the DELTA CENTER
for a thriving safety net

Delta Center Phase 1 Evaluation Report (2018-2021)

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Introduction

Started in 2017, the Delta Center for a Thriving Safety Net's mission has been to advance value-based payment and care (VBP/C) in the ambulatory care safety net as means to reach the Quintuple Aim: better care, better health, lower costs, happier staff, and reduced health disparities. The Delta Center took a novel approach to advancing this mission through collaboration with national and state primary care and behavioral health associations (PCAs and BHSAs), which reach thousands of safety net providers.

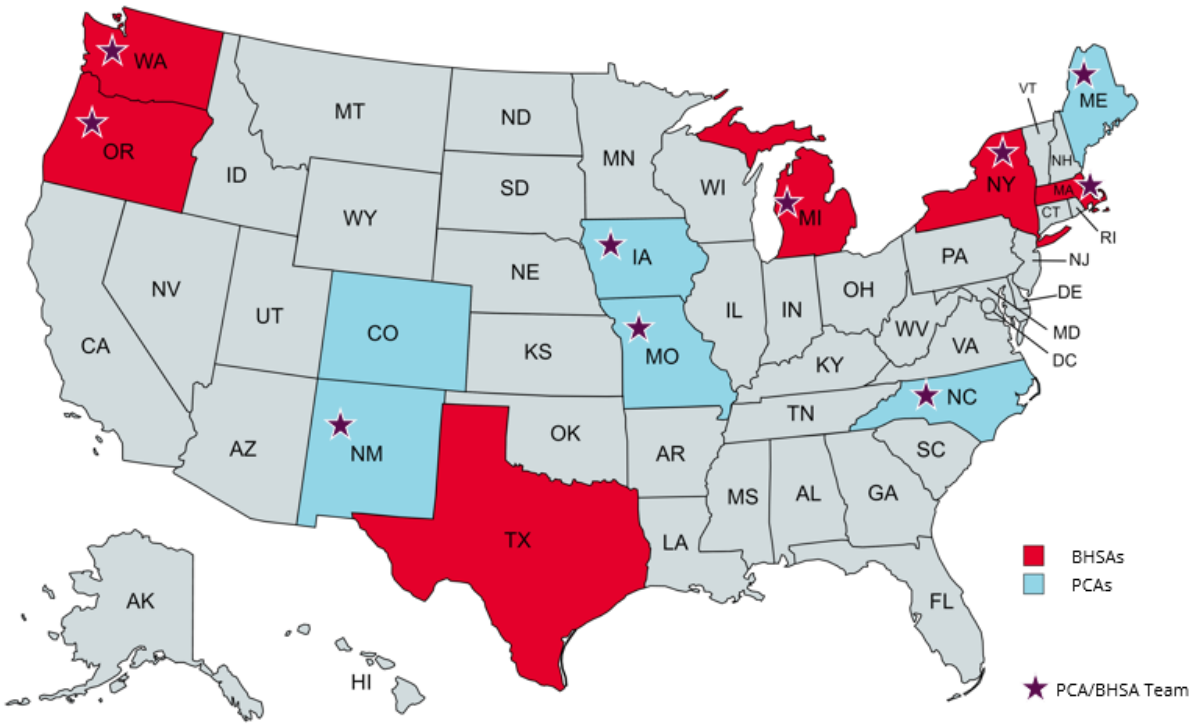
The Delta Center was organized around four key goals that supported associations' efforts in moving towards VBP/C, including:

1. Build the internal capacity of state associations to advance VBP/C
2. Build policy and advocacy capacity to advance VBP/C at a state level
3. Foster collaboration between primary care and behavioral health at the state level
4. Build capacity of state associations to provide education/T/TA to advance VBP/C among members

The Delta Center funded state associations from 12 states s for its first cohort: Colorado, Iowa, Maine, Massachusetts, Michigan, Missouri, New Mexico, New York, North Carolina, Oregon, Texas, and Washington (Exhibit 1). In ten of these states, both the PCA and BHSA participated in the Delta Center State Learning and Action Collaborative.

The PCAs and BHSAs participated in the Delta Center's State Learning and Action Collaborative, which supported their learning and relationship development through monthly coaching sessions, four in-person and two virtual convenings to learn from experts and peers, one site visit, webinars, participation in National Association of Community Health Centers and National Council of Behavioral Health annual conferences, and materials and tools. The program team developed the learning activities and content through co-design with stakeholders and the state associations, and adapted the initiative in response to the COVID-19 pandemic.

Exhibit 1. *Map of Delta Center Phase 1 States*



In this final evaluation report, we describe the progress that state associations have made in achieving Delta Center goals, some of the effects of COVID-19 on Delta Center state association plans and activities, state association staff perspectives on the Delta Center, and recommendations for Phase 2 of the Delta Center, which will include a new cohort of PCAs and BHSAs as well as "alumni" from the first phase.

Evaluation Methods

JSI, together with Mathematica, evaluated the State Learning and Action Collaborative through four main information sources (Exhibit 2). JSI administered multiple online surveys and follow-up phone calls with state associations to assess organizational capacity and engagement in VBP/C, Mathematica conducted phone interviews with state associations and provider members, and both JSI and Mathematica observed convenings of the state associations. The information collected provided a basis to assess changes in capacity over time, to help tailor technical assistance to PCAs and BHSAs, and share lessons with the broader field. Detailed methods can be found in Appendix A.

Exhibit 2. *Delta Center Phase I Evaluation Methods*

Data source	Areas of inquiry	Lead

		Evaluator
Online survey and follow-up phone call with state associations*	Organizational capacity and engagement in VBP/C	JSI
Phone interviews with state associations*	State policy context, role of the Delta Center, recommendations for Phase 2 of Delta Center, plans for sustainability	Mathematica
Phone interviews with provider members of associations**	Engagement in VBP/C, helpful resources and strategies, monitoring VBP/C performance	Mathematica
Observation of convenings with state associations	Grantee relationships, reactions, and discussions	JSI & Mathematica

** Conducted Fall 2018, 2019, 2020*
*** Conducted Fall 2019, N=35*

Building the Internal Capacity of State Associations

To invest in future strength and capability of state associations, the Delta Center prioritized internal capacity building to create and maintain strong foundations for advancing VBP/C. The organizational differences of each PCA and BHSA had implications for their capacity and willingness to advance this work both individually as associations and when working together in partnership. This section describes the overall organizational characteristics (size of staff and membership, revenue) and then their capacity related to advancing VBP/C (internal structures, strategy, and sustainability).

Size of staff and membership. PCAs had about four times as many full-time staff as BHSAs did (see Exhibit 3.1); however, BHSAs serve close to twice as many members (see Exhibit 3.2). Because BHSAs tend to have more members—and more diversity of members delivering different types of services—than PCAs, they face greater challenges engaging their members in developing common goals and strategies and working toward VBP/C.

