



Healthier Washington Medicaid Transformation
Greater Columbia Accountable Community of Health
Semi-Annual Report
Reporting Period: January 1, 2018 – June 30, 2018

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Attachments:

GCACH. SARI Attachment 1.1 LOI and CSAs Received. 7.31.18.

GCACH. SARI Attachment 1.2 GCACH CSA Final. 7.31.18.

GCACH SARI Attachment 1.3 CSA Summary Report. 7.31.18.

GCACH SARI Attachment 1.4 GCACH PTW Timeline and Bios. 7.31.18.

GCACH SARI Attachment 1.5 Organization Tier Selection for Practice Transformation and Community Partners. 7.31.18.

GCACH SARI Attachment 1.6 GCACH Org Chart. 7.31.18.

GCACH SARI Attachment 1.7 2017 RWJF County Health Rankings. 7.31.18.

GCACH SARI Attachment 1.8. 2017 GCACH Area Deprivation Index Map. 7.31.18.

GCACH SARI Attachment 1.9 GCACH SARI Workbook. 7.31.18.

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Section 1: Required Milestones for Demonstration Year (DY) 2, Quarter 2

This section outlines questions specific to the milestones required in the Medicaid Transformation Project Toolkit by DY 2, Q2. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone 1: Assessment of Current State Capacity

1. **Attestation: The ACH worked with partnering providers to complete a Current State Assessment that contributes to implementation design decisions in support of each project area in the ACH’s project portfolio and Domain 1 focus areas. Place an “X” in the appropriate box.**

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. **If the ACH checked “No” in item A.1, provide the ACH’s rationale for not completing a Current State Assessment, and the ACH’s next steps and estimated completion date. If the ACH checked “Yes” in item A.1, respond “Not Applicable.”**

ACH Response: Not Applicable.

3. **Describe assessment activities and processes that have occurred, including discussion(s) with partnering providers and other parties from which the ACH requested input. Highlight key findings, as GCACH as critical gaps and mitigation strategies, by topic area for the project portfolio and/or by project.**

ACH Response: Greater Columbia ACH conducted two regional assessments within the reporting period (Letter of Interest and Current State Assessment) to understand the activities, challenges, opportunities, capacities, and capabilities of the health network. Each assessment has contributed to an understanding of the GCACH’s system of care. The most recent assessment, the Current State Assessment (CSA) was sent in May 2018 to the 81 organizations that submitted a Letter of Interest between the fall of 2017 and spring 2018. Of the 81 organizations that received CSAs, 57 organizations responded back to the GCACH, for a response rate of more than 70%. Organizations were given a financial stipend for completing the CSA and were aware that completing the CSA was a prerequisite to possible contracting with the GCACH.

GCACH’s CSA borrowed content and input from some of its DSRIP partners: Southwest ACH, Cascade Pacific Action Alliance ACH, North Central ACH, and the HIE HCA staff and their HIE Assessment. This input was used in the development of the CSA. It also received extensive input from the GCACH’s Practice Transformation Workgroup (PTW) on the readiness assessment portion of the CSA.

Findings from the CSA will be taken to our partners and stakeholders, including the GCACH PTW, Leadership Council, Board, project teams, DM&HIE Committee, and its partnering providers.

Please refer to attachment 1.1 LOI and CSAs Received. 7.31.18.

Key Findings: Included here are the findings, interpretations, and recognized opportunities for the sections of the CSA:

Demographics

Findings and Interpretation: From the distribution of organizations by county, GCACH identified having broad organizational coverage across the nine GCACH counties and the Yakama Nation. Even the smallest county in the GCACH (i.e. Garfield County) had at least eight responding organizations designating the county as a service area. In fact, the smallest counties had a larger proportion of responding organizations per capita (Medicaid) than the larger counties. GCACH credited this to the widespread and successful outreach activities done at the grassroots level and going back several years. In terms of sector representation, the CSA received responses from most of the GCACH hospitals (11), all of its Federally Qualified Health Centers (FQHCs) (6), most public health jurisdictions (7), most syringe exchange programs (2), all the known freestanding care coordination organizations (4) and more. This indicated widespread acceptance and support of the Demonstration work. Overall, GCACH received good representation from each of the healthcare sectors across the nine counties.

Most CSA organizations surveyed had 50% or more white clients, which could include the Hispanic population. However, this indicates that many organizations are serving clients of more than one race. The Healthier Washington Measures Dashboard tells us that the GCACH Medicaid population was slightly less than 50% white and more than 50% Hispanic, the highest concentration among any ACH. The GCACH Medicaid population also had more children (53%) and females (53%), due to ethnic populations with large, young families. The Medicaid population was approximately 2% African-American in the GCACH, and most organizations responding to the CSA had less than 5% African-American clients. For the American Indian-Alaskan Native (AI-AN) population, most of organizations served populations with fewer than 4% of this demographic. However, a couple responding organizations offering alcohol and substance abuse treatment services had much higher-than-average percentages of AI-ANs, supporting the need to include some of these organizations within the GCACH program. Astria Toppenish Hospital and Triumph Treatment Services (alcohol abuse treatment) had the highest percentage of AI-AN clients, followed by Merit Resource, which also provides alcohol treatment. Some of the organizations in the network that could address disparities within this population had very high percentages (e.g. 72%) of Hispanic clients.

The CSA indicated a large representation of physicians (1,224), advanced registered nurse practitioners (283) and physician assistants (203) within the GCACH service area. GCACH also had a significant number of responding paramedics (76), EMS first responders (153), psychologists (73), licensed social workers (112), and other behavioral

health professionals (382). There was also large representation of care/case managers (324). In spite of this, GCACH understands that its region is a shortage area for primary care providers, behavioral health providers and oral health providers, as was evident in a previous analysis of Robert Wood Johnson Foundation County Health Ranking data and based on feedback from the GCACH's Medicaid provider organizations. This poses challenges for bi-directional integration, Practice Transformation and adoption of the Primary Care Medical Home, as these rely on robust networks of primary care providers and behavioral health specialists.

Analysis of reimbursement type by organization indicated that no organization relies on solely on Medicaid reimbursement. Most also depended upon Medicare or commercial insurance coverage, private grant funding, other state funding and private donations. While this mix somewhat enhances financial resilience, GCACH knows that many of its rural providers are struggling to remain financially solvent.

Most responding organizations (44%-48%) would like to participate in at least one of the GCACH selected project areas: Bi-directional Integration of Physical & Behavioral Health (44), Transitional Care (44), Addressing the Opioid Use Public Health Crisis (44) and Chronic Disease Prevention and Control (48). This is desirable and indicates a widespread commitment of resources to the Demonstration and associated project areas. GCACH views all project areas coming together as a portfolio and being in alignment with the characteristics of the Primary Care Medical Home (PCMH) approach. However, few providers claimed to have currently billed Medicaid for services tied to these project areas. The findings also indicated a low number of providers billing for chronic disease prevention.

Opportunities: It is essential that GCACH includes chemical dependency counseling and other organizations serving large numbers of AI-AN populations (e.g., Astria Toppenish Hospital) into the GCACH network, and all FQHCs, which serve large ethnic and racial populations. GCACH also identified the need for additional syringe exchange services in Southeastern Washington corner (i.e. Columbia, Garfield and Asotin) counties, which have small populations but a high prevalence of opioid use (identified through the WA Opioid Dashboard). Reviewing the CSAs indicated that many organizations seek to provide more chronic disease management. However, the low number of providers currently billing Medicaid for chronic disease prevention indicated the need for technical assistance around this type of billing delivered to healthcare providers, and perhaps to Community Paramedicine, which might perform home-based screenings and other services that might be billable through Medicaid due to recent state legislation.

Bi-Directional Integration of Care

Findings and Interpretation: Self-reported assessments as to the level of bi-directional integration by organization indicated a bell-shaped curve: most organizations were in the middle as to their level of integration. Reviewing the individual CSAs and adding local market intelligence gathered on the ground indicated that GCACH FQHCs, with one possible exception, were doing well at bi-directional integration of care. In fact, some were seen as exemplary models of care that might be emulated by other FQHCs and other

provider organizations. This may be because these organizations have been under financial risk payment arrangements (e.g. capitation) for some time. Successful implementation of bi-directional integration was less apparent in hospital-operated primary care clinics and behavioral health agencies (i.e. mental health and/or substance abuse disorder (SUD)). Even for the largest behavioral health agencies, which claimed that they are integrating, there was little integration happening other than through contracting with a primary care organization. There was a much higher prevalence of behavioral health activity co-locating into primary care than primary care co-locating into behavioral health settings.

GCACH believes one of the best way to facilitate bi-directional integration into behavioral health across the GCACH is through collaborations that assist the small behavioral health agencies, and many have indicated a willingness to do so. These collaborations could be around primary care providers linking with behavioral health providers or with SUD providers linking with mental health providers, which then might pursue primary care resources. This may also alleviate, in the short term, their needs for physical space. Larger behavioral health agencies can more easily recruit primary care because of their larger resources.

The CSA also identified organizational challenges to bi-directional integration, with the most widely indicated issues being sustainable funding (34), workforce (29), and physical space (27), followed by information technology (19). The lack of physical space was an overwhelming issue for many of these organizations, particularly the smaller behavioral health organizations. GCACH will work to find solutions, like colocation of services to address this. If an organization needs to borrow clinical human resources, GCACH could facilitate telehealth or tele-psychiatry, which might be suitable for primary care in a rural setting.

Even though information technology ranked just below the top barriers to bi-directional integration, GCACH will make consistent investments across provider organizations. GCACH expects to invest in significant IT support to the GCACH prioritized list of partnering provider organizations undergoing bi-directional integration.

The CSA also assessed challenges patient populations were experiencing relative to bi-directional integration. The greatest challenges or needs were managing individuals with chronic disease, depression and anxiety, and patient needs relating to the social determinants of health. Addressing chronic disease among individuals with behavioral health disorder is a key area of focus as this population tends to be under-served relative to primary care needs.

The CSA also assessed the top organizations most essential for developing a bi-directional integration care program. The key findings were that behavioral health agencies (e.g. Comprehensive) and care coordination organizations (e.g. Aging & Long-Term Care, Consistent Care Services) stood out as being integral for integration as were FQHCs. Care coordination is essential to the management of high-cost, high-needs populations, one of the GCACH's prime target populations, which tend to fall through

the cracks in terms of receiving comprehensive and coordinated services.

Also assessed were integrative care activities that are currently in place within the GCACH. The use of social services (31) and care team meetings (28) were the most widely cited activities. What ranked low was the use of telehealth and tele-psychiatry, which stand as possible opportunities, particularly in rural communities.

GCACH identified two types of collaboration as being important to the GCACH's work: Collaboration between different provider types (SUD with mental health with primary care) and collaboration between similar provider types (e.g. mental health with mental health). The latter type of collaboration is more difficult because of competitive pressures, but it is the greater opportunity. Behavioral health patients tend to move across similar provider types for various reasons, so coordination across these providers will help continuity of care.

The CSA indicated that few providers were taking advantage of external technical assistance for bi-directional integration (e.g. the AIMS Center, Qualis Health). The CSA also assessed the number of clinical providers who have completed either the PCMH standardized assessment tool (11) or the MeHAF assessment tool (8).

The CSA indicated that the majority of providers are interested in integration (22) or are doing it in some form (15). There were some eligible providers who do not have a plan and stated that they were not interested in developing one. However, GCACH also identified that the majority of providers who should be screening for behavioral health conditions are doing so, which is desirable. Providers are also offering different types of evidenced-based behavioral interventions and psychotherapies by behavioral health providers (e.g. cognitive behavioral therapy (24)). There is also a reasonable availability of psychiatric services by providers who should be making this available. However, there was an opportunity for more organizations, where applicable, to be conducting regular psychiatric caseload review on patients who are not improving.

Opportunities: The GCACH's initial work will be tied to shoring up organizations that have yet to achieve successful bi-directional integration of care. Because of the successful implementations already in place within the FQHCs residing in its service area, the GCACH will rely on their resources and technical assistance through contracting and other arrangements, to act as exemplars to provide consultation and technical assistance. The GCACH will also be strategically identifying and facilitating opportunities for collaboration across primary care and behavioral health providers as opportunities arise.

For physical space challenges among providers, the GCACH will also seek to identify opportunities such as colocation across providers, such as situating a community behavioral health provider within a hospital setting. In the smaller counties, this will be particularly important. Creating these collaborations, as well as finding ways to expand access, are the best ways to address workforce needs in the short-run, rather than trying to train or recruit providers.

For IT challenges, GCACH will provide specific IT investments through the addition of population health management tools on top of existing EHRs; direct secure messaging that links clinical provider to clinical provider and clinical providers to community-based providers of social services; specific software (CMT's PreManage) that will allow primary care to understand when patients have been admitted or discharged from an inpatient setting or visited the ED; and better linkages to state systems, such as integration of the Prescription Monitoring Program into the EHR, which will better coordinate opioid prescription management. For smaller agencies without EHRs, the GCACH will help them coordinate with larger healthcare organizations, such as through the purchasing of software licensure from the health larger systems.

Although care coordination organizations are not necessarily suitable for Practice Transformation (e.g., they do not empanel patients nor offer primary care services), they will be essential to care coordination for high-risk patients. GCACH will work to find funding opportunities for such organizations across the GCACH, as they are available and needed.

Creating communication pathways between similar provider types (e.g. SUD with SUD) will foster greater coordination and continuity of care. Where feasible GCACH will look to link providers together using direct secure messaging and perhaps other systems to ensure this coordination takes place.

GCACH will also identify provider needs for technical assistance and address these, either through the direct provision of services by GCACH staff or through contracting arrangements, such as through the University of Washington AIMS Center or Qualis.

GCACH will also investigate the availability of regular psychiatric caseload review within the rural areas through use of tele-psychiatry on patients who are not improving.

Transitional Care

Findings and Interpretation: When asked about which approach organizations are using for transitional care planning, the most frequently cited response was inter-agency, interdisciplinary collaborative care models (17), which is integral to the PCMH and is expected to receive a boost through the Practice Transformation efforts. The INTERACT model (4), and Community Paramedicine model (3), both evidenced based approaches included in the Project Toolkit, were the least cited approaches. More than 80% of organizations indicated that would like to implement or expand evidenced-based transitional care approaches. There also needs to be additional and enhanced clinical case management, particularly for those high-risk patients with SUD and/or mental health issues.

As to provider barriers for coordinating transitional care, a lack of social supports (30) and lack of community resources (29) were cited most often. The Astria Toppenish hospital is concerned with a lack of community social supports as they are close to opening their detox facility at the end of July. Transportation (29) was also highly rated. Social supports pertain particularly to high cost, high utilizing patients, who many times

isolate themselves. Access to follow-up appointments with the PCP (25) was also seen as lacking, which the PCMH should help remedy. There is obvious causality here: poor transportation, unstable housing, social isolation, and poor primary care access can all lead to increased utilization by patients.

An area of concern indicated within the CSA was the fact that many organizations fail to receive notification when one of their patients is admitted to or discharged from the hospital. Many providers do not receive a discharge summary or treatment plan. Too many providers are relying on faxes and paper-based methods to coordinate care, and too many high-risk patients are failing receive appropriate follow-up. In general, GCACH has identified that communication from community providers (e.g. primary care) to the hospital is proceeding reasonably. However, communication from the hospital back to the same provider is not as consistent. The referring entities – PCP, SUD – frequently are not receiving communication on treatment plans, discharge plans, and more.

There are also many provider organizations not analyzing or trending readmissions data. GCACH would like the primary care practices to pay attention to both their ED and inpatient numbers every month to find opportunities for improvement. The primary care practices also seem to analyze readmissions data more so than behavioral health and SUD providers, but it remains a problem for all three provider types. FQHCs are particularly guilty of not managing patients after an ED visit or when discharged.

The CSA indicated that there was virtually no use of standardized screening tools to assess the risk of hospital readmission (e.g. LACE (1) or BOOST/8Ps (2) tools). Through the initial State Innovation Model project, which focused on avoidable hospital readmissions, a modified BOOST tool combined with a follow-up visit from the nurse case manager proved effective in the reduction of subsequent re-admissions and ED visits.

Opportunities: Opportunities include increased use of the INTERACT model, Community Paramedicine model, nurse care coordination, and the Transitional Care Model. Some of these would focus on the needs of high utilizing ED frequent flyers (i.e. six or more ED visits within a 12-month period). Both focus on acute care conditions. Some other possible high opportunity areas would be a focus on individuals with SUD or individuals being released from correctional facilities. GCACH will also work to integrate the state's Prescription Monitoring Program into clinical providers' EHR, something the GCACH has highlighted as being essential, which will also support enhanced medication reconciliation.

There is also an opportunity for more and improved clinical case management for high-risk patients (e.g. behavioral health). Using the services of the care coordination agencies will support this outcome. Integration of PreManage in the primary care office will also support better transitions of care. GCACH could also contractually obligate in the provider's Practice Transformation Implementation Workplan that FQHCs and others routinely analyze ED and discharge data, and then transmit summary report measures back to the GCACH.

PMH Medical Center could stand as an exemplary organization and act as a model and mentor others in forming and using a Community Paramedicine program. A nurse case manager coordinates their paramedics (PMH owns their EMS services) who make patient follow-up visits, relying upon information conveyed in the patient's EHR and discharge summary and available through the hospital.

Direct secure messaging is another opportunity, and GCACH plans on instructing providers how to bill for this service. For patients with SUD, consent will need to be arranged through the PCP to comply with 42 CFR Part 2. Collaborations across providers, and the subsequent mutual agreement around workflows, will help coordinate these efforts.

Providers will also receive education around other billing opportunities for this work, for example, contacting the patient within 48 hours after an inpatient discharge. Providing a revenue model relating to this, and other areas of the project work, is critical to sustainability. GCACH also expects to look at ways to increase social contact for isolated, high-risk patients, such as through collaborating with meals-on-wheels, student nurses, community social groups, churches, etc.

GCACH has researched the idea of some form of a community resource directory, that might include healthcare and social resources. The ideal option would be a very user-friendly and intuitive website or app. However, sustainability funding becomes a concern with this option as the healthcare network is always changing. GCACH hopes to pilot a paper directory that would include social groups, programs, resources, activities, and healthcare resources.

For hospital providers not using a standardized readmission risk screening tool, GCACH hopes to pursue opportunities to increase use of such tools, such as the modified Boost tool.

Addressing the Opioid Use Crisis

Findings and Interpretation: The CSA indicated that the most frequently adopted opioid prescribing guidelines are those developed by the CDC (14). There appears to be almost no familiarity among providers with the Six Building Blocks Guidelines (6BB) (1), which poses an opportunity since these guidelines are linked to the PCMH initiative. However, many of the partnering provider organizations (e.g. FQHCs) are held accountable to the CDC guidelines, which explains their popularity. While 17 providers are following some sort of prescribing guidelines, (Bree, CDC, 6BB) 20 organizations are not using any guidelines, and incomplete responses made it difficult to understand what hospitals are doing around guidelines.

For those practices providing training, at least half (14) worked to get at least 75% of clinicians within the practice trained on the guidelines. When asked whether the practice's EHR offers decision-support capabilities for opioid prescribing guidelines, less than a third of respondents said yes. A lot of providers lacking an EHR (e.g., fire

departments, health departments) accordingly marked no here, and providers with EHRs, but no prescribing authority, also marked no. Some providers with prescribing authority and an EHR may have decision support functionality for opioid prescribing simply turned off. For those practices implementing prescribing guidelines, they seem to be doing what is expected in terms of using written patient agreements (22), documenting in the patient record (22), and providing patient education (22).

When asked whether they prescribed medication assisted treatment (MAT) and which type of treatment, around 40% confirmed they did, with the most popular treatment being Buprenorphine (12), which most often corresponds to prescription opioid addiction. Of those organizations responding, 75% indicated that they have either informal relationships with provider organizations offering acute care and recovery service or no relationship at all. The CSA also indicated that slightly more than half of responding organizations (18) established protocols for relapsing patients.

Not all provider organizations with ED departments offered take-home naloxone. The CSA also points to the need for a comprehensive community list of certified MAT treatment providers.

Opportunities: The Practice Transformation Navigators at GCACH will undergo training on the Six Building Blocks Guidelines, allowing them to act as trainers for provider organizations wanting to follow these guidelines. GCACH would like as many prescribing providers as possible within the priority practices trained with some form of opioid prescribing guidelines. GCACH will also offer training and IT support to provider practices with EHRs that have or might receive opioid guidelines training by activating the clinical decision support functionality in the EHR or by getting support from the vendor.

An opportunity that has been recognized by all the ACHs is MAT training. Community Paramedicine could provide follow-up visits after an ED visit for SUD or be contracted by the ED organization to reduce subsequent ED re-utilization.

The Benton-Franklin Community Health Alliance, one of the GCACH Local Health Improvement Networks (LHINs), supports the 6BB guidelines, and this too presents an opportunity for alignment with the GCACH's work. There may also be other opportunities with the 6BB model across the other LHINs. Statewide, the nine ACHs are seeking funding from the state for common training opportunities, including training around the 6BB model.

Creating formal collaborations between providers, perhaps through an MOU, mutually defined use case or something similar would be worthwhile to assure acute care and recovery services for those with SUD. This use case might also present opportunities for coming together under a Digital Health Commons project model, where providers collaborate around a use case and then facilitate IT integration to support it. This type of work is already successfully proceeding in the Kittitas LHIN.

GCACH will also work with hospitals, perhaps through negotiated change plans, to have

them offer take-home naloxone for SUD patients. GCACH will also work with MCOs to support funding of Community Paramedicine activities and will also support the formation of a list of MAT providers within GCACH communities to post on the GCACH website.

Chronic Disease Prevention and Control

Findings and Interpretation: When asked about risk factors that the organization routinely screens for, alcohol and drug use rank at the top (both 35), while Adverse Childhood Experiences (ACES) ranks the lowest (19). The PCMH would facilitate the screening for many of the measures included within this question, such as cholesterol (20), diabetes (25), obesity (24), hypertension (23), and more. Mental health and SUD providers responding to the CSA account for the large number screened for alcohol use (35), depression (34), and drug abuse (35), but they are not screening for other more routine risk factors (e.g. hypertension (23)). However, the CSA indicated that most providers are not being selective over who they screen: all patients are receiving screening.

When asked as to what type of intervention programs the organization uses to screen for risk factors, there are many practices not addressing high risk sexual behaviors, sexually transmitted infections, or unintentional pregnancies, which is very inconsistent with the needs within this service area.

A smaller number of organizations also had intervention programs for Adverse Childhood Events (ACEs) (15). Exercise/inactivity (15) and obesity (17) also stood out as being low in this group of interventions. When asked which overall chronic disease intervention program the organization was using, the top response was that they were referring patients to a local provider offering the chronic disease self-management program (18). Roughly similar numbers offered the Stanford Chronic Disease Self-Management Program (8) or the National Diabetes Prevention Program (6). Both programs relate to the PCMH model and will be addressed through that.

