gained a deepened understanding of the importance of doing internal DEI work before moving forward with addressing health equity for patients |

# CHC D

With 36 years of experience, CHC D serves 40,007 patients and is supported by 317 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | The goal for CHC D's Year 1 project was to improve patient experience during the Medicare Annual Wellness Visit (AWV) and increase the number of Medicare AWVs by approx. 1,000 visits. Baseline numbers for AWVs was 7%. CHC D wanted to increase that number to 32% by the end of 2021.<br><br>Additionally, they worked to improve AWV completion rates for Black or African American, Multiracial, Other Pacific Islanders, and Non-English Speaking patients to be equal to the AWV rate for white and English-speaking patients. | ▪ Significantly increased the number of annual wellness visits and addressed most complaints about experience and billing-related issues<br>▪ Improved the AWV rate across several racial groups. In some instances, the rate of completion was far above white and Non-Hispanic groups<br>▪ Saw a 15 percentage point increase from baseline for AWV rates |
| **Year 2 (2022)** | **Member Experience** | CHC D used lessons learned from Year 1 to enhance their Year 2 project. Their goal was to improve:<br>▪ Patient experience during Medicare AWV<br>▪ The number of Medicare AWV from 25% to 35% by end of 2022 (approximately 500 more visits than 2021)<br>They planned to accomplish their goal by offering alternatives like telehealth or mobile health to people with barriers to accessing care. | ▪ Significantly increased the utilization and completion of AWV for the Medicare patient population<br>▪ Efforts to reach patients, meet their needs, and eliminate barriers to care proved successful in that the racial and ethnic make-up of patients who completed their AWV represent a far more diverse group of people when compared to the overall demographic makeup of CHC D patients |

## CHC D *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Engaging Patients and Reducing Disparities** | CHC D identified a need for legal services within their patient population through SDOH screening data and partnership with outside legal services organizations where patients were referred. The goal for their Year 3 project was to hire a medical-legal partnership (MLP) attorney to represent four legal service areas that were identified based on SDOH screening responses: (1) creation of legal medical documentation; 2) access to public government benefits; 3) vacating, sealing, and expunging juvenile criminal records; and 4) assisting patients with navigating identity markers for transgender individuals. CHC D'S General Counsel planned to supervise the MLP attorney and collaborate with other senior leaders. | ▪ Hired a full-time Medical Legal Partnership attorney<br>▪ Developed the foundations of CHC D's Legal Services program and solicited feedback from entire staff before program launch<br>▪ Integrated a new legal case management software into workflows for easier referrals and tracking<br>▪ The MLP attorney is continuing to research strategies for measuring long-term impact of MLP activities and reviewing SDOH data to better understand needs among the patient population |

# CHC E

With more than 43 years of experience, CHC E serves 34,603 patients and is supported by their 295 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Chronic Condition Management** | CHC E's project goal for Year 1 was to improve blood pressure control by providing self-monitored blood pressure cuffs for patients ages 18-85 with a diagnosis of hypertension and/or uncontrolled blood pressure. They reduced barriers related to accessing blood pressure screening by eliminating the need for patients to come into the clinic for a blood pressure reading. Providing blood pressure cuffs reduced transportation and logistical barriers related to coming into the clinic, since patients could measure and track their blood pressure at home. | ▪ Procured blood pressure cuffs and storage cabinets<br>▪ Identified and developed a patient education program<br>▪ Created a staff education and implementation process for distributing home blood pressure cuffs, training providers and staff on the new program and workflow<br>▪ Enrolled 10 patients in the program using risk stratification to prioritize the initial cohort. Each patient received education and were provided a blood pressure cuff for home BP monitoring<br>▪ Engaged with key stakeholders (i.e. staff, members with high blood pressure) to inform them of future interventions |
| **Year 3 (2023)** | **SDOH Data Collection** | For their Year 3 project, CHC E implemented a standardized process for collecting and analyzing SDOH data. The previous method : 1) was cumbersome; 2) didn't collect all of the relevant data; 3) was not readily accessible or routinely analyzed; and 4) and had low clinic staff buy-in. CHC E recognized the importance of understanding and addressing SDOH to improve the overall health of their patients and wanted to prioritize that for their project. | ▪ Reinforced the importance of asking SDOH questions with clinical staff. With the support of clinic management, imported and maintained the data collection for three target SDOH variables: housing, transportation, and food security<br>▪ Received more than 15,000 responses to its SDOH questionnaire, correlating to an increase in response rate by 14% to approximately 32% of patients with a medical visit in Q4.<br>▪ Adapted existing SDOH workflow based on feedback |

# CHC F

With more than 19 years of experience, CHC F serves 24,739 patients and is supported by their 193 (FTE) dedicated staff.

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 1 (2021)** | **Member Experience** | For CHC F's Year 1 project they implemented a new patient feedback survey tool and employees completed new diversity, equity, and inclusion training. Specifically, the project goals were to address 4 elements that directly impact health equity and its role in patient satisfaction with access to routine care: 1) staff comfort with asking about sensitive topics; 2) employee practical diversity and inclusion skills and implicit bias training; 3) assistance in implementing additional health equity activities and trainings identified through the Culturally and Linguistically Appropriate Services (CLAS) committee efforts; and 4) improving methods for getting patient feedback through a new survey tool. | ▪ All employees attended live video trainings or watched recordings of DEI training sessions<br>▪ Implemented patient survey tool to solicit patient feedback, and received double the amount of reviews as the previous year |
| **Year 2 (2022)** | **Foundational Equity** | The goal for CHC F's Year 2 project was to increase equity in their service delivery through foundational employee DEI training and improve patient feedback, using data and feedback solicited in Year 1. The primary focus of Year 2 was workforce development and building a pipeline to ensure community members were given equitable opportunities for careers in the healthcare workforce and at CHC F. They worked to develop internal promotion pathways for traditionally disadvantaged workers, increasing organizational equity and supporting a fully staffed workforce reflecting the community CHC F serves. | ▪ Provided in-depth, two hour, employee-focused, "Recognizing and Navigating Microaggressions" training. The clinic was closed during training to allow uninterrupted participation. Reviewed pre- and post-training surveys to assess staff knowledge<br>▪ Restructured the equity advisory committee and developed standards for future equity trainings<br>▪ Increased the number of Certified Medical Translators<br>▪ Used a Community Partnership Framework to decide whether to enter into new community partnerships<br>▪ Continuously solicited patient feedback to inform interventions and process/workflow improvements |

## CHC F *continued*

| Program Year | Topic Area | Project Overview | Key Outcomes |
|---|---|---|---|
| **Year 3 (2023)** | **Internal DEI** | The goal for CHC F's Year 3 project was to continue employee DEI training and equity skill development and create a plan to build sustainable organizational health equity capacity. | ▪ 10 bilingual employees completed a medical terminology class to ensure staff are providing proper, consistent medical terminology in any language they use with patients<br>▪ In response to receiving positive feedback from staff, CHC F added medical terminology training to required trainings for Qualified Bilingual Staff<br>▪ Identified some barriers impacting the number of staff completing training including employee buy-in and capacity/time constraints. They worked to address these barriers and improve training participation<br>▪ Used Coordinated Quality Improvement Plan to look at all workflows and care processes through an equity lens |

AHE Advancing Health Equity

Leading care, payment, and systems transformation

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**ABOUT AHE**

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) is a national program supported by the Robert Wood Johnson Foundation and based at the University of Chicago. AHE's mission is to discover best practices for advancing health equity by fostering payment reform and sustainable care models to eliminate health and healthcare inequities.

*The views expressed here do not necessarily reflect the views of the Foundation.*