Exhibit 3.1. *Average number of full-time, part-time, and ancillary staff by PCA and BHSA.*

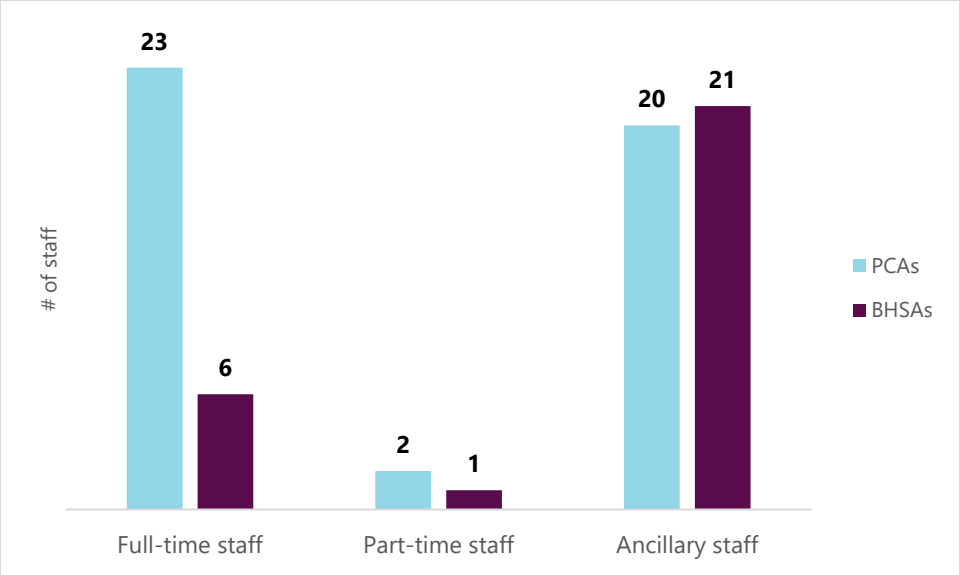
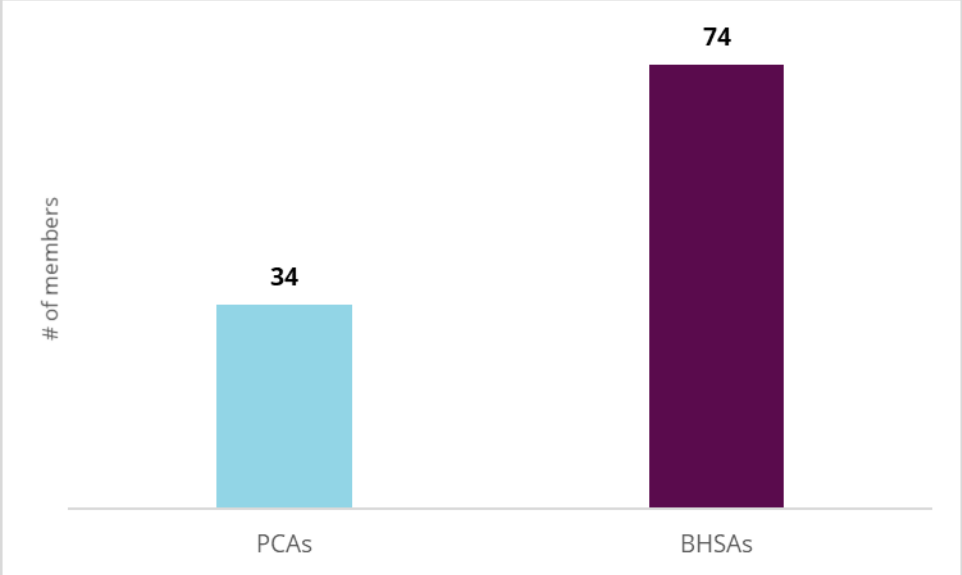


Exhibit 3.2. *Average number of association members by PCA and BHSA*



Revenue. PCAs and BHSAs had different levels and sources of annual revenue, which may have affected their capacity to advance policy agendas and serve their members. PCAs received the majority of their funds from federal, state, and private grants (about 65% for PCAs compared to about 15% for BHSAs), and BHSAs received the majority of their funds from membership dues (about 55% for BHSAs compared to about 10% for PCAs). BHSAs also typically had lower revenue dedicated to the associations' core activities of policy advocacy and T/TA, which made it more challenging to fund activities to advance VBP/C. Given the limited resources available to address competing demands and priorities, RWJF funding greatly enhanced their ability to pursue value-based payment initiatives, particularly for BHSAs.

Internal structures. State associations institutionalized their VBP/C efforts through creating formal structures and processes for both association-level activities and with members. For instance, some state associations held regular internal team meetings focused on how to embed the VBP/C work in current processes, and others created steering committees within their board structures to focus on longer-term strategy and sustainability.

Strategy. The extent to which an organization has a clear strategy demonstrates a degree of institutionalization of an organization's objectives. Between the baseline and final organizational assessments, the proportion of PCAs that reported using a clear strategy (written, consistently updated, and used by staff to guide decision-making) increased from 33 to 64% with regard to payment reform and 25 to 46% with regard to delivery reform; however, there was no increase in institutionalization of strategy for primary care and behavioral health integration. Throughout Phase 1, 50 to 60% of BHSAs reported consistent use of written strategy throughout the program across payment and delivery reform and primary care and behavioral health integration. One PCA-BHSA team created a joint roadmap to follow together, and another association plans to continue to use the Model for Advancing High Performance in Primary Care and Behavioral Health Under Value-Based Payment (MAHP 2.0[1]) and adaptive leadership frameworks to keep moving initiatives along with their members. State associations reported less prioritization of institutionalization efforts near the end of Phase 1, as the pandemic understandably shifted priorities from longer-term strategy and planning for VBP/C to more immediate needs of members.

Sustainability. Despite plans to embed aspects of their Delta Center work in their ongoing operations, state associations expected to need funding to sustain many of their VBP/C activities, and as of Fall 2020, state associations were at different points of pursuing or obtaining such funds. A few state associations noted having other grants, such as HRSA grants, or funding sources that they could repurpose or extend to these activities. With BHSAs typically having fewer resources than primary care, state associations were also thinking about ways to secure resources especially for behavioral health, for example, by offering electronic health record infrastructure that would support many aspects of VBP/C. A few state associations were applying for federal grants that they expected to help extend their work, for example with a CMS grant to focus on behavioral health outcome measures and by pursuing Certified Community Behavioral Health Clinic (CCBHC) opportunities. RWJF, recognizing the importance of sustaining the progress made through Phase 1 of the Delta Center, funded eight state associations to continue their work through alumni grants.

[1] https://deltacenter.jsi.com/sites/default/files/uploads/resources/Road-Ahead_MAHP-2.0_2019_0128_0.pdf

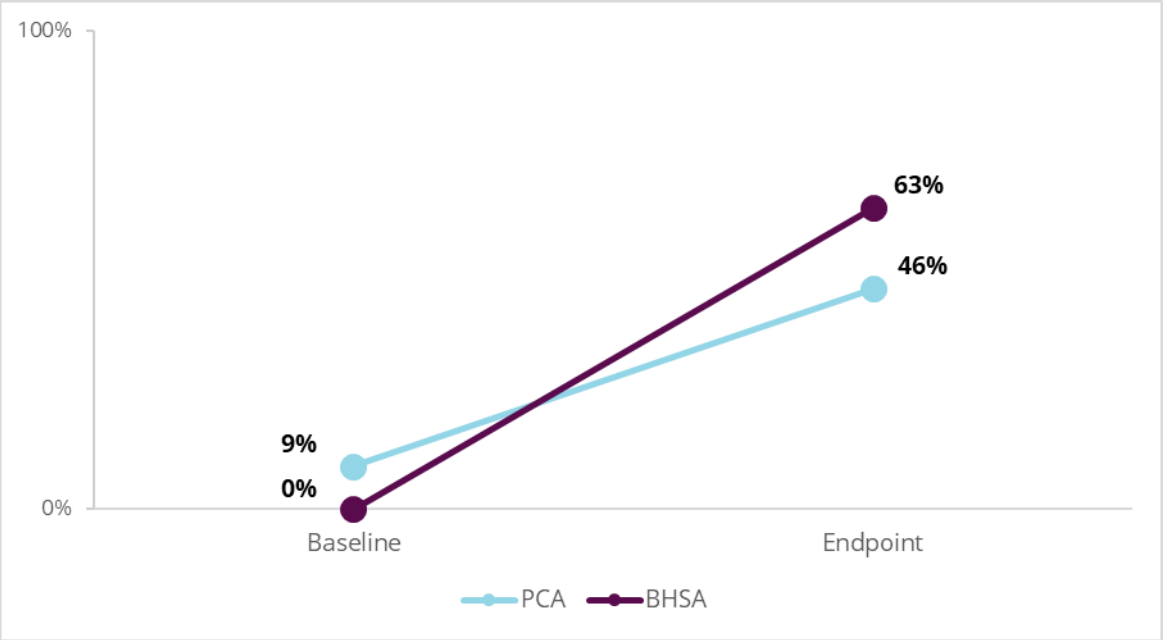
Building Policy and Advocacy Capacity to Advance VBP/C at a State Level