When asked which chronic disease category the organization currently offers, self-management or educational classes on diabetes (20) was selected more than twice as often as all the other programs listed.

Opportunities: The GCACH has long noted a need for training on trauma-informed care to address ACES, and there is a clear opportunity to train providers on screening for this. GCACH will support providers' ability to report on key data measures and more through the implementation of population health management software linked to the organization's EHR. Prioritized organizations participating in Practice Transformation will be able to choose the patient cohort (e.g. diabetes) they wish to improve performance over. This will enhance screening for risk factors pertaining to that cohort (e.g. obesity). Having some sort of program, intervention, or protocol for diabetes could be an opportunity to provide incentives.

There are opportunities for more providers within the same organization to follow

evidence-based medicine protocols, in other areas such as COPD, hypertension and asthma. Community Paramedicine might be able to provide training on some of these types of classes in the home as well.

In general, GCACH would like to support providers in doing data analysis however it makes sense. GCACH would like to facilitate some smaller providers to be linked up with an ACO organization.

Care Coordination

Findings and Interpretation: Although most provider organizations stated that they were tracking referrals to behavioral health (32), specialty care (29), social services (28), and community-based organizations (31), on-the-ground experience has informed us that these findings are overstated. Practices may not be adequately and fully tracking patient referrals, such as ensuring the patient sees the specialist, the notes that the clinics receive from the referral provider, or if the patient schedules an automatic follow-up visit with the PCP or other referring provider.

Providers acknowledged that the most important need for becoming a trauma-informed practice was training and technical assistance (31), followed by resources for staffing (27). Providers also acknowledged the same need for training and technical assistance (15) in relation to implementation of intentional pregnancy planning programming. However, very few providers are implementing this later program (4). Relating to this, only a small group of organizations are providing long-acting reversible contraceptives (11). A similar pattern held true for Chlamydia screening.

Opportunities: There is a large opportunity through education and workflows to identify what adequate referral tracking looks like. This will be a natural and consistent part of Practice Transformation.

When assessing how organizations utilized the Teach-Back technique, opportunities were identified to train provider groups. Opportunities were also identified for providing care management and coordination services to high-risk patients. In addition, while there is case management being done by the hospitals, MCOs or other contracted entities, people continue to fall through the cracks, as evidenced by the high ED utilization rates and the heavy use of faxes and paper-based referrals. This might indicate that transitional care is not well coordinated. Poor communication originating from the hospital and to other providers, and a lack of team-based coordinated care could be addressed through the PCMH and population health management tools that will help identify and manage high-needs patients (e.g. co-occurring disorders, behavioral health issues, social service needs) using risk stratification, patient registries, etc.

The Teach-Back technique is included in the statewide skill set for cross-ACH training. Opportunities exist to provide intensive care management services for high-risk patients by contracting with care coordination organizations in the network. For those organizations wishing to pursue intentional pregnancy planning, GCACH is using Upstream USA as a resource to implement this training.

Domain 1: Workforce

Findings and Interpretation: Through the CSA, recruitment was ranked as the highest need among workforce challenges. The overall rural area can prove to be a hindrance for recruitment as providers prefer more urban centers with better pay. In-person staff training is needed. Top choices were trauma-informed care (39), evidence-based practices (37) and cultural sensitivity training (35). HIPAA policy changes, emerging evidenced-based practices, and maximizing Medicaid reimbursement (25), will be part of the technical assistance coming through Practice Transformation work.

Opportunities: An opportunity in workforce may be to create “home-grown” providers (e.g. RN, ARNP, MD, DO) through the formation of curriculum or career pathways. For example, there might be an established pathway from a high-school degree, to a 2-year degree, or to a 4-year degree and perhaps beyond. GCACH would like to see these pathways established from the beginning, so people in high school could jump into a pathway and then carry it through to a degree and resulting profession. This would include high-schools, community colleges, universities and could also include internships. However, this is something that should occur at the state level and needs to be a statewide curriculum. GCACH would like to work with statewide agencies and their personnel tied to workforce development to develop standardized curriculums for people wishing to enter the healthcare clinical sector.

Placing local nursing students within provider organizations is clearly an opportunity. Most local nursing programs, such as that through Washington State University, often comment that they have difficulties making clinical placements. Yet many provider organizations are interested in offering internships, so there is a real disconnect here. With secondary school systems, WSU School of Nursing, Columbia Basin College School of Nursing and most local provider organizations being part of a group of stakeholders and partners, GCACH will seek out ways to connect nursing school students into organization placements and internships. This might be integrated into Practice Transformation as well as part of negotiated change plans.

Overall many workforce issues identified through the CSA will be addressed through Practice Transformation, including maximizing revenue, fully utilizing the EHR, time management, provider shortages, population health strategies, etc.

Domain 1: Health IT

Findings and Interpretation: Slightly less than half of responding organizations claimed that they are considering upgrading or changing their current EHR system (20 and 5). A large majority of responding organizations indicated that they neither use a population-based registry (35) to track patients needing planned care nor had a population health management system in place (37). Healthcare providers acknowledged that their EHR (35) is their primary source of data for quality improvement and population health management. Most EHRs do come with a limited list of pre-packaged reports, such as lists of missed patient appointments. Many organizations also rely on insurance company reports (20) and reporting from other sources (25).

When asked what technical investment opportunities the practice was interested in, the top responses were placing local nursing students into internal internships and practicums (38), population health management (33), mobile workforce (32), followed by different training opportunities.

When asked which HIT/HIE tools the organization currently uses, the top choices selected were manual exchange (paper/fax) (32), certified EHRs (28), and patient portals (26). Direct secure messaging (14) ranked low in this list. While use of EDIE (24) ranked high, PreManage (9) was less prevalent.

When asked to list which payment pathway or quality payment programs they were planning to participate in during 2018, the most popular choices pertained to those programs most likely to be mandated: Meaningful Use (19), MIPS (16), PQRS (15) and NCQA PCMH (10). GCACH expects that change efforts will enhance provider practice performance through these reporting and payment programs and enhance provider reimbursement as a result.

Opportunities: The use of manual exchange through fax and paper documentation spells out an opportunity for decrease. The implementation of a population health management system (which includes patient registries, risk stratification, data analytics, etc.), along with the possible implementation of PreManage, direct secure messaging, and other technological enhancements, will be part of the suite of HIT services and software GCACH will be providing to the priority list of primary care and behavioral health agencies. PreManage can be integrated into the practice's EHR system, so there isn't an extra step or sign-on. The state's Prescription Monitoring Program (24) is another opportunity that GCACH hopes to integrate in every EHR tied to a prescribing provider. The Prescription Monitoring Program user interface has been very cumbersome for providers to use. GCACH will work to fully integrate this program into individual practices' EHR, including integrating it into the medication list, all through a single sign-on.

GCACH will not be making commitments to upgrade or replace EHR systems within the participating provider organizations initially, however, GCACH will be offering enhancements to existing systems. GCACH may also make modest changes to current EHRs, such as activating dormant features in their systems (e.g. decision-support features).

Syringe Exchange Program

Findings and Interpretation: Organizations were asked whether they track clients who use syringe exchange services, with virtually no one acknowledging doing this (1). There are syringe exchange services identified within the GCACH in Walla Walla, Franklin, and Yakima counties.

Virtually no community-based organization asked for technical assistance to organize or expand a syringe exchange program (1). Few organizations also acknowledged

distributing naloxone kits (5). The state reimburses for the distribution of these kits, but EMS doesn't always bill because of their hurried work.

CSA survey data indicated that the drugs of choice by clients are Oxycodone/Hydrocodone (11), Heroin (10), and Fentanyl (6). Heroin, which is cheaper than opioids in pill form, indicates the possible need for Methadone programs. When asked about which social and treatment services clients are in most need of, the top choices were housing (15), transportation (15), and SUD treatment and recovery services (15). The general observations indicated that many SUD clients routinely need housing (15). They also have no transportation (15), have legal service needs (13), and need treatment and recovery supports (15), which corresponds to the findings of the survey. They also need employment assistance (14).

The survey indicated that a minority of organizations have protocols in place to refer people to medication assisted treatment (MAT) (11). There is also no list of MAT providers for referrals.

Opportunities: GCACH will consider including the organizations operating syringe exchange services to be part of the implementation process using direct secure messaging. One program provider received money to operate a mobile syringe exchange service, which could be used in rural southeast Washington where there is a low population but high prevalence of opioid abuse.

Distribution of naloxone kits at health fairs at the partnering provider organizations could be a way to educate families about proactive treatment of overdoses. EMS could work with local pharmacies for naloxone kits, and then coordinate with the pharmacy for reimbursement through a contractual agreement. GCACH will pursue opportunities with EMS providers and pharmacies to understand the possibility of getting EMS reimbursed for the naloxone kits they distribute to the public or use on patients.

As discussed above, GCACH will work to create a comprehensive list of providers offering MAT therapy and support the development of referral protocols for healthcare providers who might refer SUD patients.

EMS First Responders

Findings and Interpretation: The survey indicated that most Community Paramedicine programs (18) do not currently have an EHR. When asked which priority populations the target of Community Paramedicine programs should focus on, the top choices were ED frequent flyers (7), people with chronic conditions (6), and recently discharged hospital patients (6).

An area of training need for organizations responding under this section was around suicide prevention (17).

Opportunities: Direct secure messaging services, as has been described throughout this document, is a way to address communication and collaborations between healthcare

providers and Community Paramedicine programs, coupled with reimbursement.

Linking EHR between first responders and Community Paramedicine with healthcare and other providers will be part of the implementation plan for direct secure messaging. Finding opportunities for Community Paramedicine providers to collaborate in the management of ED frequent flyers and those with chronic conditions will also be considered.

Recently discharged patients are another opportunity for EMS. Research has shown how Community Paramedicine programs can reduce ED utilization.

Suicide prevention could be part of trauma-informed care training, and Community Paramedicine could provide support in the home for recent discharges due to suicide attempts, depression, or anxiety.

Please refer to attachment 1.2 GCACH CSA Final. 7.31.18.

Please refer to attachment 1.3 CSA Summary Report. 7.31.18.

Please refer to attachment 1.4 GCACH PTW Timeline and Bios 7.31.18.

4. Describe how the ACH has used the assessment(s) to inform continued project planning and implementation. Specifically provide information as to whether the ACH has adjusted projects originally proposed in project Plans, based on assessment findings.

ACH Response: The CSA assessment served many purposes including:

- Gathering data about the participating providers' resources, needs, strengths, and weaknesses, and the demographics of their clients
- Determining which organizations are ready, willing, and able to adopt the Patient Centered Medical Home (PCMH) model of care
- Prioritizing initial participating providers who will collaborate with the GCACH through Practice Transformation (and receive incentive funding), and identifying which organizations are ready to scale up and implement projects
- Informing the GCACH around provider needs and project approaches, HIT requirements, and workforce needs
- Identifying the extent of the GCACH referral network of healthcare and community-based partnering organizations

The CSA was also used by OHSU to provide an independent evaluation and selection of partnering providers.

Please refer to attachment 1.5 Organization Tier Selection for Practice Transformation and Community Partners. 7.31.18.

The CSA did not change the previous decisions around project approaches or initiatives determined by the project teams across the four project areas or chosen target

populations. The decision to implement specific evidence-based project approaches will be a negotiation with individual partnering providers, however, the findings of the CSA confirmed GCACH investments in the PCMH model of care and population health management tools, technical assistance, and communication platforms to share care plans, collaborate and send secure message via Direct Secure Messaging, PreManage and EDIE.

The CSA has informed the GCACH staff in determining specific intervention programs, gaps in services, targeted opportunities, social determinant needs, risk factors, and training needs provided internally or externally. The CSA also illuminated the need to expand the scope of community partners especially in care coordination. The findings will be shared with the PTW and Board in August to determine what other investments will be needed to support transformation.

5. Provide examples of community assets identified by the ACH and partnering providers that directly support the health equity goals of the region.

ACH Response: Greater Columbia ACH is fortunate to have four Federally Qualified Health Centers (FQHCs) and two FQHCs with satellite clinics within its boundaries, three of which are exemplar organizations: Yakima Valley Farm Workers Clinic, Yakima Neighborhood Health Services, and Community Health of Central Washington. These community health centers provide services to the majority of the 258,000 (ODS Data Warehouse, May 2018). Medicaid population across the nine counties. There are also eight Public Health Districts that offer healthcare services, forty-four housing agencies offering affordable housing, six Community Action Agencies, seven agencies offering legal services, thirteen transportation agencies, fifty-three nutrition programs, two Educational Service Districts, and thirty employment services, all of which directly support the health equity goals of the region. In addition, GCACH is very excited about working with the nine EMS/Fire Districts that have submitted Letters of Interest (LOI) to work with GCACH. This will give us the opportunity to use Community Paramedicine and mobile-integrated healthcare programs to reduce non-emergency EMS transport to hospitals and provide more appropriate medical resources for community members in need. PMH Medical Center has had a Community Paramedicine program in place since 2013 that can be an exemplar to the region.

Below are some other initiatives and resources already existing in the community that the GCACH might build upon:

OPIOID CRISIS

- **EMS Treat and Referral Program:** Pasco Fire Department offers an initial assessment of all people calling 9-1-1 for emergencies. If the assessment indicates home care that can be followed up by a social services referral, PFD contacts the referring agency to provide services.
- **Kennewick Fire Department** is addressing the Opioid Use Public Health Crisis by providing Narcan kits and training at no cost to partners in the community.

- Signal Health, a care coordination and case management organization, in Yakima supports the provision of trauma informed care management.
- Inland Northwest Recovery Alliance – (which falls under the Washington Recovery Alliance) is comprised of individuals in recovery from addiction and mental health conditions, families impacted by behavioral health conditions, and recovery community organizations driving change in two spheres related to behavioral health recovery: public policy and public understanding. The local chapter includes people from: The Greater Columbia Behavioral Health, The Living Room Community Church, Elijah Family Homes, Consistent Care, Bethel Church, Lynx Healthcare, WSU, Grace Clinic and more.

TRANSITIONAL CARE/ED UTILIZATION:

- Consistent Case Services is currently operating programs geared towards lowering ED readmissions for over utilizers (frequent flyers) and redirecting 911 calls to Urgent Care in Yakima, Tri-Cities and Walla Walla. They would like to expand the Consistent Care program to reach more Medicaid lives.
- Providence Kadlec Regional Medical Center, Virginia Mason Memorial Hospital, Providence St. Mary's Medical Center is contracting with Consistent Care Services for ED diversion services.
- Transitional care is a core component of the core services that SE WA Aging and Long Term Care is currently offering.
- The Benton-Franklin Transitions Coalition Steering Committee is collaborating with, and educating the community on difficult conversations and the acute need for comfort care. Their focus group is helping with changing the culture surrounding end of life conversations in Benton and Franklin counties.
- The City of Pasco Hot Spotters committee meets monthly to identify individuals over-utilizing medical and city/county resources. This committee consists of BHS agencies, District and Superior Court, and Consistent Care Services (CCS). CCS is placing care plans in their I-Leads (HIT) system that informs police how to manage individuals in the field in an effort to reduce jail recidivism.

BI-DIRECTIONAL

- Yakama Tribal Nation offers several different programs:
 - Equine Therapy: Equine-assisted therapy encompasses a range of treatments that involve activities with horses and other equines to promote human physical and mental health
 - The Tiinowit (drug and alcohol treatment) programs

- Home health services
- Yakama Nation Behavioral Health
- Probation Diversion Program
- Native Connection, which helps Native American communities address behavioral health needs of Native youth.
- Assured Independence offers home-based technology service that shares data by reporting historical reading and compliance information to multiple organizations directly from the patient's home.
- Signal Health Can support three elements of the Bree Collaborative - accessibility of patient information, operational systems, and data for QI.
- SE WA Aging and Long-Term Care has clients that have behavioral health diagnoses and would like to coordinate delivery of healthcare services for clients that need it.
- Consistent Care Services sponsors a monthly Community Cares meeting in Yakima, Kennewick, and Walla Walla to discuss challenges in delivering complex care to their most challenging clients. Includes EMS, ED staffs, Adult Protective Services, Aging & Long Term Care, BHS, Crisis Response Services and others.
- Lourdes Counseling Center teams meet every week with the Benton County Jail team to identify inmates in need of care coordination services on release.
- The Pullman and Pasco School Districts have programs that address childhood ACES.
- The CLEAR Trauma Informed Program is being taught in the Sunnyside Elementary school in Pullman. Strengthening Families Program (SFP) in Pasco strives to improve parental nurturing and limit-setting skills, improve communication skills for parents and youth, and encourage youth pro-social skills development.
- The Benton-Franklin Community Health Alliance would like to “train the trainers” for the 6 Building Blocks program and teach prescribers, ED staffs and clinic staff how to use the Prescription Monitoring Program.

CHRONIC DISEASE

- Virginia Mason Memorial Hospital, which serves a large Hispanic population, supports the 5210 media campaign, Diabetes Prevention Program, Chronic Disease Self-Management Program, Million Hearts Campaign, and Mind, Exercise, Nutrition, Do It! VMM sponsors a radio outreach program in Spanish on diabetes.
- The Benton-Franklin Health Department, which services many minority

populations, offers the Stanford Chronic Disease Self-Management Program.

- SignalHealth can support 5 elements of the Chronic Care Model: health system, delivery system design, clinical information systems, self-management support, and community programs.
- Yakama Nation doing the T-2, program which is an evidence-based curriculum for diabetes. Their Master Gardeners program is also working with the Tribe to support growing native fruits and vegetables that are culturally acceptable to them.
- Community Gardens – The Yakama Correctional Facility and Benton-Franklin Juvenile Justice run community gardens program for offenders. WSU Extension offices in the region are very interested in establishing community gardens in low income neighborhoods in the GCACH region.

HOUSING

- The Yakama Nation HOFPPWA housing program is an opportunity for people with AIDS.
- Triumph Treatment Services (SUD treatment provider) has a program (P-cap) that houses low income pregnant women with SUD problems.

INSURANCE SERVICES

- Merit Disability, which specializes in Social Security Disability, offers a program that links people to social security and enrolls them in insurance plans.

EMPLOYMENT

- The Benton-Franklin Workforce Development Council received a new contract called Families Forward Washington in the amount of \$682,706 to fund reemployment opportunities and training services for 100 noncustodial parents. The Benton-Franklin Workforce Development Council is the fifth location in the country to offer Families Forward. The key objective is to improve the earnings capacity of noncustodial parents, thereby increasing their ability to support their children.

- 6. Provide a brief description of the steps the ACH has taken to address health equity knowledge/skill gaps identified by partnering providers, and how those steps connect to ACH transformation objectives.**

ACH Response: The mission of the Greater Columbia ACH is to advance the health of the population by decreasing health disparities, improving the efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and engagement.

Attention to health equity is embedded in the GCACH mission statement because the partners serve this population and are anxious to improve the health of the people they serve. GCACH staff has provided extensive data around demographics, social and economic factors, health behaviors, clinical care and measures to partnering providers through presentations, project teams, monthly reports, and retreats.

Foundationally, GCACH has made a concerted effort to bring the right people to the decision-making table, and to operationalize the transformation work. GCACH has structured the committees, including the Board of Directors and Practice Transformation Workgroup (PTW) to have geographic and ethnic diversity so that discussions can represent the full spectrum of the population. GCACH has established six Local Health Improvement Networks (LHINs) to expand GCACH's understanding of local needs and hired a Community and Tribal Engagement Specialist from the Hispanic community who meets with the Community-Based Organizations (CBOs), Managed Care partners, and LHINs.

Access: GCACH is not only addressing provider schedules and panels but looking into transportation needs to improve access to care. Transportation and distance to care have been identified as barriers for the GCACH region. GCACH is working individually with providers to understand what needs would assist with these barriers, for example, community health centers that have coordinated appointments to address multiple services at one i.e., SUD, BH, PCP, vision, pharmacy, dental, etc. GCACH is working with organizations to facilitate bus routes that identify these community health centers and locations of services as opposed to street names. Bus, Uber, and taxi vouchers, bicycles, and transportation provided by community health workers are other options suggested by partnering providers to address transportation issues.

Attribution: GCACH will assist organizations at the provider level with member matching logic to link data between the various data sources and the MCOs metrics. GCACH will also work with the MCOs to understand provider attribution logic to assign members to a primary care physician as well as specialty and facility attribution for episodes of care. Classification systems, such as DRG assignment, service and utilization count assignment, episodes of care assignment, and member risk score assignment at the MCO level will be considered when working with the MCOs to ensure that all patients are being treated equally. GCACH will facilitate and assist in implementing evidence-based measures to calculate and benchmark against industry-standard quality and care metrics, and contract quality measures with the partnering providers to facilitate tracking of performance and qualification for incentive payments.

However, the overall strategy to addressing health equity is transforming 95% of the clinics to adopt the Patient-Centered Medical Home (PCMH) model and funding those organizations. This will require the following investments that have been identified by

the providers:

- Communication between clinics and Community-Based Organizations (CBOs)
- Population health management tools like disease registries, direct messaging, risk stratification, clinical dashboards, reporting capabilities, real-time notifications for emergency department and hospital readmissions
- Stipends for Tele-medicine, community health workers, Nursing internships
- Technical support in transitioning to team-based care
- Training on trauma informed interventions and approaches, opioid prescribing guidelines, and self-care skills like the Teach-Back technique, suicide prevention, population health management training, bi-directional integration and team-based care, cultural sensitivity, chronic disease management
- Education on the benefits of bi-directional integration and team-based care, maximizing Medicaid reimbursements, Adverse Childhood Experiences, diabetes
- Patient protocols for overdose education and take-home naloxone
- Investments in housing, transportation, and social supports

GCACH hired a Director of Practice Transformation and two Practice Transformation Navigators who are assessing and assisting providers to transform their business models to become Patient Centered Medical Homes (PCMHs). They are providing the technical support, developing change plans, designing workflows, supporting care teams, introducing population health management tools, providing EHR optimization, training on Medicaid reimbursement, and facilitating provider discussions around Practice Transformation.

B. Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)

1. **Attestation: During the reporting period, the ACH has identified common gaps, opportunities, and strategies for statewide health system capacity building, including HIT/HIE, workforce/Practice Transformation, and value-based payment. Place an “X” in the appropriate box.**

Yes	No
X	

2. **If the ACH checked “No” in item B.1, provide the ACH’s rationale for not identifying common gaps, opportunities, and strategies for statewide health system capacity building. Describe the steps the ACH will take to complete this milestone. If the ACH checked “Yes,” respond “Not Applicable.”**

ACH Response: Not Applicable.

3. **Describe progress the ACH has made during the reporting period to identify**

potential strategies for each Domain 1 focus area that will support the ACH’s project portfolio and specific projects, where applicable.