State associations have worked together and on their own to effect changes in state policy to advance VBP/C with greater speed, skill, and collaboration thanks to RWJF funding. Some noteworthy examples of policy successes include:

- The Texas BHSA establishing state-sponsored Certified Community Behavioral Health Clinics (CCBHCs) independent of the federal demonstration;
- New Mexico's PCA and BHSA leveraging a collective safety net voice to create an identical minimum payment rate for primary care and behavioral health visits in health centers; and
- Missouri's PCA successfully establishing a first-of-its kind patient engagement payment reform that incentivizes health centers to get "assigned but not seen" Medicaid members into care.

Work with Medicaid. The state associations reported that they worked with their state Medicaid agency most often to advocate for changes to Medicaid MCO policies. Notably, the proportion of PCAs that reported having shaped significant policy changes with their state Medicaid agency increased from 9 to 46%, and it increased from 0 to 63% among BHSAs (Exhibit 4). This change during their participation in the Delta Center appears to be related to their policy achievements, as described above.

Exhibit 4. *State associations working with their state Medicaid agency on policy change*



Policy Priorities. Although the PCAs and BHSAs worked on a large breadth of policy issues, there was significant overlap in the most common policy areas across PCAs and BHSAs. Overall, the most common types of payment reform policies that state associations worked towards involved pay for performance (P4P) for quality with health plans, and P4P for cost with health plans.

Role of Delta Center. Participation in the Delta Center was helpful in supporting state associations' policy work, as measured by the number of PCAs and BHSAs who said that the Delta Center helped them to advance their work in an array of policy areas related to Delta Center goals. For the most common policy area of P4P, more BHSAs than PCAs reported that Delta Center support was helpful (e.g., 7 of 9 BHSAs versus 5 of 11 PCAs for P4P for quality), which is expected given primary care's long history of working in managed care contracting environments, whereas P4P contracting is newer in behavioral health. Overall, the policy area in which Delta Center participation helped the most associations involved policy work on payment models promoting primary care and behavioral health integration, with 8 PCAs and 8 BHSAs reporting that their participation helped to advance this work (Exhibit 5.1 and Exhibit 5.2). The progress made in this policy area aligns with the Delta Center objectives and achievements related to fostering collaboration between primary care and behavioral health at the state level, as described in the next section.

Exhibit 5.1. *PCAs that reported that Delta Center helped in different areas of policy*

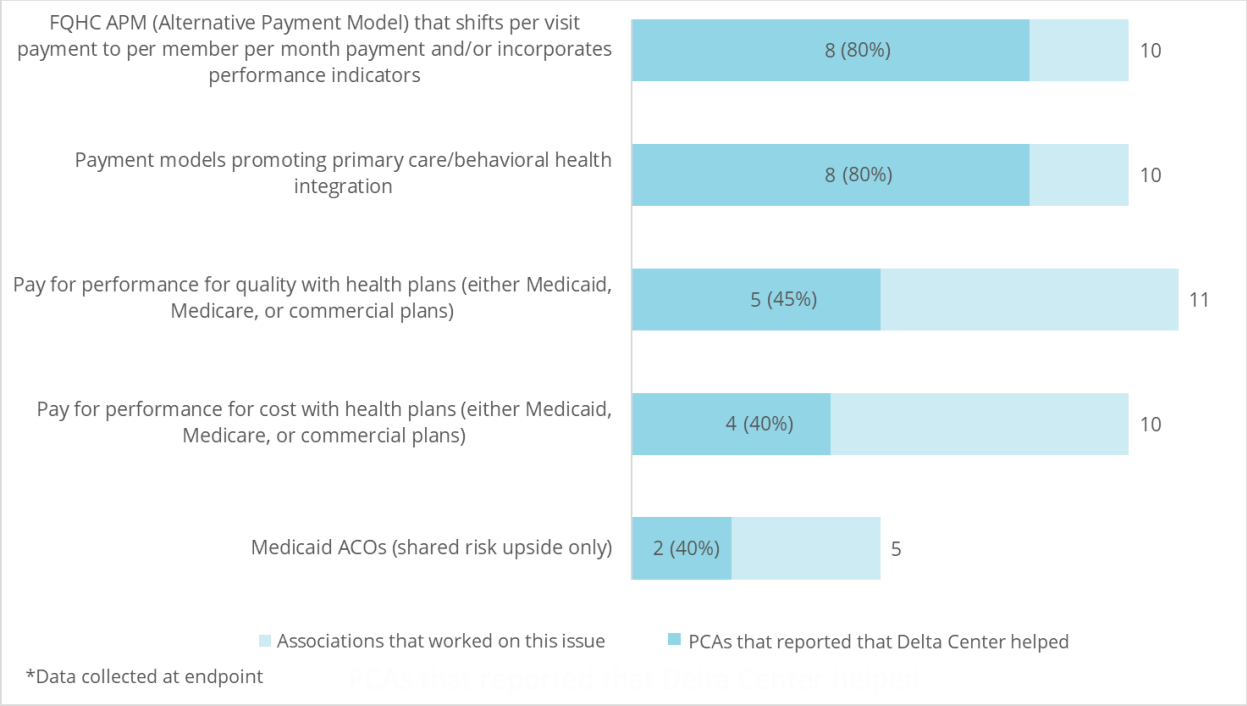
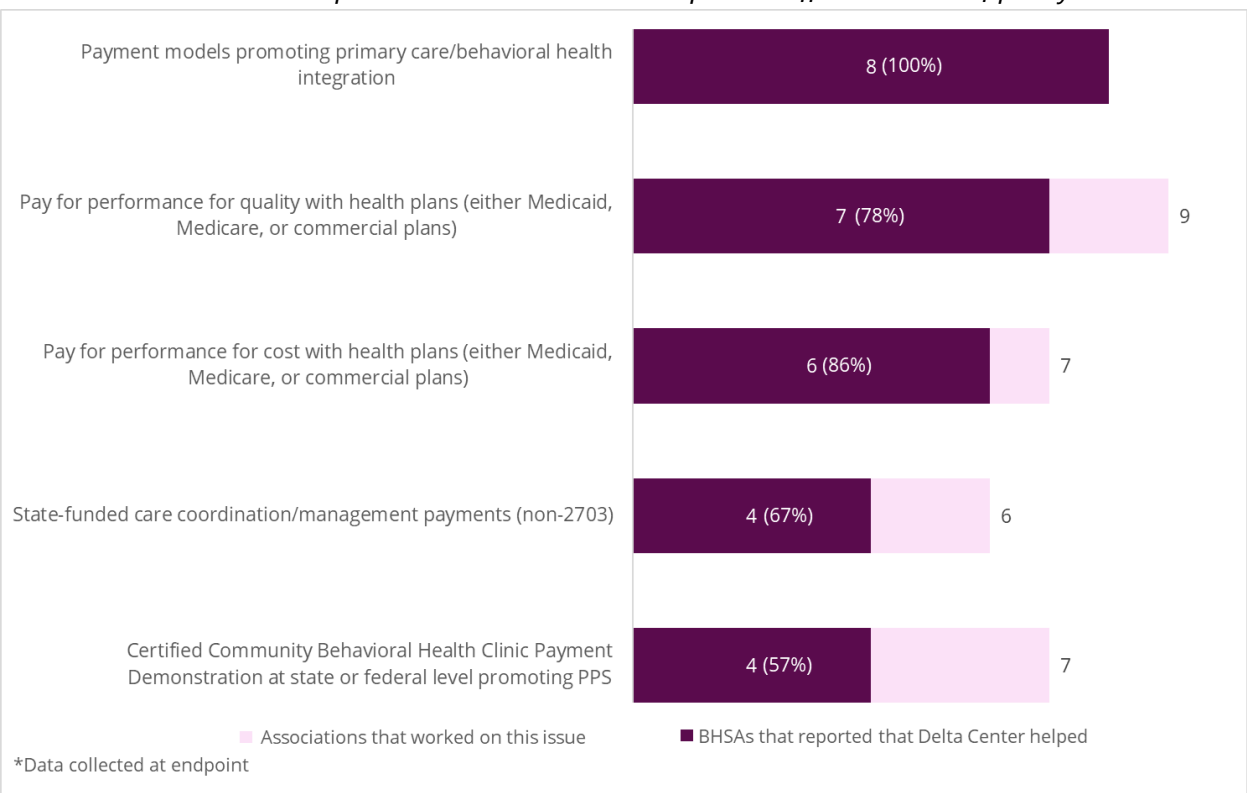