ACH Response: Greater Columbia ACH has been involved in numerous efforts to identify potential strategies for Domain 1 focus areas that support the project portfolio.

The PCMH model of care is a strategic way to address Domain 1 focus areas. PCMH strengthens primary care through workforce realignment and bi-directional integration of physical and behavioral health, improves reimbursement for services through quality improvements, especially chronic disease management, and uses population health management tools to track patients and monitor patient outcomes. Domain 1 strategies and evidence-based practices are critical to the success of PCMH.

- **Workforce:** PCMH models of care are team-based which supports bi-directional integration, transitional care, chronic disease and prevention and the opioid crisis projects.
- **Team-Based Care:** Team-based care offers many potential advantages including more effective and efficient delivery of additional services that are essential to providing high-quality care, such as behavioral health, patient education, self-management support, and care coordination. Team-based care increases job satisfaction, and provides an environment in which all medical and non-medical professionals are encouraged to perform work that is matched to their abilities (Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J. Creating Patient-Centered Team-Based Primary Care. AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2016). Team-based care is an effective approach to reduce provider burnout and more effectively manage the patient(s).

Training and technical support for team-based care will be provided to support sustainability for PCMH.

Grow Our Own: ACH and state workforce leaders are looking at strategies to “grow their own” workforce by creating career pathways that have a continuum of entry points, from high school to graduate studies. The Health Systems and Capacity Building Partnership (HSCBP) has discussed the need to support expanded site of service and scope for telehealth, address scope-of-practice, licensing, financing, and regulatory barriers for behavioral health providers, identifying common trainings for healthcare professionals, clinical practicums in areas of provider shortages, and identifying the core competencies that align provider contracts with team-based care.

Community Health Workers: Another workforce need is for community health workers (CHW), especially in coordinating care. The HSCBP identified the need to support the Department of Health’s CHW program to meet the needs of the ACHs.

All of these strategies will improve the capacity of the existing system, especially in behavioral health.

- **Population Health Management:** PCMH models of care need population health management tools like disease registries, risk stratification, empanelment, electronic care plans, and reporting tools to help physicians manage their patients. Being able to manage patients through registries allows providers to stay current with screenings for diabetes and target underserved populations. Reporting is another important function in managing patients, as the provider needs frequent feedback to monitor patient progress, or to discover who is falling through the cracks. Implementation of PreManage and EDIE (Emergency Department Information Exchange) for all healthcare partners as well as direct secure messaging for all healthcare and community partners will be funded through Delivery System Reform Incentive Payment (DSRIP) engagement funding. Change plans will include specific population health management investments to inform healthcare providers what their patient panels look like with respect to culture, disparities, chronic disease(s), and social determinants.
- **VBP:** PCMH models of care are founded on critical principles that pave the way to success for organizations wishing to compete in a market where value-based care initiatives and accountable care are built into contracting arrangements. Starting in 2019, practices that certify as a PCMH will be able to reap the benefits of Medicare's new alternative payment model program by receiving a 5% pay bonus while avoiding the down-side risk usually associated with value-based payment models such as accountable care organizations (Medical Economics: PCMH Playbook: 7 steps to plan today for a value-based payment future). Training on how to maximize Medicaid reimbursements will be offered through GCACH staff. ACH leaders are working with the HCA to ensure that team-based care and care coordination will be reimbursable beyond the life of the Medicaid Transformation Demonstration.
 - **Evidence-based Approaches:** PCMH models depend on evidence-based practices to deliver high quality care. The four project areas of GCACH are supported by evidence-based practices that result in better patient outcomes, and improved patient care thus more likely to be funded in VBP arrangements. The use of evidence-based practices will be a strategy to enhance reimbursement across all payer groups.
 - **Bi-Directional Integration of Physical and Behavioral Health:** Team-based care offers many potential advantages including more effective and efficient delivery of additional services that are essential to providing high-quality care, such as behavioral health, patient education, self-management support, and care coordination.
 - **Chronic Disease Management and Prevention:** The Chronic Care

Model (CCM) is a team-based approach that focuses on managing a population of patients, such as people with diabetes, to ensure that every patient receives optimal medical care, from the clinic to the community.

- **Transitional Care:** Meeting the patient within their setting 72-96 hours within transition is the key component to successful transition care. Home-based care and coordinating social services could be supported by CHWs, Community Paramedicine, nursing interns, and communication tools. Coordination of care and increased access are key components of the PCMH model.
- **Opioid Epidemic:** The Six Building blocks is a team-based approach to improving opioid management in primary care, and incorporates the PCMH change concepts (EHR Use, Care Coordination Key to Treating Substance Abuse, November 21, 2016, Sarah Heath, EHR Intelligence). GCACH is training the Practice Transformation Navigators to train providers and staff on this evidence-based intervention.

PCMH is a model for whole person care, and uses population health management tools, and workforce redesign to drive successful outcomes which can lead to more adoption of VBP arrangements.

However, this strategy did not just land into the GCACH's laps. It was revealed through the GCACH's growing knowledge and understanding about Practice Transformation, discussions with its State partners, ACH peers, and consultants, presentations from subject matter experts, meetings with providers, and more. Most impactful, however, was hiring an expert in Practice Transformation, Sam Werdel, who came to GCACH from Qualis, and had previously run a residency clinic at Oklahoma State University based on the PCMH model of care and the Comprehensive Primary Care Initiative (CPCI) which is directly aligned with the project areas.

Sam enlightened the staff, Board, Leadership Council, and then the Practice Transformation Workgroup about the benefits of PCMH. Combined with other strategic actions, GCACH transitioned from managing a portfolio of projects to implementing organizational change.

Disseminating this knowledge and weaving it into the governance structure has taken six months, but as a result GCACH has supported the strategy by:

- Hiring a Director of Practice Transformation
- Forming a 19-member Practice Transformation Workgroup whose charge is to be the change agents in their organizations for PCMH
- Hiring two Practice Transformation Navigators
- Hosting educational webinars and Leadership Council meetings on population health management and Practice Transformation

- Bringing in subject matter experts and state partners to discuss bi-directional integration, opioid management, and workforce
- Participating on the Health Systems and Capacity Building Partnership
- Using peer-to-peer for best practices and lessons learned to help build buy-in to integrated care
- Structuring the engagement funding allocations to reward the partnering providers for various Practice Transformation initiatives such as forming Quality Improvement Teams within their organizations, participation on the Practice Transformation Workgroup, submitting a Current State Assessment, leading a project team
- Rewarding providers that want to adopt PCMH business practices or receive PCMH recognition
- Forming a GCACH Workforce Committee and the Data Management and HIE Committee (DMHIE) to develop local strategies
- Utilizing the exemplar clinics to provide insight on different integration models, lessons learned, and how to begin the process

The Executive Director and Deputy Director have been involved in the Statewide Capacity Building Partnership meetings, and the monthly ACH Peer Learnings. The GCACH Board President, Rhonda Hauff, is a member of the MVP Action team, and another Board member, Dan Ferguson, is the Executive Director of the Washington State Allied Health Center of Excellence and is deeply involved in the WA Health Workforce Sentinel Network, the Health Workforce Councils, and is associated with the UW Center for Health Workforce Studies. The Deputy Director is a member of the AIM Committee.

GCACH has formed a Data Management and Health Information Exchange Committee (DMHIE) and a workforce committee. The Director of Practice Transformation has extensive knowledge about value-based payments, and their relationship to Patient Centered Medical Homes.

4. **Provide information as to whether the ACH has adjusted Domain 1 strategies as originally proposed in its Project Plan based on ongoing assessment.**

ACH Response: Before discovering the Patient Centered Medical Home (PCMH) model of care, GCACH was contemplating significant investments in workforce recruitment, HIE, and wondering how to “sell” value-based payment (VBP) to the providers. Luckily, PCMH is a better alternative, utilizes the existing resources, and makes the case for VBP.

- **Workforce:** PCMH revolves around team-based care which can expand the capacity of primary care by optimizing the skill set of the other team members to attend to patient needs. The addition of a behavioral health specialist can significantly impact the number of clients that a primary care physician can see during the year. According to a presentation by Thomas Bodenheimer MD entitled “Building Blocks of Primary Care” an average panel size per FTE physician is 2,000, demanding approximately 6,000 face-to-face visits of which the normal physician only has time for 4,400 visits. Team-based care can increase

that capacity by as much as 2,400 visits by taking most preventive, chronic, uncomplicated acute care, and behavioral health visits off the physicians' shoulders. Redesigning primary care services and structures to work effectively and efficiently on prevention, health promotion, and chronic disease management, can improve outcomes and the care experience in a cost-effective way, and adds value to each patient visit. Since most of the region experiences shortages in primary care and behavioral health providers, PCMH is an excellent way to expand the existing capacity of the workforce.

The emerging roles of paramedics have also changed the way GCACH is thinking about the regions' rural health needs, and transitional care. GCACH was fortunate to receive nine letters of interest from fire districts and emergency medical service providers (EMS) representing over 200 paramedics and EMS first responders. When the health care system does not work and is not coordinated, people call 911 (sometimes repeatedly) to get help for their chronic conditions. In 2015 and 2017, legislation was enacted that allows EMS to send a community resource paramedic to see a patient outside of the emergency medical system, and act as a community referral and education services program (CARES). CARES identify members of the community who utilize the 911 system or emergency departments for non-emergency or non-urgent assistant calls. The programs are required to measure reductions in the repeated use of the 911 system and any associated reductions in avoidable emergency department trips, so many EMS agencies have invested in electronic health record systems.

Locally, PMH Medical Center has operated its Community Paramedicine program since 2013, and has seen significant costs savings in their ED. They estimate avoided costs of \$696,000 based on actual interventions, and the hospital CEO has called it their "best public relations campaign ever" because they are funded by tax dollars, and the citizens love seeing the paramedics in their homes. Prosser Community Paramedicine paramedics reinforce discharge teaching, medication information, and disease management education (Prosser Community Paramedicine Program, PMH Medical Center, Spring 2016).

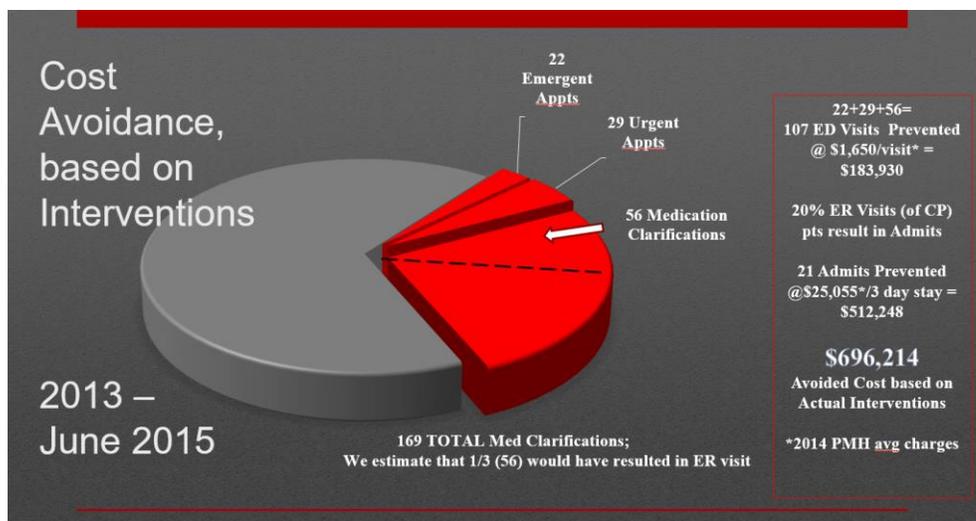


Figure 1: PMH Cost Avoidance Based on Interventions

Population Health Management: GCACH has also modified its thinking around HIE investment, and will invest in foundational tools for GCACH clinics adopting PCMH. Population health management tools like disease registries, direct secure messaging, risk stratification, clinical dashboards, reporting capabilities, real-time notifications for emergency department and hospital readmissions (EDIE) and care management tools like PreManage may be out of financial reach for some providers, but will be purchased by GCACH after a careful assessment of their IT needs. Many Electronic Health Records (EHRs) already have these capabilities or can easily be added to, however many providers are not aware of this. PreManage and EDIE can be integrated into EHR systems which provides an opportunity for GCACH and its behavioral and EMS partners to track ED utilization.

VBP: PCMH clinics use evidence-based models of care that are innovative and pave the way to success for organizations wishing to compete in a market where value-based care initiatives and accountable care are built into contracting arrangements. These project approaches are part of the Medicaid Transformation Project Toolkit and have been proven to improve patient outcomes and reduce costs of care, however, many of the providers are not familiar with them. The Chronic Care Model (CCM), for example, has proven to improve patient outcomes while reducing costs. Training on how to maximize Medicaid reimbursements will be offered through GCACH staff. ACH leaders are working with the HCA to ensure that team-based care and care coordination will be reimbursable beyond the life of the Medicaid Transformation Demonstration.

5. **Describe the ACH's need for additional support or resources, if any, from state agencies and/or state entities to be successful regarding health system capacity building in the Transformation.**

ACH Response: The nine ACHs have compiled a list of common needs for support or resources from the state in the table below.

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings.
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole person care and value-based payment.	Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between the Health Care Authority (HCA) and Managed Care Organizations (MCOs)	ACH's would benefit from additional training to fully understand GCACH's role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from GCACH partners which will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPi Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the value-based payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program.
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for Practice Transformation resources and initiatives.	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.

<p>In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes</p>	<p>Support from the state on VBP, specifically understanding how GCACH can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other technical assistance from the state.</p>	<p>ACHs wants to ensure that information held in these data repositories (<i>All-Payers Claims Database and Clinical Data Repository</i>) is accurate, accessible, timely, and useful to GCACH transformation work and to partners.</p>
<p>Systems for Population Health Management support for:</p> <ul style="list-style-type: none"> • Data governance • Interoperability • HIE • Disease Registries • Telehealth • PreManage/EDIE • Centralized registries 	<p>Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists).</p>	<p>MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid.</p>
<p>Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing, and licensed social workers</p>	<p>Training and TA for common training needs: MAT, PMP, Six Building Blocks, Transitional Care models, Trauma Informed Practices, Cultural Sensitivity, Teach-back techniques.</p>	<p>Establishing a career path for rural nursing and workforce needs, from high school, through 4-year programs.</p>
<p>Support for Dental Health Aide Therapists and other dental professions that expand scope of practice will improve dental access</p>	<p>Increased capacity for Practice Transformation support directly to participating providers-i.e. Practice Transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions.</p>	<p>Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.</p>
	<p>Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models and how it will impact them, and what steps they should take to be prepared.</p>	<p>Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care.</p>

	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.
		The state could mandate reimbursement for overdose education and take-home naloxone from MCOs.

C. Milestone 3: Define Medicaid Transformation Evidence-base Approaches or Promising Practices, Strategies, and Target Populations

For this milestone, the ACH should either:

- *Respond to items C.1-C.3 in the table following the questions, providing responses by project. (For projects the ACH is not implementing, respond “Not Applicable.”)*

Or,

- *Provide an alternative table that clearly identifies responses to the required items, C.1-C.3. The ACH may use this flexible approach as long as required items below are addressed.*

1. Medicaid Transformation Approaches and Strategies

Through the Project Planning process, ACHs have committed to a set of projects and associated strategies/approaches. For each project, please identify the approach and targeted strategies the ACH is implementing. The state recognizes that ACHs may be approaching project implementation in a variety of ways.

For each project area the ACH is implementing, the ACH should provide:

- a. A description of the ACH’s evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals, and requirements.
- b. A list of transformation activities ACH partnering providers will implement in support of project objectives. Transformation activities may include entire evidence-based approaches or promising practices, sub-components of evidence-based approaches or promising practices, or other activities and/or approaches derived from the goals and requirements of a project area.
- c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area, and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

2. Target Populations

Provide a detailed description of population(s) that transformation strategies and approaches are intended to impact. Identify all target populations by project area, including the following:

- a. Define the relevant criteria used to identify the target population(s). These criteria may include, but are not limited to: age, gender, race, geographic/regional distribution, setting(s) of care, provider groups, diagnosis, or other characteristics. Provide sufficient detail to clarify the scope of the target population.**

Note: ACHs may identify multiple target populations for a given project area or targeted strategy. Indicate which transformation strategies/approaches identified under the project are expected to reach which identified target populations.

3. Expansion or Scaling of Transformation Strategies and Approaches

- a. Successful transformation strategies and approaches may be expanded in later years of Medicaid Transformation. Describe the ACH’s current thinking about how expanding transformation strategies and approaches may expand the scope of target population and/or activities later in DSRIP years.**

Medicaid Transformation Evidence-Based Approaches or Promising Practices, Strategies and Target Populations	
Project 2A: Bi-directional Integration of Physical and Behavioral Health	
1. Transformation Strategies and Approaches	<p>Bree Collaborative Approach: Behavioral health care services integrated into primary care settings and primary care services integrated into behavioral health care settings:</p> <ol style="list-style-type: none"> 1. Integrated Care Team 2. Patient Access to Behavioral Health as a Routine Part of Primary Care 3. Accessibility and Sharing of Patient Information 4. Practice Access to Psychiatric Services 5. Operational Systems and Workflows to Support Population-Based Care 6. Evidence-Based Treatments 7. Patient Involvement in Care 8. Data for Quality Improvement <p>Collaborative Care Approach: Focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide</p>

	<p>evidence-based medication or psychosocial treatments supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.</p> <p>Key Components to This Project 2A Work:</p> <ul style="list-style-type: none"> • Analysis of current system integration resources and gaps • Identification of practices willing to integrate care • Development of data sharing systems to support integrated care • Hiring, training and supporting providers to adopt integration models targeting regional needs • Evidence-based integration models (Bree Collaborative, Collaborative Care Model) serving patients with varied levels of care needs • Population Health Management tools to identify high-risk, high-utilizing patients • Communications Platforms to share care plans, secure messaging for communications (Direct Secure Messaging, EDIE, PreManage) • PCMH/MeHAF assessments • Learning Collaborative to share best practices • Identification of behavioral health disorders in community settings (e.g., schools) • More access points to access care in community settings • Practice Navigators / Learning Collaboratives / Educational opportunities for technical assistance • Strengthen integration specifically with SUD providers
<p>2. Target Populations</p>	<ul style="list-style-type: none"> • High risk Medicaid beneficiaries with one or more chronic conditions and SUD. This includes children and adults. This is estimated at about 37,000 people in the GCACH. • 54% of ED admissions are due to behavioral health issues • 37% test/screen positive for SUD • 4% of those that test positive actually receive the services they need
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<ul style="list-style-type: none"> • Continue to focus on organizations who focus on Social Determinants of Health <ul style="list-style-type: none"> ○ Transportation, food, homelessness, housing stand out • Workforce: Higher education and BH providers are particularly in demand. <ul style="list-style-type: none"> ○ Focused training on brief interventions for BH providers in primary care is needed ○ CDP providers can only work in licensed treatment facilities unless they have dual credentials (and there are few providers who are dual-credentialed). This is a problem. GCACH need to have these restrictions lifted.

	<p>Original target population would remain the target population, but the services provided would not be limited to the target population. Need to be partners with the homeless shelters, transportation providers.</p> <ul style="list-style-type: none"> ● Palouse mentioned that there was an increasing population of homeless college students. ● Some barriers would be: <ul style="list-style-type: none"> ○ Workforce: Having the appropriate workforce with the corresponding training that is team based. ○ Education – need to have the capacity to do internships ○ Licensed facilities for substance abuse ○ Psychiatry ○ Food ○ CWP – funding for education ○ Training for integration vs. traditional behavioral health
<p>Project 2C: Transitional Care</p>	
<p>1. Transformation Strategies and Approaches</p>	<ul style="list-style-type: none"> ● Interventions to Reduce Acute Care Transfers (INTERACT): A quality improvement program that teaches strategies to improve the delivery of care by recognizing changes in conditions and prevents avoidable hospital transfers. ● Transitional Care Model (TCM): A nurse-led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up. (The TCM closely aligned with the GCACH SIM Readmission Avoidance Pilot. The pilot adapted a hospital discharge planning tool (BOOST) that used social determinants of health measures to predict future readmissions, a care coordination team that was cross-sector, relied on clinical and community resource, and stressed prevention.) ● The Care Transitions Intervention (CTI): A multi-disciplinary approach toward system redesign, incorporating physical health, behavioral health, and social health needs and perspectives. (Also known as the Skill Transfer Model) ● Existing family and patient-centered interagency interdisciplinary collaborative care models. ● Field-based nurse care coordinators, community health workers (CHW), and Community Paramedicine ● Evidence-informed approaches to transitional care for people with health and behavioral needs leaving incarceration ● Guidelines for the successful transition of people with behavioral health disorders from jail and prison ● Community Paramedicine Model <p>Key Components to This Project’s Work:</p> <ul style="list-style-type: none"> ● Expansion of collaborative Community Paramedicine efforts following hospital discharge (PMH Community Paramedicine model) ● Leveraging and expansion of existing family and patient-centered interagency interdisciplinary collaborative care models

	<ul style="list-style-type: none"> ● Expansion of use of field-based nurse care coordinators, community health workers, and Community Paramedicine ● Robust Population Health Management tools (disease registries, risk stratification) ● Communications Platform - (Direct Messaging, PreManage, EDIE) ● Workflow mapping to determine current state ● Medical care coordination by RN Case Managers, and outreach by Client Advocate Nurse case managers and community health workers ● Discharge planning that identifies high risk patients through a tool like BOOST ● Care Coordination/development of care coordination network to support patient and families <p>Development of a tracking system to track and manage referrals/transitions including specialists, hospitalizations, ED visits, and community agency referrals</p>
	<p>It was noted that hospice was not mentioned in previous reports, either as an intervention to prevent readmission or as a high-risk transition, but there is strong evidence it can reduce readmission rates. Virginia Mason Memorial Hospital (VMMH) is using their “The Surprise Question” (i.e., “Would you be surprised if this patient died in the next 6 months?”) as a trigger for palliative service consultation on admission of oncology patients. This is reasonable to extend this program to other chronic illnesses as the patient nears end-stage (e.g., heart failure, COPD, chronic kidney disease stage 4 or 5).</p> <p>INTERACT is called out as an evidence-based intervention and has been broadened to include tools for use in assisted living and adult-family homes, in addition to skilled nursing facilities and long-term care. In an IHI/Qualis-led collaborative learning project involving all 19 SNF and both hospital systems in Benton-Franklin Counties, 30-day readmission for Medicaid beneficiaries was reduced by roughly one-third.</p> <p>The PRISM tool was discussed to identify those at risk of readmission, but this is a retrospective tool with limited ability to facilitate upstream intervention. Local Transitional Care Model implementations have used the BOOST tool to identify those at high risk of readmission. This tool is a product of the Society of Hospital Medicine (https://www.hospitalmedicine.org/clinical-topics/care-transitions/). The Patient Activation Measure (PAM) tool was also mentioned as a useful tool in identifying those who would benefit most from intervention (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/).</p> <p>GCACH have discussed use of the Care Transitions Intervention model. It was suggested that Bridges (used by Providence Kadlec Regional Medical Center in collaboration with Aging & Long-Term Care), a component of Health Homes, uses a hybrid superset of this model, with the advantage of avoiding expensive training.</p> <p>VMMH is using an AI suite to predict readmission in oncology patients. It is not clear if this is validated in other populations.</p>

	<p>Kittitas is developing data tools using Pre-Manage to address these same issues. Based on a 2017 JAMDA study (https://doi.org/10.1016/j.jamda.2017.05.007), they also plan on using geriatric nurse practitioners and Community Paramedicine for close follow-up after high-risk discharges.</p> <p>Regardless of the model, the key feature that seems to predict improvement is meeting the patient in their setting within 72-96 hours of transition.</p> <p>All the local interventions discussed are innovative hybrids with evidence-based interventions deployed in novel fashion. All agreed that the nature of the ACH necessitates locally adaptive approaches. GCACH believe that these will move the needle on the P4P metrics called out in the toolkit for this project. The Transitional Care Project Team recommends calling out hospice specifically as an additional intervention for every county and the Yakama Nation because it has been shown to impact readmissions.</p>
<p>2. Target Populations</p>	<p>Target Population (Event Trigger): High-risk Transfer or Discharge.</p> <p>In general, GCACH agreed that the target population is defined by an event, specifically a high-risk transfer or discharge. GCACH clarified that this includes dual-eligible patients. GCACH discussed further the concept of high-risk, including those without appropriate access to either primary care or behavioral health. It was noted that transitions to and from chemical dependency treatment are additional high-risk transfers that should be included in the target population definition. GCACH would suggest GCACH also include hospice, as delayed start-of-care may create risk that GCACH can target.</p> <p>There was an acknowledgement that GCACH cannot save or improve every life, and that GCACH cannot intervene where the patient’s right to autonomy creates risk. While frustrating, this is part of the project nonetheless.</p>
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Successful transformation strategies and approaches may be expanded in later years of Medicaid Transformation.</p> <ul style="list-style-type: none"> ● Describe how expanding transformation strategies and approaches may expand the scope of target population and/or activities later in DSRIP years. ● Who are the necessary partners to this work (e.g. food banks)? <p>Many models GCACH discussed, including ongoing collaborative learning. As noted above, this was successful in Pierce County in the specific cases of implementing the INTERACT tool set across the county. Given the smaller populations, one could imagine 2- or 3-county cohorts serially running such collaboratives across GCACH, with all areas trained in 2-3 years. More generally, each of the 12 or 13 agencies at the session indicated a willing to share best practices and to learn from each other.</p>
<p>Project 3A: Addressing the Opioid Use Public Health Crisis</p>	
<p>1. Transformation Strategies and Approaches</p>	<p>Four Core Areas:</p> <ul style="list-style-type: none"> ● Dependence Prevention: 6 Building Blocks for opioid prescribing reform, physician referrals to case management services.