Exhibit 5.2. *BHSAs that reported that Delta Center helped in different areas of policy*



Fostering Collaboration Between Primary Care and Behavioral Health at the State Level

Partnership building, a focus of Delta Center's work with associations, resulted in many new strong working relationships among PCAs and BHSAs. State associations and their counterparts had the unique opportunity to develop an effective partnership with one another through Delta Center funding and coaching, as well as the dedicated time needed to promote meaningful relationship building. The Delta Center supported ten PCA-BHSA teams through a series of coaching calls and in-person convenings that included both didactic and facilitated peer-to-peer sessions. Each of the PCA-BHSA teams worked through a process of building and/or strengthening their relationship as they sought to align around selected goals and collaborate to pursue them.

PCA-BHSA teams overwhelmingly reported that the partnership they formed with their counterpart association was extremely beneficial, and ultimately the most valuable aspect of participating in the Delta Center. PCAs and BHSAs came together under the banner of a shared safety net identity through the Delta Center, establishing state associations as a team to serve as a foundation for influencing and partnering with state legislators, and state agencies. The relationships that state associations developed provided a foundation to support VBP/C efforts, as well as association work more broadly. The following section describes the experience of relationship building from an organizational development perspective, beginning for many at the grant application process.

For many, a new beginning

The Delta Center project proposal was the starting point of collaboration for many PCA-BHSA teams. Despite health centers and behavioral health organizations both providing critical community-based services, often with overlapping patients, many PCAs and BHSAs did not have a history of working closely together to advance policy, payment, and practice change for their provider members. Though they were aware of one another, the grant provided a novel opportunity for dialogue between PCAs and BHSAs and the impetus for jointly advancing value-based payment and care (VBP/C) and other efforts to achieve greater financial flexibility and stability for the safety net.

The joint application process initiated the beginning of a conversation that state associations would have with their counterpart around strengthening their partnership through working toward collective action and shared project goals. As one BHSA explained, "I think that we worked together more closely than we ever would have without the Delta Center. It wasn't like an antagonistic relationship before; it was a relationship that had become a bit moribund. Because of this grant, we've had the pleasure of getting to work together." This first

demonstration of commitment paved the path towards creating a mutual trust and a stronger relationship with one another.

PCAs and BHSAs that applied for the Delta Center grant together collaborated to identify:

- Opportunities and challenges in advancing payment and delivery reform in their state;
- Steps to strengthen coordination and collaboration between associations and provider members;
- The roles and level of commitment from both associations' staff; and
- Plans for sustaining their work.

"There was this tipping point when we all realized…that during the application process we had an opportunity here. [Our partner] said, 'Whether we get this money or not, we're going to work together from here on out, because this is so much better together than not together.' It was an acknowledgment of something we should have had all along. The opportunity to apply for Delta was the impetus to move together."
- Behavioral Health State Association Partner

Understanding each other's culture and history

At the early phase of their participation in the Delta Center, most PCA-BHSA teams initiated the important process of "level-setting" to learn about one another's organizational history, culture, and current context. By doing so, associations began to understand why their counterparts operate the way they do and have certain policy priorities that may or may not align with each other. The mutual understanding was helpful for informing the feasibility of the approaches association teams could take together towards advancing VBP/C efforts in their state. As shared by one PCA, "We had an initial meeting. It was a conversation on our history and a few bottom lines. I thought about what it would take to be respectful partners with a desire and intent to go down that road. I think we did that and proceeded to do it with milestones."

In particular, the increased awareness and understanding of their counterpart's financing systems (as well as the historical influence these systems have had on primary care and behavioral health policy priorities) allowed for a shift in perceptions from what were once thought to be competing policy agendas to areas of potential collaboration. PCAs have guaranteed payment under a prospective payment system (PPS), and therefore their policy priorities focus on payment that would allow for more flexible, expansive, and integrated care delivery under existing payment arrangements or alternative payment models for health centers. On the other hand, BHSAs focus on reducing disparities in payment between behavioral health and other health care providers given the chronic underfunding of the community behavioral

health system, which can be traced back to the federal block grants under the Reagan administration.

Under the auspices of the Delta Center, which promotes the notion of a shared safety net identity, PCAs and BHSAs were able to look past history of competition in some states, learn about and appreciate differences, and go on to identify opportunities for alignment and collaboration. By taking the time to be aware of their respective circumstances and bridge any gaps in knowledge, teams were able to foster both a mutual understanding of one another's capacity and willingness to collaborate, as well as build trust on a personal level.

> *"You don't know what you don't know, so it's nice to lean on the other person to get those perspectives and get actual true knowledge from someone working with it, rather than thinking you already know everything and not being open and receptive to learning new things."*
> - Primary Care Association

Devoting time together

The Delta Center hosted events and activities intentionally designed to encourage or facilitate PCA and BHSA collaboration which created a novel environment for teams to think collaboratively, build trust, and to advance their joint VBP/C efforts. State associations cited having this dedicated time to focus on their shared work together as a crucial component in their relationship development. In the words of one BHSA, "It makes a huge difference when you can get out of the 'everyday' to focus on this work."

Informal activities, such as traveling to convenings together, further broke down relationship barriers by offering a chance to connect on a more personal level, ultimately strengthening professional working relationships between staff. One PCA shared that "having travel opportunities, being on the road as a team for eight hours, and getting to know each other outside of our day to day helped," and "it was being in a place that was more focused than anything that helped with [their] relationship development." Spending time together in person, both formally and informally, provided an opportunity to build strong partnerships and social ties within PCA-BHSA teams.

Bringing members together to change practice

By collaborating with their counterpart, state association teams provided their members with shared training and technical assistance (T/TA) on how to advance VBP/C initiatives, further fostering a collaborative environment for partnerships and primary care/behavioral health integration across state associations and their members. Local member-to-member partnerships to improve community-level care further strengthened the collaborative work between state

associations and their counterparts. As one example of the PCA-BHSA partnership fostering policy and practice change, the Michigan PCA and BHSA leveraged their stronger relationship to work with the state Medicaid agency to implement a new behavioral health home model and expand opioid health homes projects, which in turn fostered greater collaboration among FQHCs and community mental health centers across the state.