- Treatment: "Onboarding," link EDs, syringe exchange programs, addiction & recovery specialists, and public health into network to identify illicit opioid users who would benefit from MAT and intensive case management services w/supportive social worker to facilitate a positive working relationship with a health care provider.
- Overdose Prevention: Identify patients most at risk of overdosing on opioids and seek engagement into program. Large-scale naloxone distribution to first responders & lay people, training on preventing overdose, encourage hospitals and EDs to prescribe naloxone to patients who over-utilize emergency services or have had recent overdose event.
- Recovery: Successful enrollment and completion of a recovery program with or without MAT. Create Opioid Project Implementation Team.

The key components are to get people on insurance, comprehensive case management, provide wrap around services, working on reducing hospital utilization, increase SUD treatment penetration, provide MAT training, case management, robust population health management tools, communications platform, the use of community health workers, peer support, providing training to providers on the PMP, syringe exchange, suboxone waiver programs and focusing on geographic areas that need treatment.

Additions to transformation strategies and approaches:

- Women who are pregnant and are using opioids
- Strong mentorship system- support for providers of MAT
- Strong collaboration with social services and housing support for those using- the need for continued community collaboration as GCACH move forward
- Learning from other coalitions- and gaining provider support to learn from their successes
- Addressing adolescents that misuse opioids
- Ability to communicate within one system- communication framework that is HIPAA compliant that allows us to discuss patient needs across healthcare providers
- ASAM testing- suggested adding this clinical guideline. Used to stratify levels of substance use treatment

Evidence Based Practices to Explore:

- OBOT- Office Based Opioid Treatment
- Nurse care navigator
- Home Health

Below is a list of transformational activities that partnering providers will implement:

- Triumph Treatment Services: five residential programs, 3 programs are for pregnant and parenting women, housing, low-barrier housing (un-funded), working on providing OUD specific treatment.

	<ul style="list-style-type: none"> ● Yakima Neighborhood Health Services: MAT program, care for the homeless, partnering with Comprehensive Healthcare, team-based approach, case management, informally reached out to an organization in Seattle for valuable feedback. Goal: breakdown the silos. ● Comprehensive Healthcare: services throughout 5 counties, integrated work, MAT program, partnership with Yakima Neighborhood Health, continuum of care of outpatient and intensive outpatient and robust therapies. ● Planned Parenthood: 12 clinics from Pullman to Wenatchee, see a high population of homeless and teens, have a social worker on their team, follow-up care. ● Benton Franklin Health District: Franklin county: SEP, petitioning to get Benton County an SEP. ● Astria Toppenish: acute care ENT, medical detox, 90-day long-term care (not referral based, court ordered) ● Community Health Plan of Washington: MCO, their role is to work with all the partners to streamline the process and make sure there are not any barriers. ● Merit Resource Services: 6 outpatient clinics between Kennewick and Ellensburg, 750 people in service, walk-in assessments, and assessments off-site (hospitals, jails, nursing facilities), intensive outpatient, have agreements with 5-7 prescribers, evidence-based programs, 38 clinicians and youth programs. ● City of Pasco- Fire Department: educating, want to identify patients, have a referral list, carrying Narcan, supporting patients, welfare checks. ● Kennewick Fire Department: they would like to identify track and connect people with resources and supply opioid kits. ● Washington Recovery Alliance: exist on a SAMSA grant. Their organization wishes to improve the process of an individual leaving the ER from overdose through peer support, trainings, housing, employment, and fighting legal barriers. They are influential in getting Ricky's law passed and the Crop law. They are working towards starting a chapter of WRA. ● Lourdes: provides medical services and a robust system for behavioral health services. Have an existing MAT program, the path grant, crisis services, behavioral health services in the jail, and diversion services. They would like to develop a coordinated system of care. ● Pharmacist, Lydia Minnick: In the process of getting a CDTA done to get the patients Narcan, education and work on educating the doctors. ● Palouse Medical: Has worked on an opioid policy that has been shared with the local providers to be on the same page. The EMS system has identified an IV drug use problem. They are working on getting more prescribers for suboxone, expanding MAT programs, and expanding more recovery options. They would like to find an easy way to educate providers. ● Consistent Care Services: contract with health plans and hospitals, do not do the service. They provide case management for patients, they have outreach workers that are going out into the community to take people to appointments and get them to food banks. They would like to do wraparound case management services and provide the connection between agencies. ● Community Health: they run a MAT program, serve about 100 patients on MAT. They use the OBOT model, they deal with high risk individuals. They also have chronic pain registries and work with Medicaid clients. ● Kittitas County: they have a syringe exchange but want to collaborate with other organizations. ● Yakima Health District: have a needle exchange supply, working on implementing HIV testing, and distribute naloxone which is free to all their clients.
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	<ul style="list-style-type: none"> ● Molina: they work mental health and behavioral health providers and communicate engagement. <p>One of the main discussions was focusing on communication. All the attendees stated that GCACH need some sort of communication framework, not only for patients but for the community at large.</p>
2. Target Populations	<ul style="list-style-type: none"> ● Broadening the patient population to include 50 MED instead of 120 ● There was concern on how pregnant women would fit into the current target population categories. ● Adolescent misuse of opioids ● IV drug users ● All patients with a history of opioid overdose ● Looking at those individuals that meet more than 1 category should be considered ● Elderly with opioid misuse <p>Discussion around whether GCACH really needed to include individuals with a chronic condition- consensus was to remove this from the target population</p>
3. Expansion or Scaling of Transformation Strategies and Approaches	<ul style="list-style-type: none"> ● The target population that GCACH would eventually want to reach would be: ● Everyone with opioid use disorder ● Chronic pain patients at risk for overdose ● Identify people that are at risk for opioid use disorder- improve the use of risk tools, screening ● Looking at family history ● Anyone that has been given Narcan (not captured in ED or healthcare system). The need to identify those not seeking care for any OD ● Users of the syringe exchange ● Part of the transformation strategies is to move upstream. By doing this, this is expanding the target population. ● Necessary partners: libraries, criminal justice, the school districts, partner with elected officials, non-clean and sober housing (low-barrier), family support in the home, nurse family partnerships and public health nurses.
Project 3D: Chronic Disease Prevention and Control	
1. Transformation Strategies and Approaches	<ul style="list-style-type: none"> ● Chronic Care Model (i.e. Care Model) in primary care practices ● Diabetes Prevention Program (CDC) evidence based: nutrition and education (already implementing) ● Chronic disease self-management: Stanford Model (already implementing) ● Cardiac (Million Hearts Campaign)- media and nutrition (already implementing) ● Community Paramedicine (already implementing) ● Hot spotting (already implanting) ● M.E.N.D. (already implementing) ● Media/Food: health screening- food plans-community gardens ● 5210 Program media campaigns and health fairs

	<p>Counties:</p> <ul style="list-style-type: none"> ● Diabetes Prevention Program: Kittitas, Benton-Franklin, Yakima ● Chronic Care: Yakima, Whitman, Benton-Franklin ● M.E.N.D: Yakima, Benton ● Community Paramedicine: Benton-Franklin, Kittitas ● Health Fair: Yakima, Benton-Franklin, Columbia, Garfield, Asotin, Whitman, Kittitas ● Media: All ● Hot Spotting: Yakima <p>Project areas will not be used by all counties as they do not all have the need, data set or population. GCACH do not want to eliminate any of the areas.</p>
<p>2. Target Populations</p>	<ul style="list-style-type: none"> ● > 6 ED visits/year ● ≥ 5 Rx ● No PCP visits ● 3+ Chronic Care Conditions ● 2+ Non-OB admits ● Target Medicaid population but don't exclude non-Medicaid ● Children & adult Medicaid beneficiaries and other high-risk population ● Same pop. = 3 or more
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<ul style="list-style-type: none"> ● Food banks ● Clinics ● Physician/Provider ● 211 ● Transportation ● Media ● City government ● Bring all 9 counties together through training and have entities already performing to bring to others. ● Involve health districts.

4. What specific outcomes does the ACH expect to achieve by the end of the Transformation if the ACH and its partnering providers are successful? How do these outcomes support regional transformation objectives?

ACH Response: Greater Columbia ACH's vision is for 95% of the partnering healthcare organizations, including primary care and behavioral health, to exhibit the hallmarks of patient-centered medical homes (PCMH), including patient-centered access, team-based care, performance measurement and better transitions of care across all care settings. This will manifest itself through the following:

Lower Cost & Utilization

- Decreases in hospital ED utilization
- Decrease in hospital admissions, re-admissions
- Decrease of 2% in overall healthcare system costs through decreased utilization
- 50% increase in the number of bi-directional integrated clinics

Increased Collaboration

- Widespread collaboration between bi-directional clinics and community-based organizations within and across the counties across of the ACH.
- Various social sector organizations (e.g., housing and transportation) will form better relationships with clinical organizations and see increased client flows
- Local Health Improvement Networks will become more self-sufficient, will operationalize more of the Demonstration projects and will collaborate more across community projects
- Greater collaboration between the healthcare system and local government (city, county)
- Greater collaboration between SUD providers and mental health providers

Stronger Provider Organizations

- Primary care and behavioral health providers will become more self-sustaining under value-based reimbursement thus increasing the number of providers in VBP arrangements
- Providers will perform better under MCO quality metrics
- Less physician burnout and turnover
- Better billing practices by primary care and behavioral health, enhancements in reimbursements and revenue
- More population health management infrastructure (e.g., HIT)
- Primary care has increased awareness of their practice profile (e.g., risk stratification, disease cohorts, quality metrics)

More Integrated Care

- Increased use by prescribing providers of the Prescription Monitoring Program

- Greater number of oral health assessments and treatment (e.g., fluoride) at primary care level
- More team-based integrative care at the primary care level
- Fewer lost opportunities (i.e., people falling through the cracks) for high-needs populations (e.g., SUD)
- Chronic disease management would be more pro-actively managed (planned) at the clinic level

Robust Community Social Services

- Community-based services (e.g., housing, transportation, Low Income Home Energy Assistance, social groups) will be incorporated into a services directory
- Transportation systems (i.e., bus transit) would link with CBOs and social services to direct commuters to community social and health services
- Larger number of community gardens

Healthier, Engaged Patients

- Better outcomes for patients with increased patient satisfaction
- Patients would be more empowered and activated and have more self-knowledge about their health and the healthcare they receive
- More clinics trained on long-acting acting reversible contraception, leading to increased use with fewer unplanned pregnancies

Better SUD Treatment

- Larger number of MAT trained providers, & SUD collaboration with BHA and primary care
- Syringe exchange programs would scale and spread

Improved Healthcare Workforce

- Greater number of community health workers
- Greater number of nursing program student placements (internships) and integration into community clinic sites
- Clinical career pathways and curricula (high-school and beyond) are established
- Clinical workers (e.g. RN, RMA) better able to practice at the top of their license
- Dental Health Aide Therapists (DHAT) are more widespread
- Increased community education offerings which integrate teaching of different systems (e.g., educating behavioral health and primary care about oral health)

Enhanced Access

- Improved primary care access (e.g., more immediate schedule, late night and weekend appointments)
- Community Paramedicine are used to provide chronic care, health education and other services into rural areas

- Fewer disparities and better equity in the provision of care

Caveat: One large hospital now, and potentially a future additional large hospital, in the participating provider network have gone to for-profit status. This may result in changes in Medicaid patient flows where patterns shift utilization from the for-profit hospitals to the remaining not-for-profit hospital in Benton-Franklin Counties.

D. Milestone 4: Identification of Partnering Providers

This milestone is completed by executing Master Services Agreements (formally referred to as Standard Partnership Agreements) with partnering providers that are registered in the Financial Executor Portal. For submission of this Semi-Annual Report, HCA will export the list of partnering providers registered in the Portal as of June 30, 2018.

- 1. The state understands that not all ACH partnering providers participating in transformation activities will be listed in the Financial Executor portal export. In the attached Excel file, under the tab D.1, “Additional Partnering Providers,” list additional partnering providers that the ACH has identified as participating in transformation activities, but are not registered in the Financial Executor Portal as of June 30, 2018.**

Complete item D.1 in the Semi-Annual Report Workbook.

ACH Response: See Excel file titled GCACH SAR1 Workbook, tab D.1. Additional Partnering Providers.

Section 2: Standard Reporting Requirements

This section outlines requests for information that will be included as standard reporting requirements for each Semi-Annual Report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-Level Reporting Requirements

A. ACH Organizational Updates

- 1. Attestations: In accordance with the Transformation’s STCs and ACH certification requirements, the ACH attests to being in compliance with the items listed below during the reporting period.**

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

- 2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes” for all items, respond “Not Applicable.”**

ACH Response: Not Applicable.

- 3. Key Staff Position Changes: Provide a current organizational chart for the ACH. Use bold italicized font to highlight changes, if any, to key staff positions during the reporting period. Place an “X” in the appropriate box below.**

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

Insert or Include as an Attachment: Organizational Chart

ACH Response: *Please refer to attachment 1.6 GCACH Org Chart*

B. Tribal Engagement and Collaboration

- 1. In the table below, provide a list of tribal engagement and collaboration activities that the ACH conducted during the reporting period. These activities may include relationship building between the ACH and tribal governments, IHS facilities, and UIHPs, or further engagement and collaboration on project planning and/or implementation. Add rows as needed.**

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Meeting with Yakama Tribe to discuss how to implement a Dental Health Aide Therapy Program	2/1/18	Yakama Tribal Council members: Charlene Tillequots, and Lottie Sam Yakama Tribal Members: Kathy Saluskin and Tonya Kreis President's Liaison for Native American Affairs, Heritage University: Maxine Janis Columbia Basin Dental Hygiene Program: Heidi Desmarais Native Dental Therapy Initiative Project Director, NW Portland Area Indian Health Board: Christina Peters Greater Columbia ACH: GCACHs Wes Luckey, Carol Moser	Lottie Sam, Charlene Tillequots, Kathy Saluskin, Tonya Kreis, Maxine Janis, Heidi Desmarais, Christina Peters, GCACHs Wes Luckey, Carol Moser	Get support for the DHAT program from the Tribal Council representatives who sit on the Health, Employment and welfare Committee (HEW)	Support from Tribal Council members Lottie Sam and Charlene Tillequots was obtained. They need to get this item in front of the Tribal Council in order to move forward. Councilwoman Lottie Sam to get on a future Tribal Council meeting agenda.
Yakama Tribal Council Meeting	3/6/18	Christina Peters, Carol Moser, Maxine Janis	Yakama Tribal Council members, Peters, Moser, and Janis	Get support for the DHAT program from the Tribal Council	The Tribal Council voted to support the DHAT program. Next step is drawing up a collaborative agreement through the Yakama's legal department.
Email from Kathy Saluskin	5/16/18	To: Nachand, Lena R. (HCA) Tanya Firemoon, NPAIHB,		CMS did not approve Washington SPA 17-0027, which is coverage	NPAIHB conference call with CMS, HCA, and Swinomish on 5/17/18 to discuss non-approval

		Heidi Desmarais, Maxine Janis, Carol Moser, Christina Peters, Tonya Kreis		and reimbursement (3rd party reimbursement) for DHAT services. HCA petitioning for reconsideration.	of the SPA. Met with HCA 5/17/18 to discuss the appeal process and next steps. NPAIHB working with IHS to understand what options exist for reimbursement through the CHAP program and IHS. 6/8/18 HCA asks feds for reconsideration on tribal dental therapists.
Email from Carol Moser	5/16/18	To: Kathy Saluskin		Discuss Plan B	Kathy to send a list of names of Tribal members to meet with to discuss other project ideas.
HCA Listening Tour	6/18/18	Jessie Dean, Administrator and Tribal Liaison, HCA, Lena Nachand, Tribal Liaison, HCA, Vicki Lowe, Executive Director, AIHC, Arlen Washines, Deputy Director Yakama Nation Human Services Administration Department, Linda Walker, Human Services, Yakama Tribal Council members Lottie Sam, and Charlene Tillequots, Kathy Saluskin, Carol Moser, Ruben Peralta	Jessie Dean, Lena Nachand, and approximately 10 Tribal representatives (no introductions), Ruben Peralta, GCACH, Carol Moser, GCACH	HCA's Listening Tour to hear from the Tribes across WA State to hear about Tribal Specific Project Plans with Medicaid Transformation funding.	Indian Healthcare Tribal dollars should focus on scopes outside of the ACH programming. No restrictions on these funds. Potential Projects: Case Management, Providers, SUD outside of White Swan, EHR license, CHW training, HIE.
GCACH/ Yakama Tribe meeting	6/22/18	Kathy Saluskin, Lottie Sam, Cookie Fiander, Stephen Selam, Ellen Swan, Joy Heemsah, Regina Brown, Julie Ferguson, Linda Moncreif, Anita Mendoza, Regina Brown, Miguel Cortez, Deena Hoptowit, Brandon Mansfield,	Kathy Saluskin, Cookie Fiander, Eric Johnson, Stephen Selam, Joy Heemsah, Regina Brown, Linda Moncreif, Debra Byrd, Catherine Ikea	Discuss alternative project ideas for Medicaid Transformation	Many ideas GCACH discussed including a cultural camp for families, vehicles for Camp Shapparel, more interaction with Indian Health System, physical therapy providers, EHR system for Behavioral Health, a way to track referrals, help with rehab and transportation to rehab, expansion of Diabetes cooking classes to include traditional foods, mobile radiology unit for Mobile Medical Diagnostic Imaging. NEXT MEETING: Aug 7, 9am, Correctional Facility

		Vernon Alvarez, Debra Byrd, Denise Hill, Marie Miller, GCACHs Wes Luckey, Jenna Shelton, Sam Werdel, Ruben Peralta, Carol Moser	Jenna Shelton, Sam Werdel, GCACHs Wes Luckey Ruben Peralta, Carol Moser		
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Project Reporting Requirements

C. Project Status Update

1. Provide a status update that highlights Transformation planning progress by listing activities that have occurred during the reporting period in the table below. Indicate the project(s) for which the activity applies. If the activity applies to all projects, indicate as such. Are project activities progressing as expected? What are the next steps? Add rows as needed.

Examples of activities may include, but are not limited to the following:

- *The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.*
- *Partnering providers have completed training on project interventions.*
- *Partnering providers have adopted and/or are using project tools/protocols.*
- *The ACH has invested in and/or provided technical assistance for partnering providers.*
- *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
- *New services are being offered/provided to Medicaid beneficiaries.*

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Assess current state capacity of provider organizations in project areas, Domain 1 activities, demographics, care coordination, syringe exchange programs and EMS First Responders	2A, 2C, 3A, 3D	Yes	<p>Greater Columbia received 57 current state assessments (CSAs) and staff has conducted a detailed analysis of the findings.</p> <p>Findings from the CSA will be taken to our partners and stakeholders, including the GCACH PTW, Leadership Council, Board, project teams, DM&HIE Committee, and its partnering providers. The GCACH will review and incorporate feedback from these groups.</p> <p>This analysis is addressed in Section 1. Included in the CSA GCACH questions regarding provider readiness to adopt the Patient Centered Medical Home model of care. GCACH has determined that for the projects to be sustained beyond the life of the Medicaid Transformation Project, clinics that adopt this model will have a much higher likelihood of success in obtaining the project measures and other quality measures in the patient populations that they serve, will get better utilization of the population health management tools that they are provided, and be more prepared for VBP arrangements.</p> <p>GCACH will still implement the four project areas but has recognized that the focus will be on those approaches that align with team-based care and fit within the model of a Patient-Centered Medical Home.</p> <p>During Practice Transformation there will be a focus on optimizing workflows, IT infrastructure, and building community partnerships to promote collaboration, particularly for stand-alone behavioral health agencies, and to fill in gaps of care from primary care clinics. After initial analysis, the Practice Transformation Navigators will work with partner staff and their Quality Improvement Teams to map workflows and use Plan-Do-Study-Act (PDSA) cycles to create and test more effective workflows. GCACH has anticipated that the analysis of workflows will reveal needs for data sharing systems and plans to provide funding and assistance for the implementation of EDIE (Emergency Department Information Exchange)/PreManage and Direct Secure Messaging. Enhancement of EHRs</p>

			<p>to include disease registries, risk stratification, and reporting tools will be determined on a case by case basis and funded through DSRIP dollars.</p> <p>GCACH will also determine other roles that healthcare partners and community-based organizations could play in implementing evidence-based approaches and supporting providers.</p>
Select Target population and evidence-based approach informed by regional health needs	2A, 2C, 3A, 3D	Yes	<p>Target populations GCACH selected during the Project Plan application phase and confirmed by project teams at the June 21, 2018 meeting. In August, the PTW, per their Charter, will review the list of selected partners to ensure that the providers involved with PCMH contracts address target populations, health disparities, and health equity.</p>
Identify how strategies for Domain 1 focus areas - Systems for Population Health Management, Workforce, Value-Based Payment - will support project	2A, 2C, 3A, 3D	Yes	<p>All ACH leaders have been involved in the Health Systems and Capacity Building Partnership work and have identified several initiatives related to workforce/Practice Transformation that will require policy changes at the state level to enact, especially regarding Practice/Licensing, Telehealth, and Team-Based Care. The Association of Washington Public Hospital Districts will manage the convenings, project management, and actions of this group.</p> <p>The ACH leaders have also been working together on understanding their role in value-based payment arrangements. Marc Provence and team are working to define “value,” and are starting to work on the attribution and assignment issue through meetings with MCOs. ACHs are also interested in creating a subset of 3-5 measures for the MCOs to fund to ensure sustainability of the projects and are hoping that the HCA will get behind these to put in MCO contracts.</p> <p>From the GCACH perspective, GCACH believe that the model of care (PCMH) delivers value because the patient receives a higher quality of care that addresses the underlying causes of disease, including those that are social, environmental, and behavioral which is why GCACH is planning to invest resources into clinics that adopt the PCMH model.</p> <p>Population health management tools, as articulated in Section B, question 3, Milestone 2 are foundational investments that GCACH will purchase for the partners to support risk stratification, manage patients with chronic disease, identify patient panels for providers, provide interoperability, and communication. GCACH is currently working with several vendors (Collective Medical Technologies, Quad Aim Partners, CSI, EMR Direct,</p>

			SureScripts, Updox, and Data Motion) for quotes on population health management tools.
<p>Identify, recruit, and secure formal commitments for participation from implementation partnering provider organizations including: BH and physical health providers, organizations, and relevant committees of councils</p> <p>Identify, recruit, and secure formal commitments for participation from all target providers/organizations via a written agreement specific to the role each will perform in the project</p>	2A, 2C, 3A, 3D	Yes	<p>GCACH has received 81 letters of interest which are non-binding but have provided the basis for receiving engagement funding. All but 14 providers are registered in the Portal, most of which have had technical issues (wrong EIN, wrong bank account number). GCACH is working with <u>primary care clinics</u> interested in adopting the Patient-Centered Medical Home (PCMH) model of care. Determination of the first cohort of <u>partners</u> (23) was accomplished through a readiness assessment embedded in the Current State Assessment. This process will be repeated throughout the Demonstration until GCACH runs out of clinics or funding. These clinics will also be implementing project 2A, 2C, 3A, and 3D in collaboration with the other partners.</p> <p>In collaboration with GCACH partners, determine <u>which</u> clinics the partners want to enroll in Practice Transformation in 2018. GCACH is planning for approximately 40 clinics in the first cohort given staff resources and funding and will negotiate with partners which evidence-based approaches they want to implement in each clinic or hospital.</p> <p>During this phase, GCACH Practice Transformation Navigators (PTN) will continue working with selected partners, their Quality Improvement Teams, and Behavioral Health organizations to complete a MeHAF, PCMH-A, Current State Assessment (if they haven't filled one out), and Qualis Billing and Information Technology Toolkit (for BH providers transitioning to integrated managed care). The information gathered from these assessments will be used to develop a Practice Transformation Implementation Workplan (PTIW) which will detail quantitative scores from the assessments, strengths, opportunities, and SMART goals for each clinic. The PTIW is a 'living document' that will be referred to and updated during each meeting between a clinic and the PTNs. Once the PTIW is finalized contracts will be written that include the PTIW.</p>

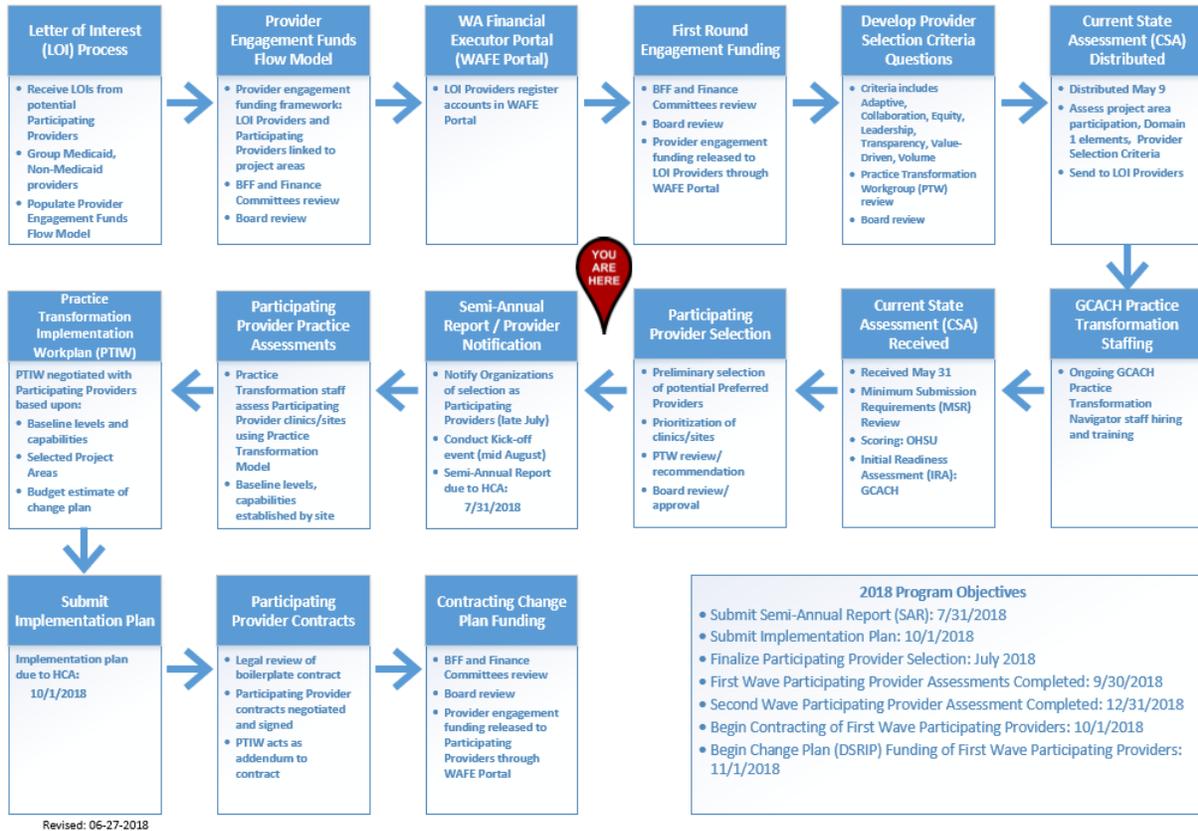


Figure 2: 2018 Participating Provider Workflow

Portfolio-Level Reporting Requirements

D. Partnering Provider Engagement

- During the reporting period, how has the ACH coordinated with other ACHs to engage partnering providers that are participating in projects in more than one ACH?

ACH Response:

Providence Health System: The ACH leads from North Sound, Southwest, Better Health Together, Healthier Here, Greater Columbia, and Cascade Pacific Action Alliance held a meeting with Whitney Haggerson, Kim Williams, and Mark Wakai from Providence St. Joseph Health (PSJH) on 6/4/18. The primary focus was to understand PSJH's Medicaid Strategy, and to talk about where and how PSJH can be a strategic partner in the years to come across all ACHs. The ACHs also learned about some of the barriers that Providence is experiencing in moving to VBP, how they are using population health management tools to track patients regarding barriers to access, working with local FQHCs, managing care coordination, and addressing social

determinants. The ACHs asked how GCACH could standardize the work to ensure that PSJH gets the metrics they need, organizing community partnerships, and addressing avoidable ED utilization and the community behavioral health system.

Yakima Valley Farm Workers: Yakima Valley Farm Workers is an FQHC headquartered in Toppenish, Washington, that provides services in both Greater Columbia ACH, and Better Health Together. They operate 20 clinics in GCACH and three in Spokane. Brian Sandoval co-chairs the GCACH Practice Transformation Workgroup and is on BHT's Provider Champion's Council. Sandra Suarez is a Board Member for GCACH, and also attends the BHT Leadership Council and Spokane County Collaborative meetings. Kai Nevala is a BHT Board Member and participates in GCACH's Whitman County Local Health Improvement Network. In this way, GCACH receive information through YVFW that guides the thinking around committee structures, project approaches, and best practices.

Comprehensive Mental Health: Comprehensive Health has eleven (11) clinics in the GCACH and two (2) in SW ACH, with their corporate headquarters in Yakima. Ed Thornbrugh is a Board Member for GCACH, and a Vice-President for Comprehensive Health. Leadership from SW ACH and GCACH have shared information to be on the same page about Practice Transformation, and project approaches in bi-directional integration, however more could be done to promote further understanding of barriers and opportunities.

Washington State Hospital Association / Washington State Medical Association: The ACH leads have met several times over the past year with the Washington State Hospital Association / Washington State Medical Association to discuss consistent messaging with partnering providers, the need for continuous communication around opioid initiatives, the interface between EDs and community-based care coordination especially when MATs are administered, having a standardized statewide reporting resource to find MAT providers, working on shared priorities for legislation, and more.

The Health Systems Capacity Building Partnership: The Health Systems Capacity Building partnership includes the Executive Director of AWPHD, Ben Lindekugel, Michael Vanderlinde, the Director of Pharmacy at Harborview Medical Center, Laura Zaichkin, Deputy Chief Policy Officer, HCA, Maria Courogan, Department of Health, and the ACH leads. The Partnership is "a strategic partnership of statewide entities and communities identifying common gaps and common opportunities statewide for health system capacity building." The June meeting culminated in identifying some workforce issues that are common across all ACHs, and touched on rural hospital needs for training, recruitment, and telehealth; partnering providers that all ACHs have in common, and legislative issues.

Better Health Together (BHT) and GCACH: GCACH and BHT share borders and patients travel frequently for health services in Spokane. Plans are in the works with the Northwest Rural Health Network to meet with providers to share strategies to improve the barriers to care and better care coordination.

MCOs: The ACHs have met with the MCOs to discuss how to work together on support provider success, improving communication and avoid over-taxing provider with multiple requests. The MCOs have talked about building evaluation upfront with Medicaid savings. The way that care has been re-designed is not necessarily the way it will be sustained, so the ACHs want a better understanding from the MCOs what they will reimburse. The ACHs are trying to create space on their monthly Peer Learnings for the MCOs.

2. **Briefly describe the ACH's expectations for partnering provider engagement in support of transformation activities.**

ACH Response: Greater Columbia ACH has been very explicit with its partners in the Medicaid Demonstration. Completion of the LOI process, completion of the Current State Assessment, registration in the WA FE portal, participation in project teams, and support of the GCACH vision and mission statement are expressed in the Local Health Improvement Network contracts. GCACH also expects ongoing participation in Leadership Council and LHIN meetings. Other expectations include, but are not limited to:

- Addressing ED and re-admission utilization through monitoring and coordinating case management for high risk, high utilizing patients
- Transparency-sharing of data
- Implementation of evidence-based approaches
- Collaborate within their organizational team and with other community organizations
- Identify gaps in population management tools
- Identify infrastructure gaps in coordinating care
- Take advantage of the technical assistance provided by GCACH
- MeHAF, PCMH and Billing and Information Technology Assessment
- Review current workflows and address areas of deficiency
- Address health disparities among their patient population
- Empanel and risk stratify patients in an uninformed manner
- Improve access to patient care and resources
- Medication reconciliation and use the PMP
- Identify gaps in current service structure and work towards implementing or collaborating to provide those services
- If applicable, MAT Training, obtain Buprenorphine waiver and obtain and utilize the PMP system
- Willingness to work with and meet with GCACH Practice Transformation staff
- Willingness to meet with GCACH Practice Transformation team regularly when project metrics are deficient and declining
- Organizations identified as exemplar to provide technical assistance, mentoring and share best practices
- Internships

These expectations are not all inclusive to all partnering organization. Specific contractual obligations will be negotiated with providers and include a combined effort to meet the organizational and GCACH goals as outlined in the Practice Transformation Implementation Work Plan (PTIW), a living document updated as goal and/or plans are changed in agreement with both parties.

- 3. Describe the ACH's efforts during the reporting period to engage partnering providers that are critical to success in transformation activities. What barriers to their participation have been identified, and what steps has the ACH taken to address those barriers? Include the steps the ACH has taken to reach partnering providers with limited engagement capacity.**

ACH Response: During the reporting period, GCACH has put forth great efforts to engage Behavioral Health Agencies (BHAs), FQHCs, hospital systems, clinicians, care coordination agencies, community-based organizations, Local Health Improvement Networks, the Yakama Tribe, and worked with other ACH leaders to connect with Washington State Hospital Association, Washington State Medical Association, MCOs, Providence, AWPHD, Qualis, the Health Workforce Sentinel Network and others in transformation activities.

Because the Leadership Council and Board meetings are accessible online, or by phone or video conferencing, the primary barrier is the time of day the meetings are held (9:00-11:30 for the Leadership Council, and 12:30-3:00pm for the Board of Directors) preventing many partners and stakeholders from attending. However, physical distance is a barrier for those wanting to attend in person. Lack of understanding of GCACH's role in the transition to integrated managed care was identified as a barrier, therefore, educating Behavioral Health Agencies (BHAs) is a priority. Trust issues around GCACH's role in healthcare transformation and "Obamacare" has also been a barrier.

GCACH hosts monthly Leadership Council meetings that are professionally facilitated and catered. These meetings often bring in subject matter experts and speak to topical areas that are germane to Practice Transformation or the four project areas. GCACH has also tried to keep partners engaged through the monthly newsletter, a robust website that is easy for site visitors to navigate and is equally usable on mobile phones, and weekly recaps to the Board of Directors that summarize staff activities. All meeting materials for the Leadership Council, Board, and the Finance, Practice Transformation Workgroup, Budget and Funds Flow committees are posted online as well as recordings of the Leadership Council meetings. GCACH also posts important documentation such as the project plan application, certification applications, and upcoming training opportunities.

GCACH staffs several committees that offer opportunities for partnering providers: Budget and Funds Flow, Finance, Practice Transformation Workgroup, Workforce, Data Management and HIE.

For providers with limited engagement capacity, GCACH has contracted with six Local Health Improvement Networks (LHINs) that meet regularly that are structured similarly to the ACHs, allowing providers to attend their local meetings:

- Benton-Franklin Community Health Alliance (BFHCA) (meets in Richland)
- Blue Mountain Region Community Health Partnership (BMRCHP) (meets in Walla Walla or Dayton)
- South East Washington Rural Health Network (SE WA RHN) (meets in Pomeroy or Clarkston)
- Whitman County Health Network (WCHN) (meets in Pullman)
- Kittitas Valley Health Network (KVHN) (meets in Ellensburg)
- Yakima Valley Health Care Coalition (YVHCC) (meets in Yakima)

The LHINs have all signed contracts with GCACH and receive funding that enables them to stipend members to attend their meetings, provide lunch, or pay for transportation to GCACH meetings and events.

GCACH also meets regularly with the Yakama Tribe, and drives to tribal administration in Toppenish due to their limited capacity to attend GCACH meetings.

Diane Halo, Project Manager for GCACH Integrated Managed Care has started three committees that are focused on getting the behavioral health providers ready for integrated managed care. They include:

- Provider Readiness Workgroup
- IMC Communications Workgroup
- Early Warning System Workgroup

These meetings are also accessible online or by phone. In these meetings it is GCACH's intent to inform the BHAs of the services that GCACH staff can provide as well as the necessary steps for BHAs to secure funding.

GCACH intends to start Learning Collaboratives in the four project areas in the fall that can take advantage of national expertise and drill down into specific evidence-based approaches and is in the preliminary stages of planning sectors meetings, especially the housing, transportation, and food-based organizations.

4. **For 2019 mid-adopter regions, describe the ACH's process to assess current capacity and readiness of Medicaid behavioral health providers to transition to fully integrated managed care. How has the ACH identified, or plan to identify, the needs of Medicaid behavioral health providers?**

ACH Response: GCACH's Practice Transformation Navigators (PTNs) and the Project Manager for Integrated Managed Care (IMC) are working with behavioral health providers in the Greater Columbia region to conduct the MeHAF and Billing and IT Toolkit assessments. GCACH staff estimates that it will take a total of 4 hours per provider to complete these assessments. To thoroughly complete each assessment, all major stakeholders (front line staff, administrators and clinicians) will need to be involved. GCACH feels that this approach will be the most beneficial as it will provide a comprehensive assessment of a practices' current state. These two assessments will help determine provider readiness and capacity for IMC. After the assessments have been completed, GCACH staff will analyze the results and develop a transformation plan for

the organization. This plan will detail quantitative results from the MeHAF, strengths, opportunities, and SMART goals for the behavioral health organization. PTNs will meet regularly with the behavioral health organizations and be available as a resource after the transformation work is complete.

Three workgroups have been developed as part of the IMC transition plan:

- Provider Readiness Workgroup
- IMC Communications Workgroup
- Early Warning System Workgroup

The Provider Readiness Workgroup consists of all the behavioral health providers, MCOs, HCA, and GCACH staff. This workgroup meets bi-weekly. The goals are to identify and resolve IT issues including but not limited to:

- MCO billing capacity
- EHR compatibility
- Provider data reporting requirements
- Technical Assistance needed by providers
- Credentialing

The IMC Communications Workgroup is comprised of MCOs, BHO, HCA, GCACH staff, Consumer Representative, Navigators, Care Coordinators, community health workers, Area Agencies on Aging, and BH Providers. This workgroup meets once a month. The goals of this workgroup are to:

- Provide recommendations and work to engage consumers and providers in system change efforts related to IMC
- Ensure that consumers maintain confidence and continuity in the care they are receiving
- Ensure a smooth transition to IMC through the development of clear communications materials, client notifications, and transparent transition process
- Leverage existing structures and avenues to collaborate with consumer groups, to gather consumer perspectives, and identify consumer concerns or gaps in understanding

The Early Warning Systems Workgroup brings together the BHO, BH Providers, HCA, Criminal Justice System Representatives, Law Enforcement, Housing, EMS, MCOs, Crisis Providers, and GCACH staff. This workgroup meets once a month. The goal of this workgroup is to develop recommendations for an Early Warning System that allows a feedback loop and triage process to identify clients who may be falling through the cracks given the transition to integrated managed care and resolve system issues as they arise. The goal is to operationalize the system by January 1, 2019, but it would be ideal to have it up and running by November to collect baseline data.

E. Community Engagement

Community engagement refers to outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

- In the table below, list the ACH's community engagement activities that occurred during the reporting period. Add rows as needed.**

Community Engagement Activities for the Reporting Period						
Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Recovery and Integration Forum	3/13/18	Introduce attendees to GCACH.	BH Providers, MCOs, CBOs	2A	BHA	Assisted in the advancement of bi-directional integration among BH providers.
SE WA RHN Meeting	3/14/18	Meet the network and be a resource to them.	Local organizations working together to improve their community's health.	2A, 2C, 3A, 3D	SE WA RHN	The Community and Tribal Engagement Specialist gathered some questions to take back to GCACH.
La Z radio station meeting	3/19/18	To gather information on their reach and cost.	Spanish speaking listeners	2A, 2C, 3A, 3D	GCACH	GCACH gathered information on their reach and cost.
La Ley radio station	3/21/18	To gather information on their reach and cost.	Spanish speaking listeners	2A, 2C, 3A, 3D	GCACH	GCACH gathered information on their reach and cost.