As another example, the Oregon PCA-BHSA team supported shared learning opportunities in their state by bringing together both membership groups for technical assistance related to VBP/C. To foster real action following these learning sessions, they worked closely with local partners and early adopting members to launch regional pilots of value-based integrated care and payment with their CCBHCs and FQHCs in one urban, one rural, and one frontier part of the state. Success looked different across pilots, ranging from securing funding for a new community center, to developing a homeless case management program to reach vulnerable residents. Their work continued to build upon Oregon's foundation of a shared policy agenda that advocates for appropriate resources to support the safety net. State associations collaborating together to foster local-level partnerships in an intentional way, such as the case with the Oregon PCA-BHSA team, has proven to be helpful in learning what local models work effectively in order to scale them sustainably and promote broader adoption across state environments.

Across the ten PCA-BHSA teams, each invested time into their partnership and pursued collaborative work given their unique priorities, with most teams that applied together having little to no history working together prior to their participation in the Delta Center. Through a process of understanding each other's culture and history, devoting time together formally and informally, and bringing together members to further foster a collaborative environment, PCA-BHSA teams were able to build a strong working relationship to collectively advance improvements in VBP/C. In describing how they envisioned sustaining these partnerships, PCA-BHSA teams explained it had "become a habit" to reach out to their counterpart about legislative priorities or other VBP/C topics, and they expect to retain a more "open door" with their partner because of the Delta Center work. One PCA-BHSA team is even considering moving into the same building to foster ongoing collaboration and communication, while all other state associations expect that their strong relationships with their counterpart associations are to sustain after the Delta Center, although potentially in a less formal or structured way.

Building Capacity of State Associations to Provide Education/T/TA to Advance VBP/C Among Members

To help support implementation at the provider level at scale, the Delta Center developed and curated VBP/C resources for PCAs and BHSAs to deliver T/TA to their provider members. Per

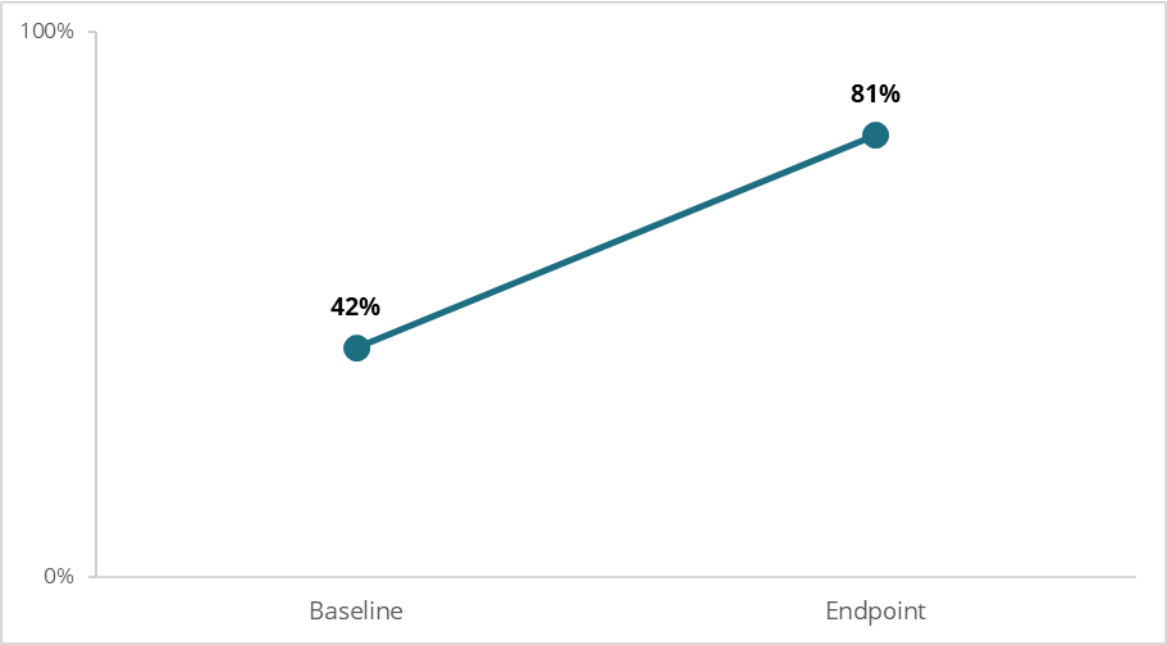
interviews with leaders of large provider organizations in the Delta Center states (see Appendix B), providers reported excitement about starting or continuing on the road towards VBP/C, and expected it to benefit their organization, staff, and clients. Provider leaders described the key role their state associations played in helping them prepare for and engage in VBP/C, especially with regard to helpful T/TA and peer-to-peer learning opportunities. As delivering T/TA to their provider members is a major function of PCAs and BHSAs, state associations expressed appreciation that the Delta Center equipped them with the T/TA and access to resources to enhance the support they could provide to their members.

The Delta Center encouraged the joint provision of T/TA to both primary care and behavioral health provider members. Examples of joint T/TA convenings to foster relationship building, and collective action at the local level include:

- Missouri's Value-Based Payment Academy and Joint Care Management Training,
- Washington's joint TA through its Payment Academy, and
- Michigan's Value-Based Payment Learning Collaborative and Practice Transformation Academy, which involved a learning collaborative of 28 organizations that for the first time includes tracks for both providers and payers.

The percentage of associations that engaged in semi-regular or regular shared opportunities to provide T/TA to members from both organizations nearly doubled from 42% to 81% (Exhibit 6).

Exhibit 6. *Total associations that engaged in semi-regular or regular shared opportunities to provide T/TA to members from both organizations*



From the outset, the majority of associations had high confidence in managing the effectiveness of their T/TA delivery process (Exhibit 7.1) and in delivering T/TA related to improving care and demonstrating value (Exhibit 7.2). This proportion shifted upward for both PCAs and BHSAS for nearly every topic at the endpoint; one exception was PCA confidence in delivering T/TA related to integrating primary care & behavioral health services bidirectionally, which decreased slightly from 50% to 46%.

Exhibit 7.1. *Confidence in managing the effectiveness of your T/TA delivery process*