La Super radio station	3/21/18	Get an idea of their reach and cost	Spanish speaking listeners	2A, 2C, 3A, 3D	GCACH	GCACH gathered information on their reach and cost.
YCHCC Meeting	3/23/18	Meet the network and be a resource to them	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	YCHCC	Met the coalition members in attendance
Yakama Nation BH Open House	4/3/18	Have a GCACH presence in tribal events to develop a trusting relationship	Tribal members and providers	2A	Yakama Nation	Helped advance the trust level with the Yakama Nation by having a GCACH presence and showing support
KCHN Advisory Council Meeting	4/3/18	Meet the network and be a resource to them	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	KCHN	Met the coalition members in attendance
Conference call with Jeanne McMinds and Fenice Fregozo (both are with Molina Healthcare)	4/3/18	Discuss best practices on how to respectfully work with the Yakama Nation	MCO, GCACH	2A, 2C, 3A, 3D	Jeanne McMinds	Learned some Dos and Don'ts plus increased GCACH's cultural intelligence regarding the Yakama Nation
Vista Hermosa Community Health Fair	4/6/18	Introduce GCACH to participants and seek collaboration opportunities	Latino, Spanish-speaking, agricultural workers and multiple health organization. MCOs, hospitals, clinics, etc.	2A, 2C, 3A, 3D	Broetje Orchard	Made connections with several organizations serving the agricultural limited English speaking community as well as learning more about the community itself

SE WA RHN Meeting	4/11/18	Participate in the meeting and be a resource to the network	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	SE WA RHN	Learned more about the rural community's exceptional needs. Seeking to get community health worker trainings in the area.
ACEs and Trauma Informed Care	4/16/18	Introduce GCACH to participant and explore how what role GCACH can play in addressing ACEs to improve physical and mental health	Physical health and BH providers as well as CBOs and MCOs.	2A, 2C, 3A, 3D	Yakima Community College	Came to the determination that ACEs need to rank high in the push for better health. GCAC as them into different aspects of its projects
BMRCHP Meeting	4/17/18	Meet the network and be a resource to them	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	BMRCHP	Came to the realization that this LHIN needs to speed up their process. The meeting felt as if it were the first one
ACH/Tribal Opioid Project Collaboration call	4/20/18	Explore ways to collaborate between the ACHs, Tribes, and the state	ACHs and Tribal representatives	3A	Lisa Rey Thomas, Olympic ACH	Set up an in-person meeting with ACH Tribal Liaisons and HCA to talk about opioids
Tribal history presentation	4/20/18	Learn history of the relationship American tribes have had with the federal government	GCACH and Molina	2A, 2C, 3A, 3D	Jeanne McMinds	Educational presentation about Native Americans. It furthered GCACH understanding of the Yakama Nation

Meeting with Ana Maria Martinez, WSU	4/24/18	Explore ways to collaborate with the Strengthening Families program to build resilience and mitigate the effects of ACEs and SDOH	GCACH, WSU	2A, 2C, 3A, 3D	GCACH	Learned more about her organization's capacity to do resiliency training to address ACEs.
Community Leader Age/Dementia Friendly Forum	4/24/18	Introduce participant to GCACH	Providers, MCOs, advocate, CBOs, and GCACH	2A, 2C, 3A, 3D	Alzheimer's Association	Gained awareness of the prevalence of dementia and the need for dementia friendly communities.
WCHN Meeting	4/25/18	Meet the network and be a resource to them	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	WCHN	Met the coalition members in attendance
Meeting with Brisa Guajardo, CHPW	4/26/18	Explore ways to collaborate in addressing SDOH	MCO, GCACH	2A, 2C, 3A, 3D	GCACH	Brisa offered her MCOs expertise with media and marketing
Indian Health Care Provider Behavioral Integration Work Group	4/27/18	Learn about Indian BH integration and the funding behind it	ACH tribal liaisons and tribal representatives	2A	HCA	Gained knowledge of Indian Health Provider specific project funding
Meeting with Erich Boltz, PSD Assistant Superintendent.	4/30/18	Explain what GCACH is and discuss possible ways of collaborating	Pasco School District, GCACH	2C, 3A, 3D	GCACH	The school district gave us access to their Bilingual Parent Advisory Committee (PAC) to provide input on SDOH and the healthcare system

Yakima Blue Zones Project Presentation and Policy Forum	5/1/18	Learn about this community wellbeing initiative and how do they match with its goals. Explore ways to collaborate	Leaders: city, county, healthcare, CBOs, MCOs, Business, education	2A, 2C, 3A, 3D	Yakima Chamber of Commerce, YCHCC	There are many correlations between what BZP accomplishes and what GCACH wants to accomplish
Meeting with Robin Henle, B-F Health District about ACEs	5/2/18	Met with Robin to discuss ACEs and see how GCACH can collaborate to expand resilience training throughout its region	GCACH, BFHD	2A, 2C, 3A, 3D	GCACH	Brainstormed ideas on how GCACH can work together and complement each other's work around ACEs.
Health Access Team Meeting	5/4/18	Meeting of health care professionals collaborating to make health access more accessible.	GCACH, BFCHA, KADLAC, Grace Clinic	2A, 2C, 3A, 3D	Grace Clinic	Gained knowledge on Medicaid insured numbers plus the question about the uninsured undocumented people
ACH Tribal Liaison Standing Meeting	5/4/18	Bi-weekly meeting to discuss best practices to reach tribal health goals	ACH's tribal liaisons, HCA	2A, 2C, 3A, 3D	HCA	More education about tribal specific projects and funding and info regarding the HCA summer speaking tour

Michelle Wilson P.S. Media.	5/10/18	Looking for quotes for media campaigns to support the healthcare improvement efforts throughout the region.	P.S. Media, GCACH	2A, 2C, 3A, 3D	GCACH	Received a quote
YCHCC Meeting	5/11/18	Participate in the meeting and be a resource to the network	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	YCHCC	Received a briefing on the Blue Zones Project visit to Yakima. GCACH may play an important role
Phone conference with René Hildebrand from CPAA	5/15/18	To learn best practices in forming consumer councils and capture their input regarding SDOH and healthcare	GCACH, CPAA	2A, 2C, 3A, 3D	GCACH	GCACH received CPAA best practices on capturing the consumer voice. Got to sample a charter.
Phone conference with Lizset Chavez from Pierce County ACH	5/16/18	To learn best practices in forming consumer councils and capture their input regarding SDOH and healthcare	GCACH, Pierce County ACH	2A, 2C, 3A, 3D	GCACH	GCACH received Pierce County ACH best practices on capturing the consumer voice. Got to sample a charter and other documents
ACH Tribal Liaison Standing Meeting	5/18/18	Bi-weekly meeting to discuss best	ACH's tribal liaisons, HCA	2A, 2C, 3A, 3D	HCA	More education about tribal specific projects and funding and info regarding the HCA summer speaking tour

		practices to reach tribal health goals				
Meeting with consumer Ana Laura Rodriguez	5/19/18	Invite her to participate in a future consumer council/forum to provide us her input on healthcare and SDOH	Ms. Rodriguez, Rubén Peralta	2A, 2C, 3A, 3D	GCACH	GCACH asked Mrs. Rodriguez to be part of a Medicaid consumer focus group. She agreed and participated on June 27
KVHN Board Meeting	5/21/18	Participate in the meeting and be a resource to the network	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	KVHN	The network is making progress in planning a summer retreat
Phone conference with Leah Wainman from North Sound ACH	5/22/18	To learn best practices in forming consumer councils and capture their input regarding SDOH and healthcare	GCACH, NSACH	2A, 2C, 3A, 3D	GCACH	GCACH received NSACH best practices on capturing the consumer voice. Got to sample a charter and other documents
WCHN Meeting	5/23/18	Participate in the meeting and be a resource to the network	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	WCHN	Learned that the network is planning to use CHF to purchase a vehicle to deliver food. I clarified that the money cannot be used for capital expenses, but they can lease a vehicle.
ACH Tribal Liaison Meeting in Person	5/24/18	Touch base with other ACH tribal liaisons and	ACH tribal liaisons, HCA	2A, 2C, 3A, 3D	HCA	In person further education on tribal law, customs, and healthcare

		update each other on the ACH and exchange tips				
Benton Franklin Medical Society meeting	6/1/18	Presentation from WSU School of Medicine on their progress	Local healthcare professionals	2A, 2C, 3A, 3D	Medical Society	GCACH representation on healthcare workforce conversation
First Quarterly LHINs Meeting	6/4/18	Initial quarterly LHINs meeting. Clarified the priority deliverables, Community Health Fund, and consumer voice	GCACH, representatives from all LHINs except for WCHN	2C, 3A, 3D	GCACH	Clarified priority deliverables due June 30. Created a subgroup to define the capture of consumer voice and the distribution process for the CHF
GCACH, WACMHC, YVFWC, TCCH, Meeting	6/5/18	Welcome and introduction of new director for WACMHC	GCACH, WACMHC, YVFWC, TCCH, Meeting	2A, 2C, 3A, 3D	GCACH	Build a new relationship with WACMHC
Meeting with Lorraine Landon, Pasco School District	6/6/18	Plan the convening of PSD's parent advisory committee to get their input on health issues	GCACH, PSD	2A, 2C, 3A, 3D	GCACH	Planned and executed a limited English speaking consumer focus group for June 27
Meeting with Omar Escalera,	6/6/18	Plan the convening of PHS's parent	GCACH, PHS	2A, 2C, 3A, 3D	GCACH	Planned and executed a limited English speaking consumer focus group for June 27

Pasco School District		group get their input on health issues				
Meeting with Lily Gonzalez, Virginia Mason	6/7/18	Discuss diabetes awareness education and joined her on her bi-weekly radio program at KDNA. Plan chronic disease campaign	GCACH, Virginia Mason	3D	GCACH	Participated in a radio program about diabetes and began the planning for a chronic disease awareness campaign.
Attended Yakama Nation Treaty Days	6/8/18	Set up a booth and hand out information about the GCACH to bring awareness to the tribe about what GCACH do while at the same time increasing the level of trust	GCACH, Yakama Nation	2A, 2C, 3A, 3D	Yakama Nation	GCACH representation at very important celebration. Increased GCACH profile within the Tribe and furthered the level of trust.
LHINs Meeting Follow Up	6/11/18	Refine the Community Health Fund distribution methodology and the framework to capture the	Local Health Improvement Networks, GCACH	2C, 3A, 3D	GCACH	LHINs subgroup completed the redefinition of CHF distribution and consumer voice methodology

		consumers' voice				
ACE/Resilience Collaborative Meeting	6/12/18	Meeting of providers, CBO, and GCACH to collaborate on efforts to mitigate the effects of ACEs	GCACH, Benton-County Health District, CBOs	2A, 2C, 3A, 3D	BFHD	Developed relationships with different providers who can potentially offer a lot to the SDOH and ACEs work.
ACH Tribal Liaison Standing Meeting	6/15/18	Touch base with other ACH tribal liaisons and update each other on the ACH and exchange tips	ACH tribal liaisons, HCA	2A, 2C, 3A, 3D	HCA	Plan discussed the upcoming HCA/GCACH meeting with the Yakama Nation
Yakama Nation Medicaid Transformation Tribal Specific Plan	6/18/18	HCA's Listening Tour to hear from the Tribes across WA State about Tribal Specific Plans with Medicaid Transformation funding	HCA, Yakama Nation, GCACH	2A, 2C, 3A, 3D	HCA	Assisted HCA in the conversation with the Yakama Tribe about tribal specifying projects and explain the different sources of funding
Meeting with Amira Al Salami, Refugee Program Specialist, World Relief	6/19/18	Convene a group of refugees to get their input on healthcare and	World Relief, GCACH	2A, 2C, 3A, 3D	GCACH	GCACH came to an agreement to touch base again towards the end of July to schedule a meeting.

		SDOH specifically				
Meeting with Ruben Alvarado, Community Impact Manager at Tierra Vida	6/20/18	Convene a group of his community residents to get their input on healthcare and SDOH specifically. Use their facility for the meeting	GCACH, Tierra Vida	2A, 2C, 3A, 3D	GCACH	Secured the facility in which to conduct the forum and put up flyers
YCHCC Meeting	6/22/18	Participate in the meeting and be a resource to the network	Local organizations working together to improve their community's health	2A, 2C, 3A, 3D	YCHCC	YCHCC charter, a committee was created by Brisa Guajardo and Sandra Suarez to create a framework for consumer engagement.
Yakama Tribe Providers meeting	6/22/18	Discuss alternative project ideas for Medicaid Transformation	Yakama Tribe providers, GCACH	2A, 2C, 3A, 3D	Yakama Nation, GCACH	GCACH heard about the barriers tribe providers face to address the health disparities of the Yakama Nation
Pasco Discovery Coalition Key Leader Luncheon	6/25/18	Discuss ways to collaborate in address drug use among youth	Pasco Discovery Coalition, Franklin Commissioner, Franklin Co. Prosecutor, Pasco Police, MCOs, CBOs, GCACH	3A	PDC	Met Rev. Terrance Taylor, the coalition's coordinator and agreed to work on putting together a focus group of African-Americans in early August.
Tierra Vida Community Council Meeting	6/25/18	Invite community members to attend a	Tierra Vida community members, GCACH	2A, 2C, 3A, 3D	GCACH	4 community members stated they will attend

		meeting on the 27 th in which they can provide their input on matters related to healthcare and specifically SDOH				
Community Engagement Benton-Franklin Community Health Alliance	6/27/18	Meeting with 8 Pasco School District Bilingual Parent Advisory Committee (PAC) members and one other consumer to get their input on healthcare and SDOH specifically.	Medicaid non-English proficient consumers	2A, 2C, 3A, 3D	GCACH	9 consumers answered survey questions that yielded valuable information on SDOH and healthcare in general. 8 are Medicaid consumers
Community Engagement Whitman County Health Network	6/27/18	Initial meeting with WCHN's Consumer Council.	Medicaid non-Hispanic white consumer	2A, 2C, 3A, 3D	WCHN	The meeting covered mostly educational issues regarding the collaboration between the different organizations and what the role of the council will be

2. Describe how the ACH and its partnering providers have reached out to populations with limited proficiency in English.

ACH Response: The largest ethnic population in Greater Columbia is Hispanics, with nearly 52% (133,000) being Medicaid beneficiaries (Healthier WA Dashboard). To reflect the diversity in the region, GCACH staff is ethnically diverse, seeks committee representation from the Hispanic community, and provides written materials in English and Spanish.

GCACH has reached out to the limited English speaking population in several ways. Community and Tribal Engagement Specialist, Rubén Peralta is bilingual, as is the Practice Transformation Navigator, Martin Sanchez. Brochures are available in English and Spanish, and GCACH works closely with the Community Health Centers and MCO representatives. GCACH staffs booths at health fairs and community events that attract the Spanish-speaking community. GCACH has participated in health fairs sponsored by Broetje Orchards, one of the largest contiguous orchards in the United State that grows, stores, and packs on site, and employs over 2,500 agricultural workers. Vista Hermosa is a community of mostly Spanish-speaking agricultural workers owned by Broetje Orchards near Prescott, Washington in Walla Walla County. There were approximately 800 attendees including vendors who were mostly providers and community-based organizations. GCACH has participated on a Spanish radio talk show about diabetes in Granger and has been exploring opportunities to host similar radio programs in the other urban regions. GCACH hospitals, MCOs, and FQHC providers use a variety of methods to outreach to the community, including the limited-English proficient population.

GCACH also had the opportunity to attend a Community Council Meeting of another Broetje Orchards community, Tierra Vida. The attendees learned who GCACH is and the goals GCACH is trying to accomplish.

To ensure that every segment of the region’s voice is considered, Greater Columbia Accountable Community of Health is organized into six Local Health Improvement Networks (LHINs). LHINs provide local engagement and cross-organizational assistance toward GCACH goals and are responsible for capturing their regions’ input on matters affecting their health, especially the input of Medicaid consumers. Each LHIN has a signed contract with GCACH that mandates the establishment of a consumer council or outreach to consumers. This type of structure is crucial for GCACH to ensure that less populated areas that tend to be older and less diverse, get their voices heard in the quest to create a culture of health. This structure also ensures that underrepresented groups’ voices from every region are also considered. It includes segments with limited English proficiency beyond Spanish speakers.

GCACH is geographically organized into 6 Local Health Improvement Networks:

- Kittitas Valley Health Network (KVHN)
- Yakima Valley Health Care Coalition (YVHCC)
- Benton-Franklin Community Health Alliance (BFHCA)
- Blue Mountain Region Community Health Partnership (BMRCHP)
- South East Washington Rural Health Network (SE WA RHN)

- Whitman County Health Network (WCHN)



Figure 3: GCACH LHIN Map

Another example of reaching out to limited English speaking populations is the participation in the All of Us research program. Downtown Pasco, in Franklin County, was one of the few communities in the country selected to be one of the launch sites. There were about 1,000 attendees, mostly Hispanic with a good share of Spanish monolinguals judging by the bilingual presentations and the language spoken at the booths. The Community and Tribal Engagement Specialist registered and will be participating in this research for the next 10 years.

In June, GCACH convened a group of 9 Spanish-speaking limited English proficient Medicaid consumers to ask them what barriers they face in achieving and maintaining good health. GCACH also asked them to share what they would change or improve about the healthcare system. The Tri-Cities office of World Relief is working with GCACH to schedule a similar meeting with a group of refugees from different countries so that GCACH may capture the input of consumers whose first language is other than English and Spanish and will have translators available to deliver and capture the content of the meeting.

GCACH is learning about other ways to reach its limited English speaking audience through members of its committees and Boards. Lily Gonzalez, a member of the Practice Transformation Workgroup is a physician by training and a diabetes educator for Virginia Mason Memorial Hospital. Lily hosts a Spanish radio talk show in Granger to educate the population about diabetes and invited the Community and Tribal Engagement Specialist to participate. GCACH is exploring how to start a similar program in the Tri-Cities on a local Spanish station or support tele-novellas in concert with KNDA radio station.

Finally, the hospitals and providers reach out to the community, included limited-English proficient populations, in several ways.

Astria Health has a Community Board that provides feedback in developing numerous educational programs for the community and partnering with tribal leaders, schools, youth organizations, churches, and civic organizations. Astria also employs a full-time

Community Liaison whose responsibilities include outreach, coordination, and service need identification. They have over 60 employees who are certified interpreters in Spanish. Each interpreter is also provided training in code of conduct for interpreters which speak to cultural awareness and sensitivity. This laser focus community involvement has translated into new and enhanced service lines, new providers, and capital projects. The plan addition of primary care and psychiatric services is also directly in response to identified community needs.

CHAS Health's QI Department convenes a Patient Advisory Council to solicit regular patient feedback. Patient Satisfaction Surveys, conducted by an outside agency, are also utilized to assess CHAS's and provider's performance. The surveys are culturally appropriate and help CHAS to analyze the organization's cultural competency. Surveys are provided in both English and Spanish. In addition to formal surveys, CHAS invites patients to fill out comment cards in the clinics. CHAS' staff regularly participate in community events, from fairs to chamber of commerce meetings, to engage with residents, organizations and businesses.

Yakima Neighborhood Health Services contracts with a third-party vendor to conduct a minimum of 100 surveys per month in English and Spanish about the patients' experience in their clinics. In addition, patients can complete a comment card at any of the clinics and they can ask to speak with a supervisor at any time. Feedback is reviewed by the quality committee on a weekly basis.

Tri-Cities Community Health partners with an MCO to contract with a third-party vendor, Crossroads, to conduct surveys in English and Spanish to gauge patient experience in the areas of medical, dental, and behavioral health. They also have comment boxes and cards posted throughout the clinics for patients to submit feedback. Their website also serves as a venue for providing feedback.

3. Focusing on community groups that may be underrepresented in Transformation efforts, identify challenges to engagement that have occurred; describe the strategies the ACH and its partnering providers have undertaken to address these challenges.

ACH Response: The principal challenge revolves around trust, either related to cultural differences, lack of awareness of what Greater Columbia ACH is attempting to accomplish through the Medicaid Demonstration, or a lack of experience in collaborating across organizations. Fully aware of the importance of earning people's trust, the GCACH's Community and Tribal Engagement Specialist has learned as much as possible about each LHIN to understand the specific challenges they may be facing while at the same time building relationships with their leaders. GCACH has become a constant presence at LHIN meetings with listening as the focus and sharing information when appropriate.

As an example, the South East Washington Rural Health Network membership is still working its way to trusting the GCACH and understanding the ACH concept. They feel misunderstood and underrepresented due to their geography. Nevertheless, GCACH is taking steps to increase their level of trust. GCACH attends their meetings to address

concerns and keep them informed and updated on GCACH matters.

There are call-in options for all Leadership Council and Board meetings to minimize travel barriers. A monthly newsletter highlighting Board actions and monthly activities goes out to all ACH members. A new website has content and resources for Board, Leadership Council, and LHINs. Finally, GCACH has established a Community Health Fund (CHF) based on a combination of Medicaid population and social determinants of health (SDOH) rankings to equalize payments to regions with higher than state average SDOH measures. As a result, the SE WA RHN was allocated the highest Community Health Fund amount per Medicaid consumer, \$6.38. The average for all the LHINs is \$2.73 per Medicaid consumer. The CHF is for LHINs to address social determinants of health affecting their regions.

Trust is also a challenge at the Medicaid consumer level. What GCACH have encountered is mainly related to cultural reasons, immigration status, or mistrust of government institutions (perhaps due to cultural reasons as well). When GCACH convened a recent meeting with a school district parent group, GCACH also invited another group. No one from the other group attended due to US Immigration and Customs Enforcement raids taking place in the region. GCACH was expecting 15-20 adults but only 9 attended. To overcome the trust factor with consumer populations, GCACH is reaching out to existing groups by contacting the organization that formed them, such as the school district, and asking them for access to their groups. It develops an instant level of trust that would take much longer to develop. GCACH found that reaching out to existing groups and meeting them in person at a familiar location facilitates more engaged and open participation.

The Yakama Nation has an inherent distrust of government and governmental agencies, so GCACH has made it a priority to meet with their leadership on site, involve other trusted partners in important conversations, have trainings for the Board, Leadership and staff members to understand their culture, and have committed financial resources toward their project plan. GCACH has established a close relationship with their Behavioral Health agency, and their representatives Tonya Kreis and Katherine Saluskin attend the monthly Board and Leadership Council meetings.

F. Health Equity Activities

Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

- 1. Provide an example of a decision the ACH and its partnering providers have made about project planning or implementation based on equity considerations.**

ACH Response: GCACH's intention is for the positive impact on the communities resulting from its decisions is felt by everyone in an equitable manner. The allocation and distribution methodology of the \$997,600 Community Health Fund (CHF) exemplifies the commitment to equity and included input from the Budget and Funds Flow

Committee, Finance Committee, Board of Directors, and the Local Health Improvement Networks (LHIN). The purpose of the CHF is to help mitigate the effects of Social Determinants in the communities which vary from county to county as demonstrated by RWJF County Health Rankings table. Because of this feedback, rural LHINs received more funding per Medicaid consumer than the ACH regional average.

Community Health Fund Use Categories	Allocation
Medicaid Population	\$500,000
Worse Than State Average	\$197,600
Regional Campaigns	\$300,000
Total	\$997,600

Table 1: Community Health Fund Use Table

Please refer to attachment 1.7 2017 RWJF County Health Rankings. 7.31.18.

The first consideration was to allocate the CHF based on the number of Medicaid consumers by LHIN region alone. However, it was determined that it would be best to explore additional factors to ensure a more equitable distribution.

- Medicaid population is the primary factor driving the allocation of the CHF to address the Social Determinants of Health. \$500,000 will be distributed based on Medicaid lives.
- RWJF County Health Rankings, “Worse Than State Average” (WTSA): \$197,600 will be distributed based on the number of measures each county performs worse than the state average.
- The remaining \$300,000 will be designated to conduct regional media campaigns and other efforts to address SDOH (Social Determinants of Health). GCACH are currently working with a media company to get an idea of what GCACH can get with this amount.

The distribution methodology of the CHF also takes equity into consideration. It empowers the LHINs to determine which SDOH need to be addressed within their regions. To ensure that Medicaid consumers are represented in the decision-making process, LHINs are required per their contract to reach out to the Medicaid population through surveys, focus groups, or creating consumer councils, but have the freedom to develop the framework by which they will capture consumers’ input. To ensure that contracts are equitably distributed, a third-party administrator will issue the Request for Proposals and award the contracts. The table below details the distribution methodology for the Medicaid population and worse than state average (WTSA) dollars.

LHIN	Total Population	Medicaid Population	% Medicaid	% GCACH Medicaid	WTSA Measures	WTSA %	Population Funds	WTSA Funds	Total Funding	Per Consumer
BFCHA	279,170	94,605	33.9%	37.0%	25	16.2%	\$185,191	\$32,078	\$217,269	\$2.30
BMRCHP	60,730	17,155	28.2%	6.7%	29	18.8%	\$33,581	\$37,210	\$70,792	\$3.86
KCHN	43,710	10,436	23.9%	4.1%	23	14.9%	\$20,429	\$29,512	\$49,940	\$4.79
SEWA RHN	28,400	8,705	30.7%	3.4%	30	19.5%	\$17,040	\$38,494	\$55,534	\$6.38
WCHN	47,940	8,392	17.5%	3.3%	18	11.7%	\$16,427	\$23,096	\$39,524	\$4.71
YCHCC	250,900	116,133	46.3%	45.5%	29	18.8%	\$227,332	\$37,210	\$264,542	\$2.28
Totals	710,850	255,426		100%	154	100%	\$500,000	\$197,600	\$697,600	\$2.73

Table 2: Distribution Methodology for the Medicaid Population and Worse Than State Average (WTSA) Dollars

2. How will the ACH and its partnering providers assess and prioritize community health equity issues in the region during the Medicaid Transformation?