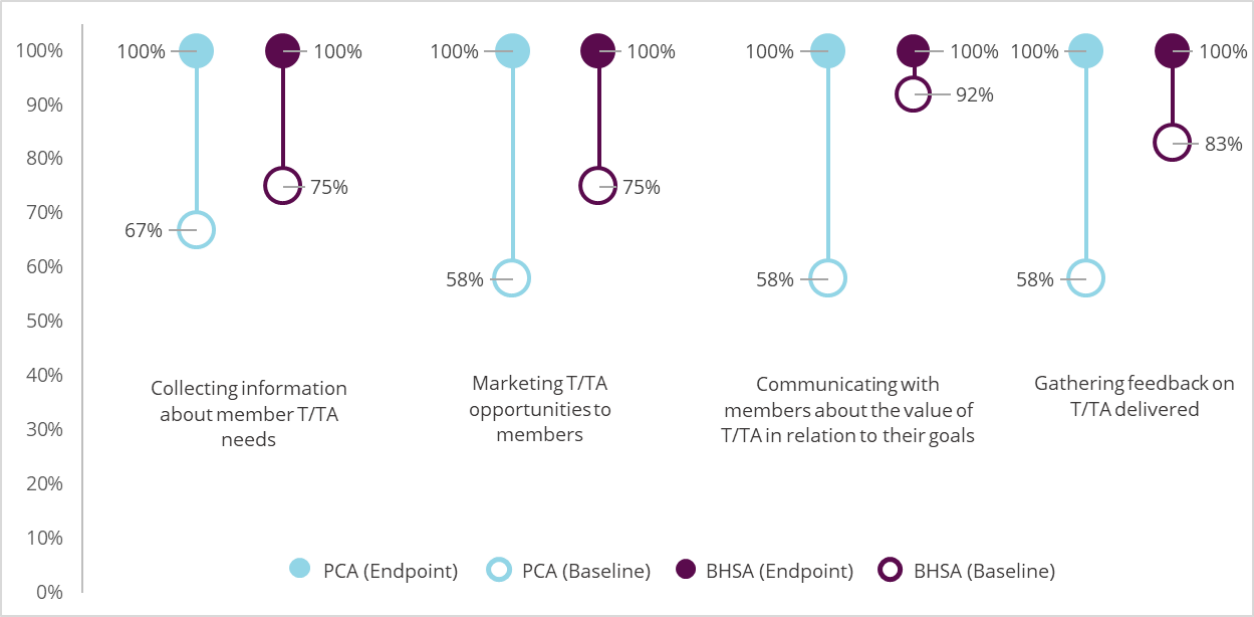
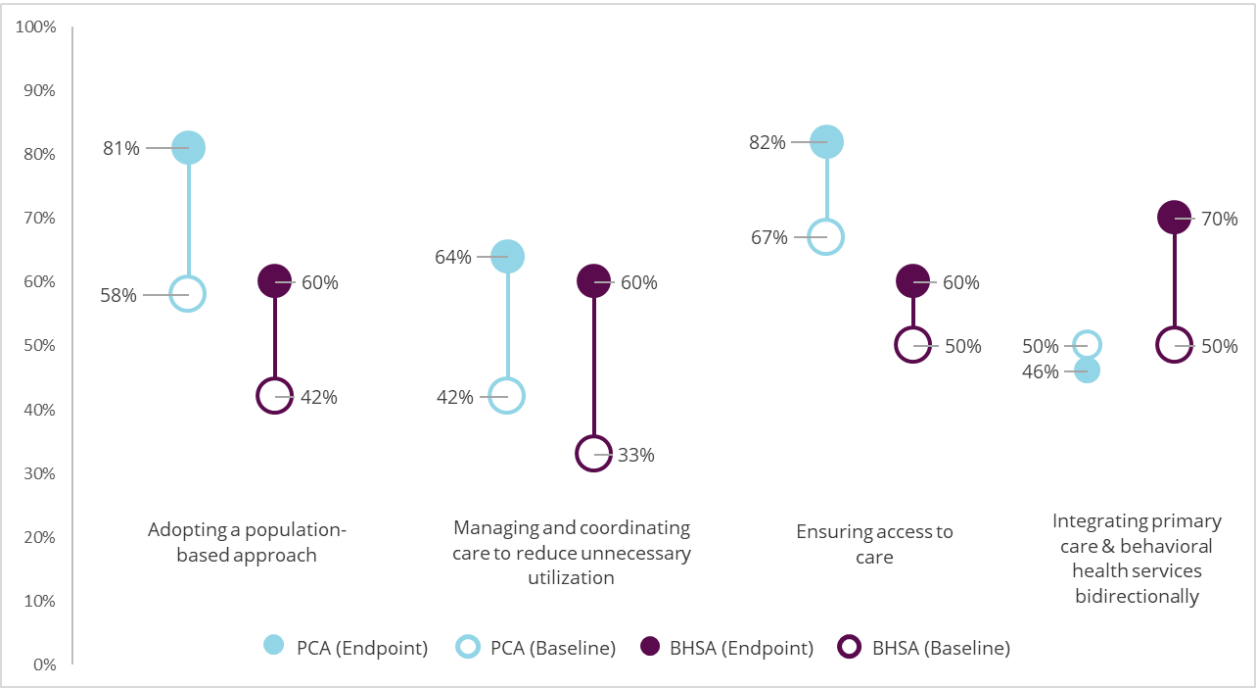


Exhibit 7.2. *Confidence in delivering T/TA related to improving care and demonstrating value*



In collaboration with their counterpart, PCAs and BHSAs educated their members by providing shared training and technical assistance (T/TA) on the knowledge and frameworks for advancing VBP/C initiatives, further infusing a system of partnership and primary care/behavioral health integration across state associations. Through joint effort and dedication, PCAs and BHSAs were able to engage members in unprecedented ways, with some reporting that under the Delta Center, they brought their members together with the members of their counterpart association

for the first time to provide T/TA. Joint T/TA academies held by some PCAs and BHSAs represented a systematic approach to unifying the safety net by expanding VBP/C opportunities for more providers, and supporting their members through learning collaboratives and other educational opportunities. These joint events also helped provide opportunities for respective memberships to connect with one another.

Several state associations noted that past experience providing learning communities and other TA for their members gives them confidence that they can sustain learning activities in the future for VBP/C and other priority areas. Some grantees expected to receive funding from their state or other sources to enable them to continue conducting joint T/TA and pursue primary care and behavioral health integration, while another grantee did not expect to receive external funding and so was considering charging members special assessments to participate in VBP/C trainings and other TA going forward.

Responding To COVID-19

The COVID-19 pandemic created twin challenges for primary care and behavioral health providers: altering operations to deliver care effectively while minimizing risk of COVID-19 transmission, and obtaining sufficient revenue to continue delivering care. State associations dedicated themselves to supporting their provider members through policy and T/TA, in what the Massachusetts PCA described as "all consuming" efforts to respond to the crisis.

As shown in Exhibit 8.1, since the pandemic, all of the PCAs and BHSAs, have been working extensively with state policymakers to effect policies to deliver and reimburse care in the COVID-19 context. Within the broad area of telehealth, nearly all of the state associations are working actively to maintain emergency rules for payment parity between in person visits and telehealth visits, equivalent payments for phone visits, and flexibility in workforce rules. Associations have placed a high priority on obtaining or maintaining payment parity between in person and phone visits because of its importance to ensuring equitable access to care, as patients from communities of color were more likely to lack access to reliable and affordable internet and telehealth technologies. Associations in Maine and New York reported that their progress on telehealth policies in their states likely would not have been possible without the collaboration they forged through the Delta Center work.

"Parity for telephone visits is a health equity issue. The majority of health centers who use audio-only are patient driven. You inherently create an unfair system if based on patient capabilities, the providers who care for them are reimbursed at a lower rate. We often mention

the ability for telehealth to ensure ongoing access to primary care and behavioral health care for communities with some of the worst health disparities. However, we are keenly aware of the potential for telehealth to exacerbate existing health disparities if not used intentionally and equitably."
- Primary Care Association

Exhibit 8.1. *COVID-19 Related Policies State Associations Have Worked Towards Advancing or Maintaining.*

	PCA (N=11)		BHSA (N=10)	
	N	**%**	**N**	**%**
Improved payment parity between in-person and telehealth (audio or video) visits	11	100%	10	100%
Improved payment parity between in-person and audio-only visits	11	100%	9	90%
Regulatory and/or workforce barriers to telehealth (e.g. allowing a broader range of health workers to be paid)	10	91%	9	100%
Coordination with state agencies (e.g. Medicaid, rural health, public health, aging services) to identify and serve patients in most urgent need of social and human services effectively	9	82%	10	100%
Financial support for patient internet access and/or technologies for telehealth (e.g. mobile phones, tablets)	8	80%	8	80%
Reimbursement to support telehealth-specific workflow activities (e.g. assisting patients with downloading and using video call platforms)	5	45%	8	80%
Requirement of the provision of culturally and linguistically appropriate services (CLAS)	5	45%	8	80%
Provision of subsidies through the state or MCOs to provider members	4	50%	7	70%
Requirement of Medicaid MCOs or specialty behavioral health	3	43%	4	50%

	PCA (N=11)		BHSA (N=10)	
	N	%	N	%
plans to provide monthly per capita advance payments to provider members				

State associations struggled to support their members, who mostly relied on the fee-for service payment system, which was ill-suited to this public health crisis and compromised the financial viability of the ambulatory safety providers across the country. In contrast, the experience of safety-net providers receiving upfront reimbursement such as Oregon and Washington health centers operating under an APM was much more favorable financially. The buffering effects of upfront and capitated payments underscored the need and the opportunity to continue moving towards VBP/C.

State associations also responded rapidly to support their members in new ways specific to the COVID-19 context (see Exhibit 8.2). Providing member support for telehealth delivery and billing was a top priority, as was being actively involved in monitoring the financial health of members (100% for both PCAs and BHSAs). Nearly all of the state associations assumed entirely new responsibilities during the pandemic, including assisting in the procurement of PPE and facility modifications (e.g. plastic partitions) to deliver services more safely (90% for PCAs versus 80% for BHSAs).

Exhibit 8.2. *COVID-19 Related Assistance State Associations Have Provided for Members.*

	PCA (N=11)		BHSA (N=10)	
	N	**%**	**N**	**%**
Delivering T/TA to support members' provision of telehealth services across service lines	11	100%	9	90%
Delivering T/TA to support members' billing for telehealth services	11	100%	8	80%
Assisting members to address social needs that may have been exacerbated by COVID-19 (e.g, food insecurity, social isolation)	11	100%	7	70%
Monitoring the financial health of members	10	100%	10	100%
Assisting members to address health equity through T/TA and other mechanisms (e.g. the adoption of provision of CLAS services)	10	91%	9	90%
Assisting in the procurement of PPE and facility modifications (e.g. plastic partitions) to deliver services more safely	9	90%	8	80%
Supporting members' provision of telehealth-enabling technologies to patients (e.g. Wi-Fi hotspots, mobile phones, tablets)	8	73%	9	90%
Assisting rural members in addressing rural-specific issues through T/TA	7	64%	9	88%

Most PCAs and BHSAs reported that they felt compelled to shift priorities away from their original Delta Center objectives as they grappled with the immediate and catastrophic situation facing member organizations. However, about six months after the pandemic began, PCAs and BHSAs were able to start to shift their attention back to developing a long-term strategy for their associations while taking into account the new health care context. Many Delta Center partnerships demonstrated resilience through the crisis of the pandemic, as eight PCA-BHSA teams applied and were awarded alumni grants for a second phase to continue their work together, with many shifting their policy and practice priorities towards telehealth payment policy and health equity.

"We're trying to figure out how to insert [lessons from COVID-19] into our upcoming strategic planning process… I would really like to get through this, and then really think about the strategic partnerships. We're all so fatigued, we're going to need to rely on each other way more than we thought 3-4 years ago, before we knew what the pandemic would do to us as individuals and as organizations."
- Primary Care Association

Addressing Health Equity and Incorporating Consumer Experience

Delta Center Phase 1 did not require PCAs and BHSAs to work toward achieving health equity nor to incorporate consumer experience in their VBP/C work. However, a focus on these areas grew throughout the grant period, with the COVID-19 pandemic further exposing inequities in health outcomes for minority groups and the murder of George Floyd and other Black Americans by police shining a spotlight on structural racism. State associations reported a renewed sense of urgency to advance health equity for the communities they serve. Associations described several types of activities they had started to undertake to advance health equity, but acknowledged that they have much more to do and desired more assistance and support in this work, especially to combat structural racism.

With an eye towards the next phase of the Delta Center, starting with the mid-point interviews Mathematica asked for associations' perspectives on how important these areas are to improving the care delivery system, the extent to which they were already working in these areas, what would be help them advance this work, and how the Delta Center might approach these priority areas in the future.

Health Equity

Although health equity is inherently core to their mission as safety net providers, state associations shared that acting more intentionally on health equity has become a higher priority for them and their members over the past year, prompting them to identify and address inequities among populations in their states. State associations described several types of activities they had started to undertake to advance health equity but acknowledged that they have a lot more to do and could use more assistance and support in this work, especially to combat structural racism. Associations' ideas about where they and other state PCAs and BHSAs could use more help fell into several main areas:

Developing specific goals related to health equity and embedding these goals in strategies and work processes to ensure that this new priority on health equity endures

beyond the pandemic. Associations stressed the need to place health equity front and center in their strategic priorities, and to conduct all VBP/C work through a health equity lens, and to make specific plans to reach these goals. They discussed specific plans to incorporate health equity into strategic planning activities and committees at both the association and board levels. They shared that adopting equity frameworks would be helpful for understanding steps to take and mapping activities to them in a deliberate way to reach their goals.

Embracing trainings for their own staff on achieving diversity, equity, and inclusion (DEI). Associations reported participating in trainings offered by national associations, attending webinars and presentations by people with lived experience, obtaining guidance from experts on how to transform their organizations and care. Some associations emphasized a commitment to achieving leadership and staff composition that reflects the diversity of the patients and clients their members serve.

Encouraging and assisting provider members to directly work on health equity. Some state associations want to apply the same structure for health equity as the Delta Center used for VBP/C: building capabilities among PCAs and BHSAs for them to then transfer their knowledge to their members. For example, one association is helping its members assess the diversity of their boards and provide staff trainings on health equity. Another is providing learning communities for its members and with the broader community.

Addressing social determinants of health (SDOH) and working more directly with community organizations. In addition to focusing on access to health services and health outcomes, associations are taking a "whole person" perspective, to include disparities in access to health-related social needs such as affordable housing, food, and transportation. Some PCAs mentioned NACHC's PRAPARE tool as useful for their members to assess and track SDOH and another association is building its own database toward this end. Grantees need more ideas and examples from other places on how to best approach SDOH, including how to risk adjust VBP/C arrangements to account for social needs. Funding and tools to help associations partner with community based and other local organizations (for example, Medicaid ACOs) that have more experience with and direct connections with SDOH and other health equity issues would be valuable.

"The violent and public murder of George Floyd is not even the most recent in a long history of injustices delivered to Black and Brown communities across the country. It has served as a critical flashpoint for our associations to re-evaluate our complicity in systems that have never been equity forward. It is not enough for PC and BH providers to serve every patient "equally."

Instead, to truly serve through an equity lens, our associations and our providers must learn to combat racial injustice in all that they do and take the time to learn how some of their clients experience the world much differently than others."
- Behavioral Health State Association

Incorporating Consumer Experience

When asked about how the Delta Center could help elevate RWJF's focus on making consumer experiences more central, state associations noted that efforts to integrate the views of patients and clients into their work on VBP/C were very important and would support health equity goals as well. The more consumers have a venue to share their personal stories and lived experiences and participate in care delivery and policy decisions, the more can be learned about responding to their needs in ways that can be successful. State associations want to move away from relying on their own experience and anecdotes about what patients and clients might want and how VBP/C and other changes might affect them, and instead solicit input from patients and clients directly and systematically. This could include learning about the outcomes consumers want and then focusing on activities and pathways to achieve those results. Yet incorporating consumer experience is challenging for associations to do on their own because they do not interact directly with patients and clients. They described several strategies for approaching this work and where they could benefit from more tools and other guidance:

Leverage consumers already involved. Associations and providers could involve the consumers they have on their boards (FQHCs are already required to have consumer representation) more, recruit more consumers to these boards, and establish new consumer committees or advisory panels. State associations emphasized that they could use more guidance on how specifically to leverage these groups and integrate their recommendations into practice and policy.