ACH Response: Providers interested in participating in one or more of the projects were given a Current State Assessment to gauge their readiness and capacity for Practice Transformation. One of the factors playing a role in the selection process was equity. In other words, what is their willingness to empanel patients with higher than regional average of ethnicity and Social Determinants of Health. In addition, Local Health Improvement Networks are capturing consumer input, as are their member organizations. As they capture consumer input, they make sure they reach out to every segment of their region’s demographics. Every LHIN will also provide input based on their communities’ health needs assessments. This data will allow the LHINs to prioritize, in an equitable manner, the most pressing SDOH affecting their regions.

3. What steps has the ACH taken to provide the ACH board/staff/partnering providers with tools to address health equity? How will the ACH monitor the use of health equity tools by partnering providers?

ACH Response: The ACH has tried to identify sophisticated tools and data to assess health disparities by county and sub-county region. One such tool is the Area Deprivation Index (ADI). The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA). It allows for rankings of neighborhoods by socioeconomic status disadvantage in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups. The RWJF also provides important data regarding social determinants which were used to develop the

CHF funding model.

GCACH is also addressing health equity through the Community Health Fund, The PCMH model of care enhances care delivery for all patients through the right focus, the right business model and the right population health management tools.

GCACH’s Community and Tribal Engagement Specialist is part of the Governor’s Interagency Council on Health Disparities workgroup that is developing a toolkit for ACH’s and state agencies. The immediate goals are to create a resource on key equity-related terms and definitions along with guidance on preferred equity-related language to use (and not use). Another immediate goal is to create guidance on integrating equity assessments into decision making (policy, program, and budget development). Once these two are established by the workgroup, GCACH will create the methodology to monitor the use of health equity tools by providers. PRAPARE is a social determinant screening tool used by some of the FQHCs. GCACH is considering supporting broader use of this standardized tool with other partnering organizations.

These tools can be included in the change plans and monitored by the PTNs as the PCMH-As are updated during practice facilitation and follow-up.

Please refer to attachment 1.8 2017 GCACH Area Deprivation Index Map. 7.31.18.

Budget and Funds Flow

Note: HCA will provide ACHs with a Semi-Annual Report Workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of June 30, 2018.

1. **Attestation: The ACH organization or its equivalent fiscal sponsor has received a financial audit in the past year. Place an “X” in the appropriate box.**

Note: the IA and HCA reserve the right to request documentation in support of

Yes	No
X	

- a. **If the ACH checked “Yes” in item G.1, have all audit findings and questions been appropriately resolved? If not, please briefly elaborate as to the plan to resolve. If the ACH checked “No” in item G.1, respond “Not Applicable.”**

ACH Response: No audit findings were found by Moss Adams. Internal operation strengthening was presented and GCACH has taken all recommendations into consideration. Processes have been put in place to update and correct all recommendations from auditors Moss Adams.

- b. If the ACH checked “No” in item G.1, describe the ACH’s process and timeline for financial audits. If the ACH checked “Yes” in item G.1, respond “Not Applicable.”**

ACH Response: Not Applicable.

2. Design Funds

Complete items outlined in tab G.2 of the Semi-Annual Report Workbook.

3. DY 1 Earned Incentives

Complete items outlined in tab G.3 of the Semi-Annual Report Workbook.

4. Integration Incentives

For early- and mid-adopter regions only, complete the items outlined tab G.4 of the Semi-Annual Report Workbook and respond to the following:

- a. Describe how the ACH has prioritized, or will prioritize, integration incentives to assist Medicaid behavioral health providers transitioning to fully integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have or will participate in discussions on the prioritization of these incentives.**

ACH Response: The GCACH Board of Directors have determined that the entire Phase I funding of \$4 million dollars in integration incentives will be made available for the 17 organizations currently contracted with Greater Columbia BH-ASO (GCBH-ASO) to successfully transition to fully integrated managed care by January 1, 2019. The funding formula is based on a traditional allocation methodology that GCBH-ASO developed for the Provider Network and was proposed by the Provider Network to the Board at their June 21st meeting.

This formula includes a 15% contingency, 2% administrative fee to GCACH, and 83% distribution to the GCBH providers which is based on Medicaid eligible populations within each County. The final formula is still under consideration by the Provider Network who have been given the latitude to propose a formula that provides the necessary resources and support to be ready for integration. Recently, a modification to the original formula was introduced to incorporate in-patient and residential treatment services in addition to the mental health and substance use providers. While the funding formula has not yet been approved, GCACH staff is working closely with the HCA, GCBH Provider Network,

GCBH-ASO, and North Central ACH to arrive at a formula that meets the needs of the providers.

- b. Describe the decision-making process the ACH will use to determine the distribution of integration incentives. Include how the ACH will verify that providers receiving assistance or funding through the integration incentive funds will serve the Medicaid population at the time of implementation.**

ACH Response: The GCACH Board of Directors received a proposal by the GCBH Provider Network at their June 21, 2018 meeting to self-determine a funding formula for Phase I funds based on their traditional allocation methodology from Greater Columbia Behavioral Health. This formula included a 15% contingency, 2% administrative fee to GCACH, and 83% distribution to the GCBH providers which is based on Medicaid eligible populations within each County. While the funding formula has not yet been approved, GCACH staff is working closely with the GC-BHO and Provider Network. The proposal will be brought back by the August Board meeting for final approval.

The providers have proposed that they would evaluate their most pressing needs, and create a plan regarding successfully transitioning to a fully integrated model. It was noted that providers may need to invest in emerging needs/requirements. For example, a final determination has not been made by the Health Care Authority regarding what data elements must be submitted by the Managed Care Organizations (MCOs).

The GCBH Provider Network discussed how to be accountable for the HCA Mid-Adopter Incentive Funds that they would receive. One suggestion was that quarterly reports (narrative in form) could be submitted to GCACH, however, the GCACH Board of Directors has approved a contract that outlines the expectations and deliverables for each provider that includes a detailed budget with use categories, a transition plan to a fully integrated model, and a thorough description of the planned use of funding. It is a binding agreement “to collaborate, design, develop and implement a fully integrated managed care plan to be ready for financial integration of Medicaid benefits, “Mid-Adopter” by January 1, 2019 using Medicaid Transformation Integration Incentive Funding (hereinafter “IIF”).” Additionally, GCACH reserves the right to review all transaction expenses to ensure funds are being expended for “allowable costs.” On March 29, 2018, the HCA issued a document titled “Expectations Regarding Use of Medicaid Transformation Integration Incentive Funding.” GCACH has included the thirteen expectations in the contract and reserves the right to offset funding that has been used on unallowable costs. Once the deliverables have been met, the funding will be distributed to the organization.

The GCBH Provider Network is determining the best approach to the funding allocation and has sought advice and guidance from other providers that have already gone through this process, especially in the North Central ACH. They have formed a subcommittee to bring back a proposal for the August Board meeting.

It should be noted that Greater Columbia ACH is under contract with the Health Care Authority (HCA) to project manage the work related to IMC. GCACH has created a position, Project Manager for GCACH Integrated Managed Care, and is working closely with the GCACH Practice Transformation staff and the HCA to provide technical assistance. Practice Transformation Navigators are working with providers to conduct MeHAF assessments, guide them through the Qualis Billing toolkit, assist with developing actionable transition plans, and providing guidance on health IT infrastructure. The Project Manager has formed three working groups, Communications, Provider Readiness, and the Early Warning System, and is populating them with subject matter experts. One of the benefits of this arrangement includes the relationship building between the Project Manager, Practice Transformation Navigators, and the providers. In addition to ensuring their successful transition to fully integrated managed care, GCACH staff are helping providers make connections with primary care, mental health, substance abuse, and housing agencies.

5. Total Medicaid Transformation Incentives

The items outlined in tab G.5 of the Semi-Annual Report Workbook is informational only. ACHs are not required to complete any items in this tab of the Workbook.

Please refer to attachment 1.9 GCACH SARI Workbook. 7.31.18.

GCACH Current State Assessment (CSA) Summary Report

In May 2018, the Greater Columbia Accountable Community of Health (GCACH) conducted a Current State Assessment (CSA) of its potential partnering provider organizations. The CSA survey was sent to the 78 organizations and programs who previously responded to the GCACH's Letter of Interest (LOI), originally distributed in September 2017. The survey was sent to both Medicaid billing and Non-Medicaid providers. Of the 78 receiving the CSA, 57 organizations completed and returned their CSA back to the GCACH, for a response rate of more than 73%.

The CSA included 110 questions relating to:

- Demographics of populations-served
- The four GCACH-chosen project areas: Bi-directional Integration of Care, Transitional Care, Opioid Use Crisis, and Chronic Disease Prevention and Control
- Coordination of care
- Domain 1 areas: Workforce, HIT/HIE, and Value-Based Payment
- Syringe exchange programs
- EMS First Responders
- Pay-for-reporting

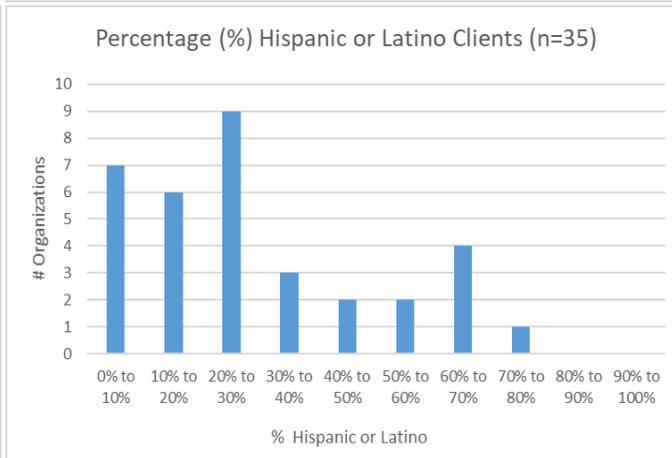
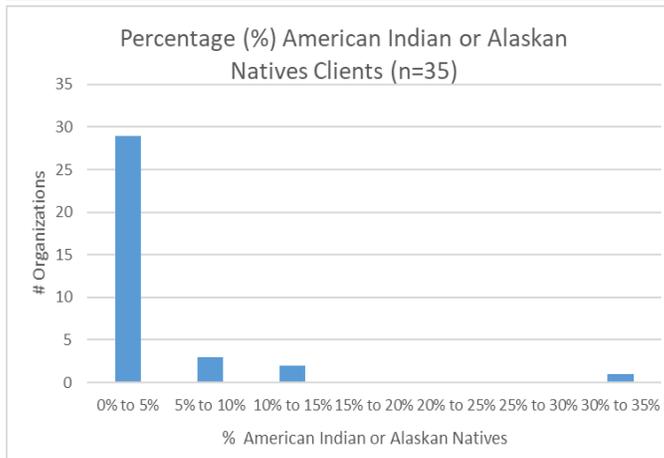
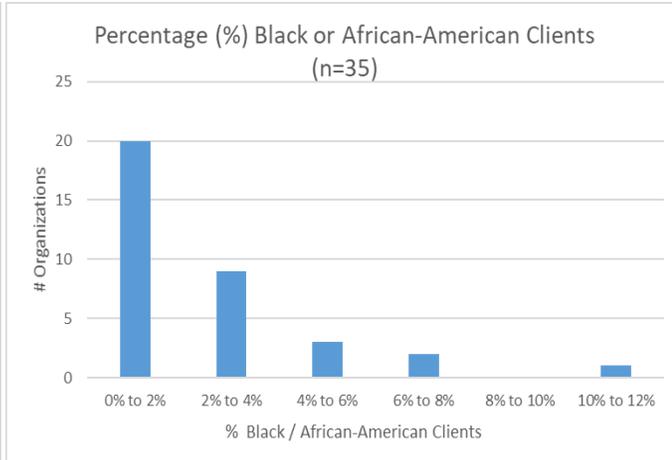
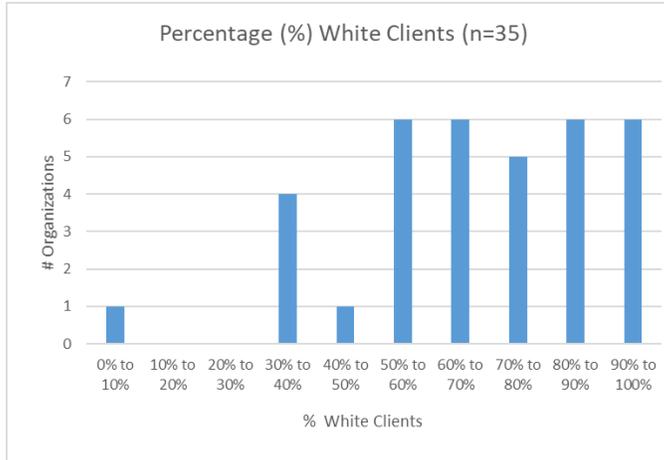
The main purpose of the CSA is to identify gaps, barriers, and assets in existing services. The CSA will also be used to respond to questions and sections contained within the first Semi-Annual Report (SAR), due to HCA on 07/31/2018. Findings from the CSA will be transmitted to the GCACH Leadership Council, Board of Directors, the Practice Transformation Workgroup, the Data Management & HIE Committee and other GCACH partners and stakeholders.

The CSA contains questions that assess participating provider readiness and willingness to partner with the GCACH. This is done through assessment questions across several domains that relate to Primary Care Medical Home essential change concepts. Questions within the CSA will be grouped within these domains and used to prioritize providers for Practice Transformation work, which will be facilitated by the GCACH through technical assistance, IT investments and more. The domains relating to the essential change concepts are as follows:

- **Adaptability:** Assesses providers' willingness to adapt current office practice and culture to incorporate process and quality improvements
- **Collaboration:** Assesses providers' willingness to integrate community based organizations/social service organizations into patient care workflows and to refer and share important clinical and other information with these organizations
- **Equity:** Assesses providers' willingness to empanel patients with higher-than-regional-average ethnicity and social determinant needs into primary care patient panels
- **Leadership:** Based on the number and types of clinical and office leadership and staff engaged in transformational work and on providers' willingness to conduct the Primary Care Medical Home Assessment (PCMH-A) tool and/or the Maine Health Access Foundation's (MeHAF) tools
- **Value-Driven:** Assesses providers' willingness to focus quality improvement efforts on "upstream" or underlying causes of conditions and poor health and to support wellness and prevention activities that address these causes
- **Volume:** Based on the number of Medicaid beneficiaries served by the individual provider practice, with preference given to practices serving larger Medicaid populations

DEMOGRAPHICS

- Question 2: For your total unduplicated client base (all sites and locations combined) served in 2016-2017, what percent of your clients were the following:



- Question 3: Please identify all the counties where the majority of your patients or clients reside.

County	Program Count	State Medicaid Programs	
		Graph	Enrollment
Asotin	11		6,816
Benton	27		57,959
Columbia	12		1,243
Franklin	25		35,718
Garfield	8		630
Kittitas	12		9,913
Walla Walla	15		17,056
Whitman	9		8,237
Yakima	24		113,909
Yakama Nation	11		

Sector	Count
Behavioral Health	6
Care Coordination	4
CBO	9
FQHC	6
Hospital	11
Medical Provider	6
Public Health	7
Public Safety	4
Schools	1
Syringe Exchange	1
Transportation	2

Local Health Improvement Network	Count	Graph
Benton-Franklin Community Health Alliance	52	
Blue Mountain Region Community Health Partnership	27	
Kittitas Valley Health Network	12	
South East Washington Rural Health Network	31	
Whitman County Health Network	9	
Yakima County Health Care Coalition	24	

- Question 4: What types of providers (healthcare) and approximately how many providers work within your organization?

Provider Type	Count	Graph
Physicians (MDs and DOs)	1224	
Advanced Registered Nurse Practitioners (ARNPs)	283	
Physician's Assistants (PAs)	203	
Paramedics	76	
EMS First Responders	153	
Doctor of Psychology (PhD)	73	
Licensed Social Workers (LICSW)	112	
Peer Support/Community Health Worker/Care Manager	324	
Other behavioral health licensed professionals	382	

- Question 5: How do you receive reimbursement for the services your organization provides?

Reimbursement Type	Count
Medicaid	46
Medicare or commercial insurance	39
Grant funding	39
State funding	36
Donated funds	30

- Question 6a: Which Project Areas would you be accountable to and be committing resources toward?

Project Area	Count	Graph
Bi Directional Integration of Physical & Behavioral Health	44	
Transitional Care	44	
Addressing the Opioid Use Public Health Crisis	44	
Chronic Disease Prevention and Control	48	

- Question 6b: Do you currently bill Medicaid for this type of service?

Project Area	Yes Count
Bi Directional Integration of Physical & Behavioral Health	20
Transitional Care	16
Addressing the Opioid Use Public Health Crisis	18
Chronic Disease Prevention and Control	14

BI-DIRECTIONAL INTEGRATION OF CARE

- *Question 16: Which level of integration best describes your practice/clinic/organization?*

Integration Level	Count	%	Graph
Level 1	5	9%	
Level 2	19	33%	
Level 3	11	19%	
Level 4	16	28%	
Level 5	6	11%	

- *Question 17: What are your organization's biggest challenges to implementing integrated behavioral health and primary care program?*

Challenge	Count	Graph
Staffing	35	
Information technology	19	
Physical space	27	
Equipment	10	
Lack of Technical assistance (TA)	8	
Education	15	
Start-up cost is too high	12	
Long-term, sustainable funding (reimbursement)	34	
Lack of support from administrative leaders	1	
Lack of support from clinical staff	3	
Workforce shortages	29	
None	0	
Unsure where to start	6	

- *Question 18: Please rank order your organization's patient population's greatest needs that could be addressed with integrated care.*

Challenge	Average Ranking	Graph
Anxiety	3.7	
Depression	3.1	
Severe persistent mental illness (bipolar disorder, schizophrenia)	4.6	
Suicide-related	5.6	
Social Determinants of Health Needs	3.2	
Chronic Disease	2.7	
Dental Needs	5.9	
Other	2.9	

- *Question 19: Please list the top five partners or types of partners that are or would be most helpful in developing an integrated care program:*

Top Integrative Care Partners	Count	Graph
Comprehensive Healthcare	13	
SE WA Aging and Long Term Care	7	
Hospitals	7	
Managed Care Organizations	6	
Primary Care Provider	6	
Yakima Neighborhood Health Services	6	
Yakima Valley Farm Worker's Clinic	6	
Community Health of Central Washington	5	
Consistent Care	5	
Behavioral Health Agencies	4	
CHAS	4	
Community Based Organizations	4	
FQHC	4	
Kadlec Hospital and Clinics	4	
Mental health organizations	4	
Quality Behavioral Health	4	
SUD Providers	3	

- *Question 20: Please check all of the following aspects of integrated care that you are currently performing.*

Integrative Care Activities	Count	Graph
Integrated care teams	20	
Data sharing agreements between physical and behavioral health	24	
Co-location of physical and behavioral health providers in the same facility	19	
Opioid use disorder treatment	11	
Substance use disorder treatment	16	
Care team meetings or case staffing	28	
Tele-health	8	
Tele-psychiatry	10	
Enhanced collaboration	17	
Shared workforce	17	
Social Services	31	

- *Question 21: Are you currently receiving technical assistance (TA) to implement integrated care from any of the following sources?*

Technical Assistance Activities	Count	Graph
Advancing Integrated Mental Health Solutions (AIMS) Center	6	
Bree Collaborative	0	
Qualis Health	8	
Substance Abuse and Mental Health Services Administration (SAMHSA)	4	
Pediatric-Transforming Clinical Practice Initiative (P-TCPI)	4	

- *Question 22: Has your practice location been assessed using the Maine Health Access Foundation (MeHAF) or Patient-Centered Medical Home Assessment (PCMH-A)?*

Practice Assessment Tool	Yes Count	Graph
MeHAF	8	
PCMH-A	11	
Other	5	

- *Question 23: Which of the following best describes your practice's primary care/behavioral health integration planning.*

Integration Planning	Count	Graph
We have a functioning integration plan in place	13	
We are in initial stages of integration plan development	15	
We are interested in developing an integration plan	22	
We do not have a plan and are not interested in developing a plan	6	

- *Question 24: Which of the following best describes your current state of patient behavioral health assessment?*

State of Patient Assessment	Count	Graph
We screen all patients for behavioral health conditions	19	
We selectively screen patients	20	
We do not screen for behavioral conditions	13	

- *Question 27: Which evidence-based brief interventions and psychotherapies are offered to your patients by a behavioral health provider in your practice?*

Types of Interventions and Therapies	Count	Graph
Problem Solving Treatment	18	
Cognitive Behavioral Therapy	24	
Behavioral Activation	15	
None	19	

- *Question 28: Are psychiatric services available to your patients in your practice?*

Availability of Psychiatric Services	Count	Graph
Yes, onsite	13	
Yes, with a partner organization	11	
Yes, via tele-psychiatry	10	
No	30	

- *Question 29: Does your practice conduct regular (e.g. weekly) psychiatric caseload review on patients who are not improving?*

Regular Case Load Review	Count	%
Yes	13	27%
No	36	73%

TRANSITIONAL CARE

- *Question 31: Which Transitional Care Approach does your organization use for transitional care planning needs?*

Transitional Care Planning Approach	Count	Graph
Transitional Care Approach	12	
Interventions to Reduce Acute Care Transfers (INTERACT)	4	
Community Para-medicine Model	3	
Existing family and patient-centered interagency interdisciplinary collaborative care models	17	
Field-based nurse care coordinators, CHWs, and community paramedics	11	
Transitional Care Model	10	
None	14	

- *Question 32: Does your organization want to implement or expand transitional care evidence-based methods?*

Expand Transitional Care	Count	%
Yes	39	81%
No	9	19%

- *Question 33: For patients who have been discharged from the hospital, which of the following transitions of care activities has your practice adopted?*

Transitions of Care Activities	Count	Graph
Clinical case management for high risk, complex patients	19	
Medication reconciliation	27	
Patient and caregiver education using the “teach back” method	15	
Follow-up visit with primary care provider within 7 days	19	
Follow-up visit with primary care provider within 30 days	15	
Patient and family engagement in treatment plan	23	

- *Question 34: What barriers do you face when coordinating transitional care?*

Barriers to Coordination	Count	Graph
Access to transitional facilities (long term care, skilled nursing, etc.)	19	
Access to follow-up appointments (PCP, specialty care, physical therapy)	25	
Transportation	29	
Stable housing	26	
Poor social supports	30	
Lack of Community Resources	29	
Poor communication with family or caregiver	22	

- *Question 35: How does your practice manage inpatient admissions and discharges?*

Follow-up Notification	Count: Yes	Count: No	%Yes
Receive notification when one of your patients is admitted to the hospital?	19	30	39%
Receive notification when one of your patients is discharged from the hospital?	21	28	43%
Receive a discharge summary or treatment plan?	22	28	44%
Follow up / provide feedback to the hospital?	15	33	31%

- Question 36: Please tell us how you receive or send communications involving transitions of care:

Communication Type	Count	Graph
Shared EHR	8	
Regional or statewide HIE	11	
Fax	21	

- Question 37. Does your organization have any of the following (transitional care planning):

Transitional Care Planning	Count	Graph
Transitional care planning for Medicaid behavioral health patients only	6	
Transitional care planning applied to all behavioral health patients	13	
Transitional care planning applied to all in-patient medical patients	13	
No, we do not have transitional care planning	26	

- Question 38. If your hospital is currently conducting systematic screening to determine the risk of hospital readmission, which tool are you using?

Readmission Screening Tool	Count
LACE tool	1
HOSPITAL score	1
BOOST / 8Ps	2

- Question 39. Do you receive a discharge summary or treatment plan?

Receive Treatment Plan	Count	Graph
Yes, directly from the discharging facility	17	
Yes, the patient provides a copy	9	
No	22	

- Question 40. Does your organization communicate any discharge concerns with the hospital and/or primary care when the patient is discharged from the hospital?

Discharge Communication	Count	Graph
Yes, we regularly exchange information	16	
Yes, but communication varies based on the provider	14	
Yes, but we seldom get feedback in return	5	
No, we do not regularly communicate with medical providers	12	

- Question 41. How does your organization analyze and trend readmission data, and look for root causes:

Readmission Data Analysis	Count	Graph
Reassesses the effectiveness of discharge planning process on an ongoing basis	10	
Tracks readmissions to hospital on an ongoing basis (at least quarterly)	17	
Tracks Emergency Department utilization	16	
We don't analyze readmission data	30	

- *Question 42. How does your organization notify primary care providers (and other involved services such as in-home and skilled nursing facilities) of their patient’s emergency department visit and/or hospital admission?*

PCP Notification Method	Count	Graph
Electronic health record (EHR)	15	
Health information exchange (HIE)	9	
Fax	16	
Direct Messaging	14	
No notifications to providers	14	

Addressing the Opioid Use Crisis

- *Question 44. Which opioid prescribing guidelines does your practice follow?*

Opioid Prescribing Guidelines	Count	Graph
The Bree Collaborative	2	
CDC - Center for Disease Control and Prevention	14	
AMDG - Agency Medical Directors' Group	2	
6 Building Blocks guidelines	1	
SUDP - Substance Use During Pregnancy None	0	
Not currently using any prescribing guidelines	20	

- *Question 45. What proportion of the clinicians participating at your practice sites have undergone training on opioid prescribing guidelines?*

% of Clinicians Receiving Training	Count	Graph
75-100%	14	
50-74%	4	
25-49%	2	
Less than 25% of providers trained	8	
No providers trained at this time	24	

- *Question 46. Does the practice/clinic site offer clinical decision support for opioid prescribing guidelines through an EHR or through another system?*

Opioid Clinical Decision Support	Count	Graph
Yes	14	
No	37	

- *Question 48. Are any of the following used in your practice to implement opioid prescribing guidelines and/or ensure safe opioid prescribing practices?*

Opioid Implementation Protocol	Count
Use written patient/provider agreements	22
Include documentation in patient records	22
Provide patient education	22

- **Question 49.** Do any providers in your practice prescribe medication assisted treatment (MAT)?

Use of MAT Therapy	Count	Graph
Yes, buprenorphine	12	
Yes, methadone	4	
Yes, naltrexone	3	
Yes, some other form	1	
No	31	
Unsure	5	

- **Question 50.** Have providers in your practice been trained in the Buprenorphine Waiver Training program?

Buprenorphine Waiver Training	Count	Graph
Yes	12	
No	36	

- **Question 51.** What systems, if any, are in place to ensure people with opioid use disorders (OUDs) are connected to the acute care and recovery services they need?

Coordination of Care for OUD	Count	Graph
Employment with providers who offer these services	6	
Contracting with providers who offer these services	5	
Formalized referral relationship (through MOU or a similar arrangement)	14	
Informal referral relationships with providers who offer these services	35	
None	10	

- **Question 52.** What is your protocol for patients/clients with opioid use or substance use disorder when they relapse?

Protocol for OUD/SUD Relapse	Count	Graph
Yes	18	
No	16	

- **Question 53.** If you have an ED site, do you have protocols in place to offer overdose education and take home naloxone for individuals seen for opioid overdose?

Patient Protocol for OUD/SUD	Count	Graph
Overdose education	11	
Take-home naloxone	7	
Peer education	4	

- **Question 56.** Do you have protocols in place that refer people with opioid use disorders to providers of medication-assisted treatment?

MAT Referral Protocol	Count	Graph
Yes	20	
No	29	

Chronic Disease Prevention and Control

- *Question 58. Does your practice routinely assess and document patients for the following risk factors?*

Risk Factors	Count	Graph
Adverse Childhood Experiences (ACES)	19	
Alcohol use	35	
Cholesterol	20	
Depression / other mental illness	34	
Diabetes risk	25	
Domestic Violence	28	
Drug abuse	35	
Exercise / inactivity	24	
High risk sexual behavior	23	
Housing	26	
Hypertension	23	
Medication adherence	29	
Nutrition / Healthy Eating	30	
Obesity	24	
Tobacco use	33	
Transportation	24	

- *Question 59. If only screening some patient for risk factors, which patients receive screening?*

Patients Screened	Count	Graph
Patients under age 65	7	
Patients equal to or over age 65	7	
Multiple diagnosis and co-morbidities	7	
Greater than 5 complex medications	5	
Impaired mobility	6	
Impaired self-care skills	6	
Poor cognitive status	7	
Catastrophic injury or illness	4	
Homeless	7	
Poor social supports	8	
Chronic illness	9	
Anticipated long term health care needs	5	
Substance abuse	7	
History of multiple hospital admissions	7	
History of multiple ED visits	6	
All patients	31	

- **Question 61.** Does your practice have a well-defined intervention program (written care plan, tool kit, or referral source) to specifically address those risk factors?

Intervention Programs	Count	Graph
Adverse Childhood Experiences (ACES)	15	
Alcohol use	25	
Cholesterol	14	
Depression / other mental illness	29	
Diabetes risk	20	
Domestic Violence	20	
Drug abuse	26	
Exercise / inactivity	15	
High risk sexual behavior	12	
Housing	16	
Hypertension	20	
Medication adherence	22	
Nutrition / Healthy Eating	17	
Obesity	17	
Tobacco use	22	
Transportation	15	

- **Question 62.** Please select the response option that best describes your practice:

Intervention Programs	Count	Graph
Our practice offers the Stanford Chronic Disease Self-Management Program (CDSMP)	8	
Our practice offers the National Diabetes Prevention Program (NDPP)	6	
Our practice does not offer or refer to the CDSMP	9	
Our practice refers patients to a local/community-based organization that offers CDSMP	18	

- **Question 63.** Our organization currently offers the following chronic disease self-management or educational classes:

Self-Management Programs	Count	Graph
Asthma education	8	
Home visits for asthma services	7	
COPD - Chronic Obstructive Pulmonary Disease - education	6	
Home visits for COPD - Chronic Obstructive Pulmonary Disease - services	8	
Hypertension education	7	
Home visits for hypertension	8	
Support for home-based blood pressure monitoring	11	
Diabetes education	20	

- **Question 64.** Do you monitor patients, ages 5-64 years, for appropriately dispensed asthma medication and treatment period for persistent asthma?

Asthma Monitoring	Count	Graph
Yes	23	
No	30	

Care Coordination

- *Question 66. Does your practice track referrals to any of the following?*

Referral Tracking	Count	Graph
Behavioral health	32	
Primary Care	25	
Specialty care	29	
Social services	28	
Community-based resources	31	
No	12	

- *Question 67. What do you most need to become a trauma-informed care practice?*

Trauma Informed Practice Needs	Count	Graph
Training and technical assistance	31	
Additional information	17	
Stipend or resources for staffing	27	
Cultural challenges	13	
Help with language barriers	8	
Not going to implement	2	
Already implementing	17	

- *Question 68. What do you most need to implement One Key Question (Intentional Pregnancy Planning)?*

Intentional Pregnancy Planning	Count	Graph
Training and technical assistance	15	
Additional information	13	
Stipend or resources for staffing	9	
Cultural challenges	8	
Help with language barriers	6	
Not going to implement	24	
Already implementing	4	

- *Question 69. What do you most need to provide long-acting reversible contraceptives?*

LARC Needs	Count	Graph
Training and technical assistance	10	
Additional information	7	
Stipend or resources for staffing	7	
Cultural challenges	7	
Help with language barriers	5	
Not going to implement	26	
Already implementing	11	

- *Question 70. What do you most need to increase chlamydia screenings in women ages 16-24?*

Chlamydia Screening	Count	Graph
Training and technical assistance	11	
Additional information	8	
Stipend or resources for staffing	9	
Cultural challenges	6	
Help with language barriers	4	
Not going to implement	23	
Already implementing	14	

- *Question 71. If only screening some patients, which patients receive screening?*

Chlamydia Screening	Count	Graph
Patients under age 65	5	
Patients equal to or over age 65	3	
Multiple diagnosis and co-morbidities	4	
Greater than 5 complex medications	3	
Impaired mobility	3	
Impaired self-care skills	3	
Poor cognitive status	4	
Catastrophic injury or illness	3	
Homeless	3	
Poor social supports	4	
Chronic illness	3	
Anticipated long term health care needs (e.g. new diabetic)	2	
Substance abuse	7	
History of multiple hospital admissions	4	
History of multiple ED visits	6	
All patients	19	

- *Question 72. Which self-care skills does your organization teach patients and their families using the teach-back technique:*

Self-Care Skills	Count	Graph
Education and training provided to the patient or patient's caregiver(s) is tailored to the patient	23	
Teach-back is used to confirm understanding	15	
Teach-back technique is not used, but we would like to	16	

- Question 75. Which of the following best describes your process to provide care management/coordination services to the patients you identify as high-risk?

Care Management/Coordination for High Risk Patients	Count	Graph
We provide ongoing care management/coordination services to all high-risk patients	16	
We provide care management/coordination services to some high-risk patients, but not all are identified	20	
We identify high-risk patients, but we do not have the resources or capacity to provide care	8	
We provide care management/coordination services for only those high-risk patients for which we	2	
Our practice does not identify high-risk patients	1	

- Question 76. Who is providing care management or care coordination to patients in the ED that need those services?

Care Management/Coordination for ED Patients	Count	Graph
Hospital Case Management	23	
Managed Care Case Management	8	
Have contracted Case Management	4	
Area Aging on Long-Term Care	7	

Domain 1: Workforce

- Question 78. What are the most significant workforce challenges at your organization?

Most Significant workforce Challenges	Average Rank
Recruitment	1.37
Retention	2.31
Training	2.53

- Question 79. What type of in-person training would you like to offer your staff?

Staff In-Person Training Needs	Count	Graph
Cultural sensitivity	35	
Trauma-informed approach and trauma-specific interventions	39	
Long-Acting Reversible Contraceptives (LARC)	11	
How to maximize Medicaid reimbursements	25	
How to utilize the full functionality of your EHR	17	
Time management	24	
Financial incentives related to Patient Centered Medical Homes	13	
Emerging evidenced-based practices	37	
Oral-systemic link	15	
Alternatives in pain management	23	
Community Health Workers	27	
How to drive the shift to Value-Based Payment/reimbursement	25	
Population Health strategies	31	
Benefits of Bi-Directional Integration of Physical and Behavioral Health	27	
Changes in policies related to HIPPA	31	
Buprenorphine Waiver Training Program	12	
Prescription Drug Monitoring Program	17	

Domain 1: Health IT

- *Question 80. Are you currently considering a change or upgrade to your current EHR system?*

EHR Change or Upgrade	Count	Graph
Yes	20	
Maybe	5	
No	28	

- *Question 81. Does your practice use a population-based registry to systematically track patients?*

Population-based Registry	Count	Graph
Yes	19	
No	35	

- *Question 82. Do you currently have a population health management system?*

Population-health Management	Count	Graph
Yes	16	
No	37	

- *Question 84. Are you interested in a compatible EHR (electronic health record)/EBR (electronic behavioral health record) platforms to support health information exchange?*

Support HIE	Count	Graph
Yes	32	
No	6	
Unsure	15	

- *Question 85. What is the source of data your practice uses for quality improvement and population health management?*

QI and PHM Data Source	Count	Graph
Electronic Health Record	35	
Insurance company reports (public and private)	20	
Health system	10	
Outside data vendor	9	
Free standing registry	17	
Other (please specify below)	25	

- *Question 86. Is your organization interested in the following investment opportunities?*

Interest in Investment Opportunities	Count	Graph
Advocating for scope of practice changes	23	
Shared recruitment and retention tools	29	
Placing nursing students and residents from local community colleges in internships and practicums	38	
Shared workforce (e.g., specialists)	29	
Mobile workforce (e.g., mobile dental van)	32	
Virtual team-based care	28	
Population health management: training in how to make a referral, use a registry, etc...	33	
AIMS Center Bi-directional Integration Training	29	
AIMS Center Problem-Solving Treatment Training	25	
AIMS Center Patient Activation Training	23	

- Question 87. Please answer the following regarding population health management:

Population Health Management Opportunities	Count	Graph
Are you interested in a shared population health management strategy?	49	
Are you interested in investing in a compatible EHR platform to support health information exchange?	29	

- Question 88. Please identify which of the following HIT/HIE tools your organization currently uses:

HIT / HIE Tools	Count	Graph
Certified EHR	28	
Direct Secure Messaging (DSM)	14	
Exchange using EDIE	24	
Exchange using PreManage	9	
Exchange using OHP/CDR	9	
Manual exchange (paper, fax)	32	
Patient Portal	26	
Regional Health Information Exchange	10	
Population Health Patient Registry	12	
WA State Prescription Monitoring Program	24	
Washington State Immunization Information System	23	
All	3	
None	7	

- Question 89. Which payment pathway or quality program are you planning to participate in during the 2018 performance year?

Quality / Payment Programs	Count	Graph
Merit-based Incentive Payment System (MIPS)	16	
Medicare Shared Savings Program	11	
Advanced Alternative Payment Model (AAPM)	5	
Physician Quality Reporting System (PQRS)	15	
Meaningful Use	19	
WA State Performance Measures Coordinating Committee (PMCC) Statewide Measure Set	2	
Medicare Access and CHIP Reauthorization Act (MACRA)	8	
NCQA Patient-Centered Medical Home (PCMH)	10	
Other Patient-Centered Medical Home (PCMH)	1	
WA Managed Care Organization (MCO) measures	13	
1519 Cross-System Outcome Measures for Adults Enrolled in Medicaid	3	

Syringe Exchange Program

- Question 96. Are you tracking clients who use the syringe exchange service (e.g., assign each individual a number or code)?

Tracking Syringe Exchange Clients	Count	Graph
Yes	1	
No	17	

- Question 97. Did your CBO receive technical assistance to organize or expand a syringe exchange program?

TA to Organize / Expand Syringe Exchange	Count	Graph
Yes, we received technical assistance	1	
We asked for but did not receive technical assistance	0	
We did not ask for technical assistance	17	

- Question 98. Did your program distribute naloxone kits at any point in 2017?

Distribute Naloxone Kits	Count	Graph
Yes	5	
No	18	

- Question 99. What are the top reported drugs being used by your clients?

Top Reported Drugs	Count	Graph
Heroin	10	
Fentanyl	6	
Oxycodone/Hydrocodone	11	

- Question 100. Please rank order what services the clients in your program most need?

Top Reported Drugs	Count	Graph
Housing	15	
Transportation	15	
Legal	13	
Language	10	
Nutrition	14	
Employment	14	
Child Care	14	
Peer Support	10	
Mentoring	12	
Community education	13	
Detox	14	
MAT - Medication Assisted Treatment Overdose Prevention	11	
SUD - Substance Use Disorder Treatment Recovery Supports	15	

- Question 101. Do you have protocols in place to refer people with opioid use disorders to providers of medication-assisted treatment?

Referral Protocols for MAT	Count	Graph
Yes	11	
No	16	

EMS First Responders

- *Question 105. Do you currently have an electronic medical record or other electronic documentation of patient / client contacts with the community para-medicine program plan?*

Paramedicine EHR	Count	Graph
Yes	3	
No	18	

- *Question 106. What are the priority populations you plan to focus on with the community para-medicine program?*

Paramedicine Priority Populations	Count	Graph
High utilizers of emergency medical services - EMS	7	
Chronic Conditions	6	
Homeless	3	
Mental Health Conditions	4	
Patients recently discharged from in-patient services	6	
High utilizers of the Emergency Department	6	
Specific facilities (homeless shelters, etc.)	2	

- *Question 107. Would you or your organization be willing to conduct the following activities:*

Paramedicine Activities	Count	Graph
Health screening (e.g. diabetes)	14	
Health fairs	19	
Safety education	16	
Follow-up visits post-inpatient discharge	17	
Follow-up visits post-ED visit	16	
None	1	

- *Question 108. What types of training would be most beneficial to your organization?*

Paramedicine Training Activities	Count	Graph
Trauma-informed care	13	
Community health worker	15	
Suicide prevention	17	
Cultural competency	14	
Medicaid billing	7	
Medicaid Assisted Treatment orientation	5	
None	3	

Robert Wood Johnson Foundation County Health Rankings 2017, State Population (Attachment 1.7)

RWJF County Health Rankings, 2017
Statewide Population

		■ Worse than average ■ Better than average									Graph
		Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	WA State
County Demographics	Population	22,105	190,309	3,944	88,807	2,219	43,269	60,338	48,177	248,830	7,170,351
	% below 18 years of age	20.7%	26.7%	18.5%	33.1%	19.8%	17.8%	21.4%	15.0%	29.8%	23%
	% 65 and older	21.2%	13.8%	27.4%	8.3%	25.1%	15.1%	16.9%	10.0%	13.1%	14%
	% American Indian and Alaskan Native	1.6%	1.2%	1.6%	1.5%	0.5%	1.2%	1.4%	0.8%	6.2%	2%
	% Hispanic	3.8%	21.0%	6.9%	52.4%	5.2%	8.9%	21.6%	5.9%	48.3%	12%
	% Non-Hispanic white	91.0%	71.5%	87.9%	41.5%	91.3%	84.1%	72.1%	79.6%	44.3%	70%
	% not proficient in English	0.3%	4.0%	0.9%	14.1%	0.2%	1.3%	4.3%	1.3%	11.1%	4%
	% Females	51.5%	49.8%	50.3%	48.1%	50.6%	49.7%	48.8%	49.1%	50.0%	50%
	% Rural	6.7%	10.6%	34.3%	13.3%	100.0%	40.1%	17.1%	27.5%	23.5%	16%
Social & Economic Factors	Median household income	\$ 46,573	\$ 62,698	\$ 40,209	\$ 58,246	\$ 47,087	\$ 47,378	\$ 50,120	\$ 43,817	\$ 46,891	\$ 64,100
	Income inequality	4.4	4.5	4.3	3.9	3.9	5.4	4.7	7.2	4.0	4.5
	Unemployment	5%	7%	6%	8%	6%	6%	6%	5%	8%	6%
	High school graduation	67%	79%	N/A	75%	N/A	82%	80%	87%	73%	81%
	Children in poverty	24%	20%	25%	21%	22%	16%	21%	14%	16%	16%
	Children: free or reduced price lunch	54%	52%	56%	74%	47%	44%	57%	35%	76%	46%
	Children in single-parent households	34%	31%	20%	34%	23%	25%	32%	25%	39%	29%
	Social associations	11.3	9.0	15.1	6.7	13.5	9.6	9.0	10.5	8.5	9.0
	Violent crime	235	214	83	237	177	116	215	148	288	290
	Injury deaths	75	54	80	38	N/A	65	71	43	63	61
Health Behaviors	Adult smoking	16%	14%	17%	16%	16%	16%	15%	16%	17%	15%
	Adult obesity	33%	32%	30%	30%	33%	29%	28%	23%	30%	27%
	Food environment index	7.4	7.9	6.8	7.7	4.4	6.4	7.5	5.9	8.1	7.6
	Physical inactivity	22%	19%	22%	17%	28%	17%	20%	16%	24%	17%
	Access to exercise opportunities	73%	82%	66%	55%	74%	72%	76%	78%	69%	88%
	Excessive drinking	18%	20%	15%	19%	18%	19%	20%	21%	17%	18%
	Alcohol-impaired driving deaths	60%	24%	100%	28%	0%	31%	16%	27%	50%	35%
	Sexually transmitted infections	325.6	358.8	223.2	496.3	221.6	399.3	324.2	672.1	613.7	381.2
	Teen births	40	36	25	60	N/A	9	28	4	59	26
	Food insecurity	15%	12%	15%	9%	13%	17%	13%	20%	12%	14%
Limited access to healthy foods	5%	4%	10%	12%	36%	10%	7%	8%	5%	5%	
Drug overdose deaths	N/A	14	N/A	7	N/A	11	19	8	9	14	
Clinical Care	Uninsured	11%	11%	12%	18%	9%	12%	14%	10%	18%	11%
	Primary care physicians ratio	1,057	1,413	996	3,252	2,215	1,575	798	1,511	1,432	1,190
	Dentists ratio	2,211	1,475	1,315	2,537	2,219	2,704	1,341	2,834	1,595	1,270
	Mental health providers ratio	381	570	563	925	2,219	709	434	753	431	360
	Preventable hospital stays	33	47	38	41	37	47	25	43	45	33
	Diabetes monitoring	84%	86%	86%	87%	86%	90%	88%	88%	88%	86%
Mammography screening	66%	65%	43%	61%	77%	62%	63%	60%	59%	61%	
Outcomes	Premature death	6,714	5,239	8,170	4,898	N/A	5,106	6,530	4,868	7,106	5,500
	Poor or fair health	16%	14%	16%	21%	14%	15%	16%	16%	24%	14%
	Poor physical health days	4.2	3.5	4.0	4.0	3.7	3.7	3.9	4.1	4.5	3.6
	Poor mental health days	3.8	3.5	3.9	3.9	3.7	3.8	3.6	4.1	4.1	3.7
	Diabetes prevalence	13%	10%	12%	7%	14%	8%	10%	7%	10%	9%

Source: 2017 RWJF County Health Rankings

2017 Master County Tables B Present w/lookup

Greater Columbia ACH Area Deprivation Index Map (Attachment 1.8)