Gather more information directly from patients and clients. Many associations and/or their members currently conduct patient satisfaction surveys, but modifications and improvements are necessary to ask questions more directly related to VBP/C. For example, a survey could ask patients how they felt about specific changes providers made to care delivery as part of a new value-based arrangement. Associations reported that they could use more guidance in framing meaningful and helpful questions for consumers to understand and interpret the questions as intended.

Integrate peers into decision-making and practice. Some associations stressed the value of incorporating the experience and perspectives of consumers more directly to help patients and clients coming from similar backgrounds and facing similar issues. Inviting such individuals to

serve as peers for patients and clients could help build trust and be particularly effective to not only directly help patients but also to generate rich and nuanced information to inform the state associations' policy priorities and provider practice changes. Associations noted the value of creating peer support programs and peer advisory groups, as well as involving peers in care at provider sites, which can be particularly useful for improving mental health and substance use disorder treatment. Yet associations and their members would benefit from a better understanding of how to meaningfully and successfully integrate peers into clinical teams.

Feedback from Delta Center Associations

Mathematica conducted interviews with the Delta Center participants to elicit their feedback on the program. The state associations commented on what they found to be the most valuable aspects of the Delta Center, suggestions for Phase 2 of the Delta Center, and the future of their work on VBP/C.

First, state associations overwhelmingly cited collaboration with their PCA or BHSA counterpart as the single most valuable aspect of their Delta Center participation. They described their collaboration as offering the following benefits:

- Better understanding of their partner's challenges and opportunities
- Strength in numbers to effect policy changes and have a "seat at the table" for policy advocacy
- Education of their members and bringing together members from primary care and behavioral health communities
- Collaboration brought a specific focus to VBP/C and an ongoing momentum to keep this work moving

Many state associations also valued the prestige that their Delta Center participation brought to their members and state policymakers. Interacting with other state associations and with national experts brought credibility to their state efforts to advance VBP/C and to create a "collective voice for the ambulatory safety net."

Delta Center participants also appreciated the flexibility of the grant, which allowed state associations to:

- Mold their projects to the level of maturity of VBP/C in their state and move forward with what made sense for their organizations, members, and context
- Invest the time required to build their relationship with their partner PCA/BHSA, which proved which proved crucial to their progress and accomplishments together
- Adapt their goals, based on new learnings and evolving member and state needs

- Respond effectively to the challenges of the COVID-19 pandemic and make progress on important issues such as telehealth policies

State associations valued the information gained from Delta Center convenings, coaching, and technical assistance. The staff from the state associations valued being part of an "active learning community" composed of their counterparts in their own and other states, as well as coaches and other staff from the Delta Center and its national partners. PCAs and BHSAs cited learning from other states as an important part of their Delta Center experience to understand what might or might not work in their states. Coaches extended the associations' depth of knowledge and was tailored to individual state and association needs. State associations also valued new ways to think about VBP/C and new resources for technical assistance and capacity building that could be applied to how they engage with their members.

Suggestions from participants for Phase 2 of the Delta Center included:

- More explicit emphasis on fostering partnerships between PCAs and BHSAs
- More time for peer learning with other state associations in the Delta Center
- More tangible, operational information on how to make progress in implementing VBP/C (e.g., roadmaps, examples of specifics involved in VBP/C arrangements)
- Greater use of the evaluation tools (e.g. organizational assessment) as tools for capacity building
- More opportunities and information about how to engage payers in VBP/C, including common standards and better data

Finally, grantees reported that while they had achieved better relationships, knowledge, and technical skills to advance VBP/C in their states and among their members through their involvement the Delta Center, they also felt they had more work to do and wished for more time in the Delta Center to continue their efforts. Indeed, the grantees wanted and expected progress to continue because they view VBP/C as the way of the future. They anticipate that successful VBP/C arrangements ultimately could be budget neutral for their state Medicaid programs and therefore be self-sustaining, but typically face a lot more work and expense to reach that point. Eight of the twelve state associations applied for and received an alumni grant to help them continue particular projects over the coming year.

Recommendations for the Delta Center 2.0 Learning and Action Collaborative

The State Learning and Action Collaborative in Phase 2 of the Delta Center began in Spring of 2021. The goals of Phase 2 have adapted in response to Phase 1 findings, including a greater

focus on collaboration and collective action between primary care and behavioral health, and - by working through a racial equity lens and incorporating consumer voice - ensuring that state associations' work will meet the goals and needs of individuals and families. With regard to the Phase 2 State Learning and Action Collaborative specifically:

1. The Delta Center should maintain and even strengthen its priority on forging strong collaborations between PCAs and BHSA, given the importance of collective action to achieve state-level policy and practice goals. Specific suggestions are to devote curriculum content and time in the convenings to relationship building in their states, to create a shared vision of the ambulatory safety net to guide policy and practice development across organizations, and to foster partnership development across different levels of partner organizations to support sustainability beyond the program.

2. The Delta Center should focus more attention on behavioral health issues and reducing the disparities in payment rates between primary care and behavioral health in the ambulatory safety net during convenings**.** Staff from the PCAs felt that working with their behavioral health counterparts at the state level gave them new insights into their own efforts to integrate behavioral health into primary care services at community health centers. PCAs and BHSAs stressed the need to do more at the policy level to reduce payment disparities between behavioral health and primary care offered in different ambulatory settings, as well as do more to design and implement arrangements that meaningfully support integration of primary care and behavioral health at the care delivery level, in order to advance VBP/C and achieve health equity.

3. The Delta Center should support state associations' efforts to incorporate health equity and consumer voice into their work, with a specific emphasis on advancing racial equity. In the Delta Center context, incorporating health equity and consumer voice should be integrated into capacity building, PCA and BHSA partnerships, and policy and practice objectives. The Delta Center can help alumni and incoming state associations achieve their newly specified plans through T/TA resources, peer learning opportunities, and ongoing feedback on their progress.

4. The Delta Center should create more opportunities and share more information about how to engage payers in VBP/C. As findings from this evaluation show, managed care contracting is currently the most common way that state associations and their members are participating in VBP/C. The Delta Center PCAs and BHSAs believe that both the Alumni and the Delta Center 2.0 PCA-BHSA teams could benefit from interaction with payers and from more coaching and consulting on how Independent Practice Association (IPA) structures could help them effectively contract with payers, with a

particular emphasis on developing joint IPAs spanning primary care and behavioral health.

5. The Delta Center should continue to provide state associations significant flexibility in implementing their specific projects with their partners. Phase 1 state associations greatly valued the flexibility offered as it allowed them to adapt their Delta Center plans to changes in their organizational priorities and capacities, including challenges of responding to COVID-19. As the political and economic landscape continues to transform under a new federal administration, maintaining this flexibility will be more important than ever to take advantage of opportunities effectively.

Conclusion

The Delta Center has helped PCAs and BHSAs to advance VBP/C by supporting their internal capacity, policy and advocacy work, collaboration with their state association counterpart, and T/TA to members. State associations reported that their participation in the Delta Center was extremely valuable to their ability to achieve progress in advancing VBP/C, and also offered helpful suggestions for Phase 2 of the Delta Center. The associations readily embraced the new goals for Phase 2 of advancing health equity and incorporating the consumer voice into Delta Center activities.

Appendices

A. Evaluation Methods
B. Provider Insights on Adoption of VBP/C